State of Vermont
Agency of Human Services

Global Commitment to Health
11-W-00194/1

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

Quarterly Report for the period
July 1, 2016 – September 30, 2016

Submitted Via PMDA Portal on November 30, 2016

Table of Contents

I. Background and Introduction

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

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

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

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

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

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

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

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

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

As Vermont's Medicaid Single State Agency and under the Terms and Conditions of the Global Commitment to Health Waiver, AHS has entered into an Inter-governmental Agreement (IGA) with the Department of Vermont Health Access (DVHA). The AHS/DVHA IGA functions similarly to a Medicaid Managed Care contract in that it delineates program requirements and responsibilities between AHS and DVHA and according to federal Medicaid Managed Care requirements found at 42 CFR 438. DVHA also has sub-agreements with the other State entities that provide specialty care for GC enrollees (e.g., mental health services, developmental disability services, and specialized child and family services).
One of the Terms and Conditions of the Global Commitment Waiver requires the State to submit progress reports 60 days following the end of each quarter. ***This is the third quarterly report for waiver year 11, covering the period from July 1, 2016 through September 30, 2016 (QE0916).***

II. Enrollment Information and Counts

Key updates from QE0916:

- There were enrollment fluctuations greater than 5% this quarter (7.62%).

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

Table 1 is populated based on reports run the Monday after the last day of the quarter, in this case on October 3, 2016. Results yielding ≤5% fluctuation from quarter to quarter are considered as illustrating normal deviations reflecting retroactive eligibility determinations and expected terminations. Results reflecting >5% fluctuation between quarters are reviewed by staff from DVHA and AHS to provide further detail and explanation of the changes in enrollment. The explanation of any substantial fluctuations observed in Demonstration Populations during QE0916 would be in Section VII: Member Month Reporting. During this quarter, there was an unusually large overall drop in enrollment with fluctuations of -7.62% across the Demonstration Populations.

Table 1. Enrollment Information and Counts for Demonstration Populations*, QE0916

Demonstration Population	Current Enrollees Last Day of Qtr	Previously Reported Enrollees Last Day of Qtr	Percent Variance 6/30/2016 to 9/30/2016	Variance by Enrollee Count 6/30/2016 to 9/30/2016
	September 30, 2016	June 30, 2016		
Demonstration Population 1:	28,747	32,887	-12.59%	(4,140)
Demonstration Population 2:	74,899	82,228	-8.91%	(7,329)
Demonstration Population 3:	57,523	60,838	-5.45%	(3,315)
Demonstration Population 4:	2,877	2,865	0.42%	12
Demonstration Population 5:	1,019	1,003	1.60%	16
Demonstration Population 6:	797	819	-2.69%	(22)
Demonstration Population 7:	7,698	7,552	1.93%	146
Demonstration Population 8:	4,235	4,263	-0.66%	(28)
	177,795	192,455	-7.62%	

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

III. Outreach Activities

i. Member Relations

Key updates from QE0916:

- Provider Enrollment
- Payment Error Rate Measurement (PERM)
- The Medicaid and Exchange Advisory Board (MEAB)

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

Provider Enrollment

Due to 42 CFR §§455.410 and §455.450 that require all providers, whether new or existing, be screened, the PMR Unit is experiencing a delay in processing new enrollments. At this time our Fiscal Agent, Hewlett Packard Enterprise is averaging 300 new applications a month. The PMR Unit provides an expedited renewal process if a provider has extenuating circumstances and needs to be enrolled immediately as not doing so will hinder necessary care to members. These situations are reviewed by PMR on a case on a case by case basis.

Payment Error Rate Measurement (PERM)

The FY2016 Centers for Medicare and Medicaid Services (CMS) Payment Error Rate Measurement (PERM) first phase of the audit was done October 17 - 28, 2016 . The audit is derived from the Improper Payments Information Act of 2002 (IPIA; Public Law 107-300). The IPIA directs Federal agencies to annually review its programs and report any improper payments to Congress. Because the Department of Vermont Health Access (Vermont Medicaid) is identified as a federal program, our participation is both active and required. The auditors reviewed 1268 claims. We received a favorable exit review and final findings will be published Summer 2017. DVHA is still collecting data from the provider community for quarter 3 and quarter 4 for federal fiscal year 2016 (October 1, 2015 to September 30, 2016). Auditors will return in March 2017 for the final review.

Medicaid and Exchange Advisory Board (MEAB)

The Medicaid and Exchange Advisory Board (MEAB) held meetings on July 25, 2016, August 22, 2016, and September 24, 2016. Agendas and minutes are publicly posted at: http://info.healthconnect.vermont.gov/advisory_board/meeting_materials

IV. Operational/Policy Developments/Issues

i. Vermont Health Connect

Key updates from QE0916:

- Vermont Health Connect completed outreach to more than 75,000 MAGI Medicaid households.
- High call volume related to Medicaid renewals led to long summer wait times; Maximus expanded staffing capacity to meet service level targets for the fall and beyond.
- Operational metrics related to integration, work processing, and escalated cases improved dramatically after the spring defect-remediation effort and stayed strong throughout the quarter.

Medicaid renewals were a major focus during QE0916. During the previous quarter, VHC had contacted more than 26,000 MAGI Medicaid households from the State's legacy system (ACCESS) to help them transition to Medicaid or qualified health plans in the Vermont Health Connect (VHC) system, then proceeding with redeterminations and verifications for MAGI Medicaid members whose cases are already in the VHC system (approximately 54,000 households). The effort continued at a pace of 9,000 households per month and consisted of an initial notice, a reminder notice a few weeks later, and a closure notice the following month. By the end of QE0916, over 90 percent of MAGI Medicaid households had been contacted, with the balance largely consisting of "mixed households" – those households that have members in both qualified health plans (QHP) and Medicaid. These mixed households are slated to be renewed during QHP open enrollment in QE1216.

In addition, monthly redeterminations for Medicaid for the Aged, Blind and Disabled (MABD) beneficiaries – which had restarted in November 2015 – continued at a rate of approximately 1,000 households per month throughout the quarter.

Vermont Health Connect and Optum deployed its final system upgrade in March in order to enable the processing of Medicaid renewals. With the completion of major system development work, the teams no longer had to manage continual cycles of major code changes. Instead they could focus on identifying and remediating defects and making process improvements within a stable system. This effort came to be known as the Maintenance and Operations (M&O) Surge. The M&O Surge ran throughout QE0616 and and was completed in QE0916.

The results of the M&O Surge were clearly visible by the start of QE0916. Escalated cases were down 80 percent from March levels. Integration errors were also down 80 percent. Customer requests were being processed in an increasingly timely manner. The Level 1 Customer Support Center was resolving more phone calls themselves without having to transfer.

In addition, VHC had set a target earlier in the year of completing 75% of customer requests within ten days by October. This target was set after the unit completed 56% of requests within ten days over first ten weeks of the year. The Surge's technical fixes, combined with refinements to staff training and structure, enabled VHC to exceed the target ahead of schedule. Over the course of QE0916, more than 84% of all customer requests were completed within ten days.

All of this happened at a time that, with Medicaid renewals, the Customer Support Center and Health

Access Eligibility and Enrollment Unit were experiencing the highest call volumes of the year --even higher than during QHP open enrollment.

Maximus continues to manage the VHC Customer Support Center (call center), but struggled to adequately hire staff in Burlington, Vermont during the spring and summer, utilizing 89 customer service representatives (monthly average for the quarter). The call center serves Vermonters enrolled in both public and private health insurance coverage, providing Level 1 call center support, which includes phone applications, payment, basic coverage questions, and change of circumstance requests. Maximus is also the entry point for individuals requiring greater levels of assistance with case resolution. Maximus representatives transfer such calls to the State's Health Access Eligibility & Enrollment Unit for resolution and log service requests, which are escalated to the appropriate resolver group. The Customer Support Center struggled with incoming call volume, receiving approximately 175,000 calls over the quarter – more than a 30% increase over the previous quarter -- with an abandon rate of 25.39% and answering more than half (52.03%) of calls within 30 seconds.

On August 1, after meetings with DVHA leadership, Maximus agreed to open an overflow call center in Chicago and to more than double its staff capacity in order to ensure a prompt turnaround. This aggressive action brought service performance to appropriate levels by the second half of September.

Throughout QE0916, the system continued to operate as expected. The average page load time for the quarter was about 1.2 seconds – well under the two second target – and minimal downtime resulted in availability of more than 99.9%.

Vermont Health Connect was supported throughout the state by 217 Assisters (51 Navigators, 86 CACs, and 80 Brokers) in QE0916. Many of these CACs work for a Department of Corrections contractor and focus on helping connect justice-involved individuals with coverage. Overall, Navigators and CACs largely focused on helping Vermonters with Medicaid renewals, particularly new Vermonters who speak English as a second language and others with accessibility challenges. Navigators alone had more than 5,000 consultations in the quarter.

Health insurance literacy was a major focus of outreach work in QE0916. Vermont Health Connect also engaged health care providers, libraries, state offices, and legislators in helping Vermonters understand the importance of responding to Medicaid renewal notices and comparing options for qualified health plans. Vermont Health Connect's website continued to be a key source of information for current and prospective customers alike, receiving more than 180,000 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.

ii. Choices for Care

Key updates from QE0916:

- Implemented a 2% rate increase for Choices for Care 9/1/2016.
- Choices for Care legislative "savings" for reinvestment.
- HCBS regulations and conflict-free case management.

Rate Increases

The Department of Disabilities, Aging and Independent Living (DAIL) received legislative approval for its annual budget for State Fiscal Year (SFY) 2017 beginning July 1, 2016. The budget included a 2% rate increase for Choices for Care home-based and Enhanced Residential Care services. Rates were implemented effective 9/1/2016.

Legislative Report

Each year, DAIL is required to submit a legislative report on "The Adequacy of the Choices for Care Provider System" by October 1st. The report is intended to outline areas of need in order to inform the Choices for Care program "savings" and "reinvestment" process as defined by the legislature via Budget Adjustment Act (BAA) testimony.

This year the report identified some recurring themes:

- Staffing shortages
- Moderate Needs funding
- Lack of adequate housing & residential care options (especially for people with complex needs)

It is anticipated that approximately $800,000 will be available to "reinvest" back into long-term services and supports. Due to the timing of the BAA process, any reinvestment approved by the legislature would likely be implemented either mi-year SFY2017 or the beginning of SFY2018.

The full report can be found at: http://legislature.vermont.gov/assets/Legislative-Reports/CFC-Adequacy-Report-9.6.16-v3.pdf

HCBS Federal Regulations

During this reporting period, Vermont continued discussions with stakeholders and CMS about the federal HCBS (Home & Community-Based Services) regulations and conflict-free case management. After some technical assistance calls with CMS, Vermont submitted a written communication to CMS on July 19, 2016 inviting CMS to help Vermont develop a plan that aligns the State's objectives while mitigating any unintended consequences in addressing conflicts of interest. The State intends to use the CMS response to develop next steps regarding conflict-free case management. NOTE: As of 9/27/16, the State had not received a response to the communication.

iii. Global Commitment Register

Key updates from QE0916:

- Since the Global Commitment Register (GCR) launched in November 2015, 51 final GCR policies have been publicly posted.

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

engaging with stakeholders as an essential part of any policy change, and has fully integrated stakeholder engagement into the change process via the GCR.

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

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

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

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

V. Expenditure Containment Initiatives

i. Medicaid Shared Savings Program

Key updates from QE0916:

- As of September, 74,783 Medicaid beneficiaries are attributed to two accountable care organizations (ACOs) through the Vermont Medicaid Shared Savings Program (VMSSP).
- Year 2 preliminary final financial and quality data calculated and sent to ACOs for validation.

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

Beneficiary attribution in the VMSSP remains stable, with 1015 providers participating in the program and 74,783 total beneficiaries attributed—43,404 lives in OneCare Vermont (OCVT) and 31,379 lives

in Community Health Accountable Care (CHAC).

In September, DVHA worked with its analytics contractor to calculate preliminary final financial and quality results for Year 2 of the VMSSP. These calculations were sent to the ACOs for review and validation, and results will be made public and any achieved savings for Year 2 will be distributed in Q4 2016.

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

ii. Vermont Chronic Care Initiative (VCCI)

Key updates from QE0916:

- The VCCI completed the third quarter of business operation in the new Medicaid Management Information System/Care Management (MMIS/CM).
- The VCCI team continued collaboration with AHS Enterprise Partners and the Enterprise MMIS/CM vendor, eQ Health, for completion of Release 1 requirements and user acceptance testing (UAT) toward the release one (R1) final deployment scheduled for deployment in fall 2016.

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

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

The VCCI continues its collaboration with two ACO partners and the Blueprint for Health, to enhance the number of hospitals providing secure File Transfer Protocol (FTP) data feeds for its focused efforts

on transitions in care and prevention of 30-day hospital readmissions. Unfortunately, it has been challenging to expand beyond the current 6 hospitals that provide these data for collaborative case management for our Medicaid members transitioning from the inpatient to outpatient setting. While the VCCI receives electronic data from 6 partner hospitals, the goal to standardize and receive electronic census data from all hospitals in FFY 2016 will not be achieved. The VCCI has updated and standardized a template with eQH for the new data elements and to assure all hospitals are sharing the same data for upload into eQSuite and consideration of acuity and utilization patterns (predictive risk) in 'real time'. This will continue to be a goal for FFY 2017 in order to optimize the enhanced capability of the eQHealth data management system and to enable direct referrals to VCCI case managers based on this point in time data, and allow case managers to intervene upon hospital discharge to lessen the risk of readmission.

The VCCI has supplemented its embedded model with a nurse 'liaison role' to each hospital given space constraints at provider and hospital sites. All 14 hospitals have a designated VCCI staff 'liaison' assigned who meets with hospital case managers to support the reduction of Ambulatory Care Sensitive (ACS) ED utilization by assuring member access to a Medical Home, as well as support transitions from inpatient to outpatient care to avoid 30-day readmission rates. Liaisons also meet with several large Medicaid practices to support referrals and communication on high risk members – a common metric among VCCI, Blueprint and ACO partners. VCCI and ACO leadership have had to suspend proactive meetings on service collaboration and coordination due to challenges and limitations of provider practices to meet with care managers. This limitation is largely related to staff availability and data limitations given care management system transitions among partner organizations. There continues to be a push-back from ACO and Blueprint/CHT partners on referrals to the Medicaid/VCCI staff, although several are proactively working with VCCI and see the benefit of this partnership, given resource constraints as well as common goals (clinical and financial). Internal meetings have ensued among the DVHA senior leadership team, the Blueprint for Health and VCCI to level set and support community referrals to the VCCI local staff, thus minimizing the danger of service replication and maximizing capacity building for Medicaid member supports.

The vision of enhanced local coordination and a single plan of care remains a component of the long term state vision. The AHS Enterprise MMIS Care Management system offers this opportunity as part of the 'future state' for AHS Departments and partner data sharing. Specifically, the Enterprise Medicaid Management Information Systems/Care Management Solution will support the work initiated in our SIM grant. In addition to provider and consumer portals, the vision is to have the Enterprise MMIS/CM system accept data interfaces from the Medicaid contracted next generation ACO, scheduled to launch in 2017. This will leverage and maximize the CMS investments to the State via ACA funding.

<u>Medicaid Obstetric and Maternal Supports (MOMS) Care Management Services</u>

The VCCI initially launched the service line for pregnancy case management in October 2013 and which has steadily evolved based on staff and partner input. There is a centralized resource/expert available to the field staff as well as community and statewide partners. Since this change in structure and staff, the initiative had been able to move forward at an accelerated rate, developing and administering a training curriculum for VCCI and community partner staff to help facilitate a common approach to care management for Medicaid members who are pregnant. The MOMs resource is increasingly being utilized as evidenced by an increase in referrals this past quarter and likely related to the replacement of the MOMS case manager in the same time frame. This position is an important resource to the statewide VCCI team as well as to our partners supporting at risk pregnant women and

women of child bearing years. As we mature our new case manager in this role, we also anticipate the expansion of pregnancy case management in the new eQH system, scheduled as part of release 2 in early 2017.

Enterprise Care Management vendor transition:

The VCCI was the initial DVHA unit to go live in the new enterprise care management system with eQHealth (eQH) late in CY 2015. The VCCI was heavily engaged in planning and development of system design including data migration, development of eligibility rules, workflow mapping, assessments and related alerts in the new system. These efforts led to the VCCI staff assisting with UAT for system functionality and successful Go-Live in December 2015. During the first quarter, the VCCI and MMIS project team were challenged by technical issues (bugs, defects; data transfer) and supplemental functionality released, such that staff have been unable to build back up to their normal case load level of 25 or greater cases/FTE. This coupled with staff engaged in training, and additional UAT; as well as the decline in overall VCCI FTE's with the sun-setting of the former vendor, guarantees a decline in overall caseload for the remaining fiscal year. The VCCI was not able to secure additional state FTEs in SFY 2017 to replace the vendor staff, due to State budget constraints.

In the last quarter, the vendor and state staff, including VCCI staff, continued to address bugs/defects testing with fixes to be deployed prior to final Release 1(R1) testing. Joint efforts included UAT, staging tests, document review, training of 'trainers' and training of staff on new features to be deployed. These efforts were concurrent with JAD sessions for R2 functionality during this quarter. As of QE0916, the state and vendor were in final stages of readiness testing and document approval with a anticipated release date of October 2016.

With the continued support of the Organizational Change Management (OCM) team at the state and with eQH, we are continuing to develop and expand on training materials and guides for the team, supplemented by weekly feedback sessions, monthly staff meeting agenda items, 'trained trainer' sessions followed by small group hands on training with supplemental practice sessions and materials in the training environment to assure expertise pending the actual launch date. The VCCI remains below our anticipated case load level per staff and continue our PDSA cycles related to staff performance as well as system performance to assure intervention at the right level for corrective action. A time study approach has been developed, however will be delayed until fixes are launched and new functionality in R1 final is available.

Training documents and policies have been updated to include direct referral within the enterprise system by the internal DVHA's Clinical Operations Unit and the Quality Improvement Units. Both units will utilize the eQH system after R1 final is launched and functionality required is available across teams. This process of direct referral will also eliminate the need for manual workarounds existing between units.

iii. Blueprint for Health

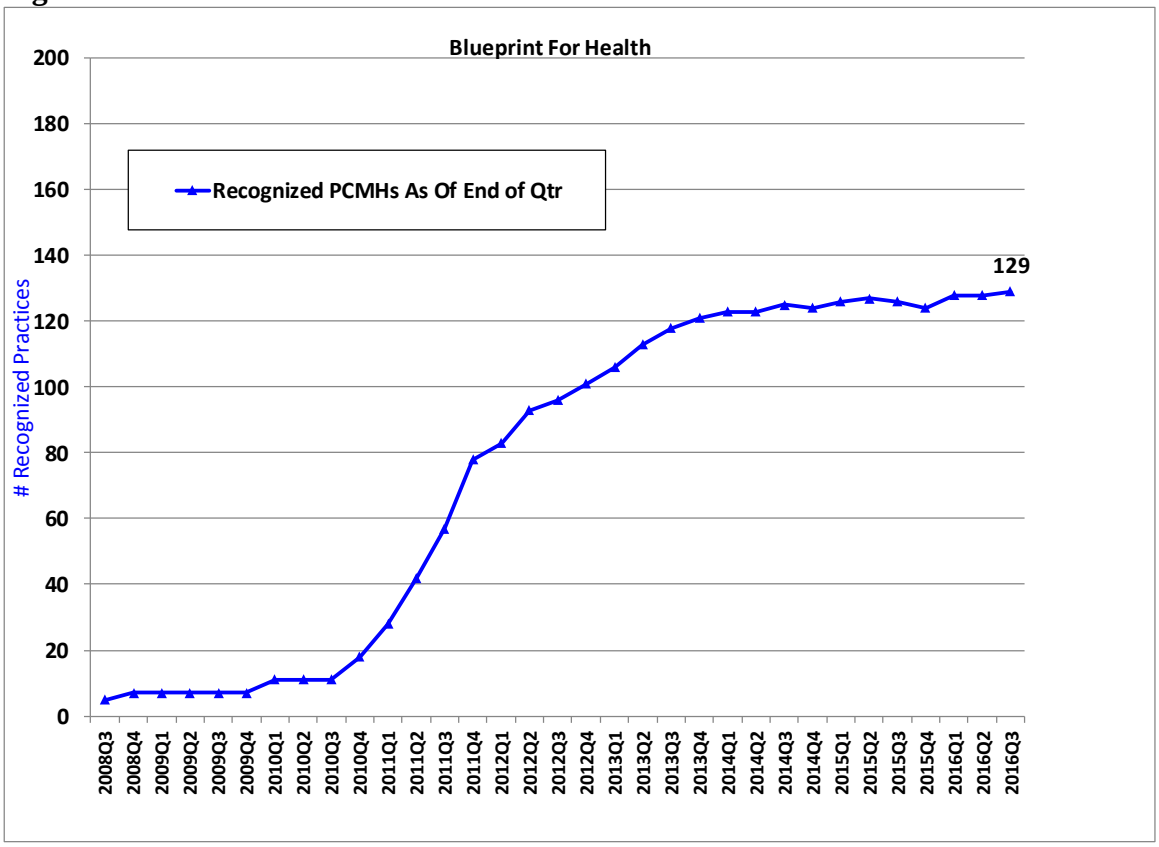
Key updates from QE0916:

- Craig Jones resigned as Blueprint Executive Director as of the end of July to work on a consulting basis with CMMI. Beth Tanzman was appointed Interim Executive Director. The Blueprint Director is appointed by the Governor and it is anticipated that the next administration will make a permanent appointment.

Patient Centered Medical Homes

In the past quarter, the Blueprint for Health program has had no net change in the number of NCQA-recognized primary care practices. One practice underwent a buy-out and conversion to FQHC ownership at the end of the quarter, one practice closed, and one new practice qualified and joined the Blueprint. The Blueprint has approached a saturation point where the program has recruited most of the available primary care practices in the state, and the rate of onboarding of new practices has generally plateaued. The number of Blueprint PCMH practices (MAPCP and non-MAPCP) as of the end of the quarter was 129.

Figure 1. Patient Centered Medical Homes



Hub and Spoke Program

The "Hubs" are regional specialty addictions treatment programs. The “Spokes” are counselors, nurses and social workers who provide support for patients in the primary care setting, and are

members of the local Community Health Teams.

Planning for three learning collaboratives was completed in this quarter. Each collaborative will involve four in-person sessions, common measurement, commitment to undertake and share quality improvement activities, and medical CME lecture. The planned activities are 1) Office Based Opioid Treatment for new providers and practice teams, 2) Spoke Staff Learning Community for the 50+ FTE spoke nurses and licensed counselors who work across 80 different practices, and 3) a Hub & Spoke regional collaborative in the Chittenden area to improve the flow of referrals and consultation between Hubs and Spokes.

Program development for the new Hub program in Northwestern Vermont continues and the community is reacting in a positive and supportive fashion to hosting the Hub.

The Blueprint team in collaboration with an analytics contractor, Onpoint Health Data, began to develop profiles of health service utilization and expenditures for Medicaid beneficiaries served in Hubs and Spokes. The Blueprint team also began to link incarceration data to the health claims data for Hub and Spoke beneficiaries. The profiles will be released in the first quarter of calendar year 2017.

The Vermont Department of Health commissioned a qualitative research study to conduct detailed interviews with Hub and Spoke participants about their experience of care. This study will take place over the next 18 months.

The number of Spoke providers continues to grow.

Figure 2. MAT-SPOKE Implementation January 2013 – September 2016 Staffing

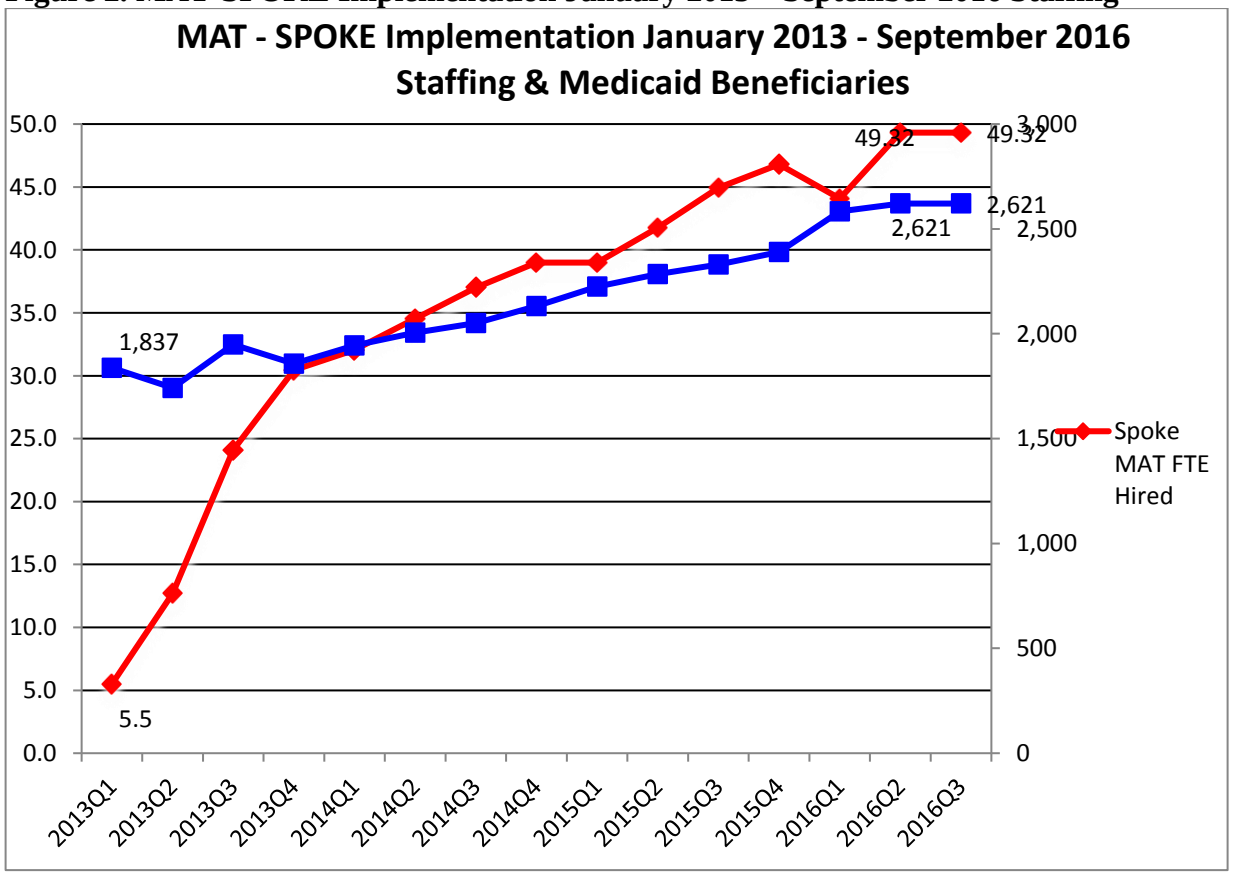
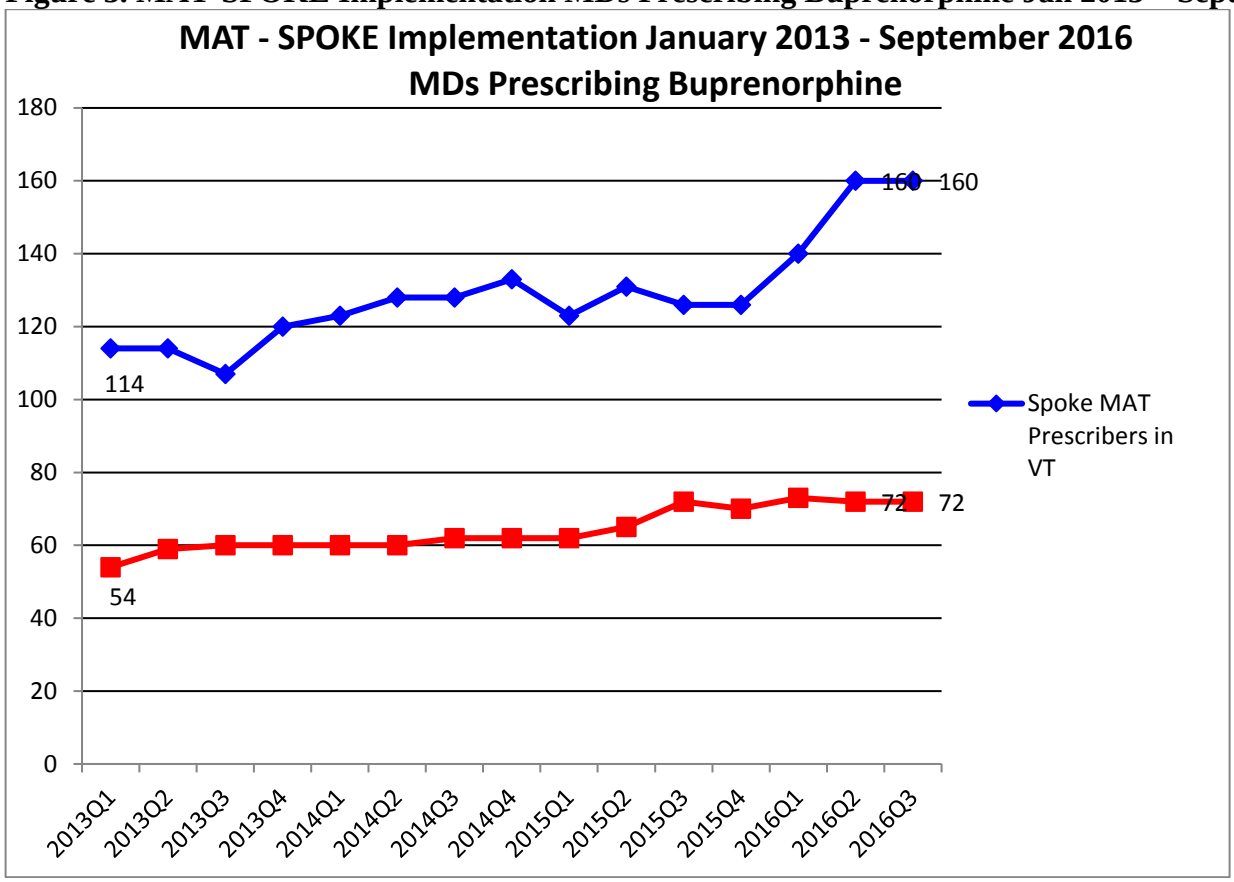


Figure 3. MAT-SPOKE Implementation MDs Prescribing Buprenorphine Jan 2013 – Sept 2016



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

Table 2. Hub Implementation as of September 26, 2016

Program	Region	Start Date	# Clients	# Buprenorphine	# Methadone	# Vivitrol
Chittenden Center	Chittenden, Franklin, Grand Isle & Addison	1/1/2013	912	263	643	0
BAART Central Vermont	Washington, Lamoille, Orange	7/1/2013	537	262	275	0
Habit OPCO/Retreat	Windsor, Windham	7/1/2013	637	172	465	0
West Ridge	Rutland, Bennington	11/6/2013	371	90	259	0
BAART NEK	Essex, Orleans, Caledonia	1/1/2014	722	188	530	4
Statewide		Total	3,179	975	2,172	4

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

Table 3. Spoke Implementation as of September 30, 2016

Region	Total # MD prescribing pts	# MD prescribing to ≥ 10 pts	Staff FTE Hired	Medicaid Beneficiaries
Bennington	11	5	5.6	236
St. Albans	15	11	6.6	390
Rutland	12	6	4.05	223
Chittenden	71	15	14.1	553
Brattleboro	10	5	2.57	138
Springfield	4	1	1.5	55
Windsor	9	3	3	197
Randolph	6	5	1.7	130
Barre	21	7	5.5	268
Lamoille	10	4	2.6	145
Newport & St Johnsbury	11	2	2	90
Addison	5	2	2	77
Upper Valley	5	1	1.5	34
Total	187*	64*	52.72	2,535

Table Notes: Beneficiary count based on pharmacy claims July - September, 2016; an additional **174** Medicaid beneficiaries are served by **31** out-of-state providers. Staff hired based on Blueprint portal report 9/30/16.
*3 providers prescribe in more than one region.

iv. Behavioral Health

Key updates from QE0916:

- Inpatient Psychiatric Reimbursement Methodology Adjusted to Reduce Administrative Burden
- Temporary Administrative Criteria Created for Children's Inpatient Psychiatric Authorizations
- Applied Behavior Analysis (ABA) authorizations are ongoing, additional ABA providers are continuing to enroll with the Vermont Medicaid program

The DVHA Behavioral Health Team offers a comprehensive approach for behavioral health care coordination. The Team is responsible for concurrent review and authorization of inpatient psychiatric and detox services for Medicaid primary members as well as the utilization management activities for

substance abuse residential services for Medicaid primary and uninsured Vermonters. The Team works closely with staff at the inpatient and residential facilities and, when appropriate, the Team collaborates directly with and supports collaboration between facility staff and staff from VCCI, DCF, DMH and ADAP to ensure timely and appropriate transitions of care. The Team also manages the Team Care Program (lock-in) for Medicaid members.

During this reporting period, the Team has led two projects involving the authorization and reimbursement of inpatient psychiatric services as well as an additional initiative regarding correct coding and reimbursement of outpatient hospital based intensive outpatient and partial hospital programs (IOP/PHPs) for the treatment of mental health disorders. An interim administrative criteria set was developed for authorizing continued stays for inpatient psychiatric stays for children and adolescents and is scheduled to remain in effect until October 31, 2016. In addition, the team led an initiative to make needed adjustments to the reimbursement methodology and payment authorization requirements to reduce administrative burden on providers and eliminate inefficiencies in the DVHA process. This adjustment to the reimbursement methodology is scheduled to become effective October 1, 2016. The correct coding and reimbursement of IOP/PHPs was a joint effort between the Reimbursement and Quality Units. Correct codes for these programs were opened to providers and the reimbursement methodology was transitioned to a per diem payment for these valuable programs.

The Applied Behavior Analysis (ABA) benefit was implemented July 1, 2015 and there continue to be a steady interest from providers submitting applications to become enrolled as Vermont Medicaid providers, representing both designated agency staff and private practitioners. The Autism Specialist is continuing to review clinical documentation and provide initial and continued review authorization decisions for applied behavior analysis services for Vermont Medicaid members. At the time of this report, the Autism Specialist was managing over 70 active cases. The Autism Specialist continues to provide regular and extensive technical assistance via phone to individual providers and groups with regard to the prior authorization process and other questions about additional enrollments, claims and coverage.

The Behavioral Health Team, in collaboration with the Clinical Operations Unit and the Quality Team completed the chart reviews for the HEDIS hybrid medical record review (MRR) on the controlling high blood pressure (CBP) and adult BMI assessment (ABA) measures during the previous reporting period. During this reporting period, the Team received positive feedback from our External Quality Review Organization during the on-site review of the HEDIS MRR and the measures were deemed valid at the time of the review.

In early 2016, the Department of Vermont Health Access (DVHA) developed and then issued a Request for Proposals (RFP) for one or more Accountable Care Organizations (ACOs) to participate in a new population-based payment model. Based on CMS' *Next Generation* ACO Model, the new payment model would pay an ACO a prospective, all-inclusive population-based payment (AIPBP) for providing an array of services to its assigned beneficiary population. The model would hold the ACO accountable for both the cost and quality of health care provided, as measured by a set of quality metrics as well as clinical and utilization management requirements that the DVHA Quality Unit Behavioral Health Team staff were integral in helping to develop. During this reporting period, the Unit staff have been participating in the development of a reporting matrix to be used for monitoring and oversight of the ACO (more information found at section vii).

v. Mental Health System of Care

Key updates from QE0916:

- Mental Health Block Grant Planning Council, an advisory body under federal law, developing governance structure to better fulfill its role in monitoring, evaluation, and allocation of block grant dollars to be matched by Global Commitment.
- Social determinants of health are examined in national symposium with DMH representation.
- VPCH's Electronic Health Record was set to go live on October 1, 2016.

Mental Health Block Grant (MHBG)

The U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA), granted Vermont's request for technical assistance to develop a governance structure, diversify membership, and guide approaches to advocacy for the Mental Health Block Grant Planning Council.

The Congressionally-approved increase in the MHBG program for FFY2016 enabled Vermont to add block grant funding to programs that support adults with serious mental illness and/or children with severe emotional disturbance. The Mental Health Block Grant Planning Council, an advisory body defined in the federal block grant statute, selected the Vermont Support Line and Suicide Prevention, and the department concurred. For these program expansions and for other recipients of the Mental Health Block Grant, the expenditure of state revenues, organizational and community resources, and Global Commitment together form an implementation support structure that helps assure program sustainability.

Healthcare Reform and the Mental Health System of Care

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

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

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

New statutory language enacted by the Vermont legislature in Q2 helps to ensure that flexibility is part of the various healthcare reform bills considered by the health-related legislative committees of jurisdiction. As a result, Act 113[1] , signed into law this spring, has a far greater focus on community services than it had at the beginning of the session.

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

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

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

Integration of Public Funding for Mental Health Care Services

The Department of Mental Health (DMH) and the Department of Vermont Health Access (DVHA) continue their joint planning process as directed by Act No. 58 of 2015, the budget enacted by the Vermont General Assembly for SFY 2016. Integration of mental and physical health within the State's overall health reform framework, i.e., an integrated health care system, is the goal enunciated in Act 58 and a broadly shared principle. Preliminary to constructing an implementation plan for a unified service and financial allocation for publicly funded mental health services is examination of the current mental health delivery system and the financial, data, quality, policy and oversight functions performed by the Department of Mental Health in fulfillment of its statutory charge to address the mental health needs of all Vermonters. The needs and the activities of this delivery system must be delineated and considered in the effort to integrate Medicaid programs across the Agency of Human Services (AHS) enterprise. Principles to guide the DMH/DVHA planning process must be established. Near and long term initiatives must be identified and sequenced. Action steps required to support meaningful integration across all AHS publicly funded mental and physical health services must be supported with the resources necessary to engage in the planning contemplated by Act 58 viewed in the full context of Medicaid programs and services.

[1] http://legislature.vermont.gov/bill/status/2016/H.812

Vermont Psychiatric Care Hospital

Electronic Health Record – "Thrive"

The Vermont Psychiatric Care Hospital (VPCH) continued this quarter to be actively involved in preparing for the implementation of the Electronic Health Record (EHR). At the close of Q2, the EHR was ready and, indeed, went live on October 1, 2016. Following this implementation phase will be a contractor-supported maintenance and operation phase. Meeting this goal was a major step toward completion of the new psychiatric Level I hospital essential to achievement of a full continuum of mental health care. The EHR is called Thrive. The Medical Director, doctors, and nursing staff worked to fine tune the conversion of physician documents. Work on integration and interoperability of the components of Thrive continues.

vi. Pharmacy and 340B Drug Discount Program

Key updates from QE0916:

- The Drug Utilization Review Board held meetings on July 12th and September 13th. Fifteen new drugs and eleven therapeutic classes were reviewed, two reviews of Newly-Developed/Revised Clinical Coverage Criteria, two RetroDUR reviews and seven safety alerts were presented.
- DVHA sent three provider communications out on topics of Cost of Dispensing Survey, Goold Health Systems Name Change to Change Healthcare, Changes to Suboxone Film Prior Authorization Requirements Effective 09/09/16.

Pharmacy Benefit Management Program

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

Pharmacy Operations

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

Clinical

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

Initiatives to be Implemented

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

Drug Utilization Review Board (DURB)

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

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

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

Meetings of the DURB occur eight times per year. In Q4 FFY 2016, the DURB held 2 meetings. Information on the DURB and its activities in 2016 is available: http://dvha.vermont.gov/advisory-boards.

DUR Board Decisions

Updates from July 12th and September 13th DUR meetings:

Full New Drug Reviews

Viberzi tablets, Belbuca film, Enstilar foam, Veltassa Powder, Uptravi tablets, Adzenys XR ODT, Spritam tablets, Zepatier tablets, Epclusa tablets, Dyanavel XR suspension, Quillichew ER chewable tablets, Vraylar capsules, Kovaltry antihemophilic factor, Idelvion coagulation Factor IX, Xeljanz XR tablets were reviewed for placement on the preferred drug list.

Therapeutic Drug Class Reviews

Antiparkinson Agents, Pancreatic Enzymes, Parathyroid Agents, Posphate Binders, Non Biologics for Psoriasis-Topical & Oral, Antidepressants, SSRIs, Antidepressants, Other, Antipsychotics, Stimulants, Analgesics SA Narcotics and Analgesics, LA Narcotics were reviewed for placement on the preferred drug list.

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

-Nucala injection

-2016/17 Seasonal Influenza Vaccine

RetroDUR/DUR

-Use of Angiotensin Modifying Medications in Patients with Diabetes Mellitus and Hypertension

-Overuse of Butalbital Containing Medications

340B Drug Discount Program

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

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

To encourage participation in the Vermont Medicaid 340B program, DVHA offers a "shared savings"

program whereby covered entities receive a share of the total savings generated for the state by the 340b program. DVHA identified the following goals in establishing its proposed 340B reimbursement methodology:

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

More details about the program can be found on the 340B link at www.vtmedicaid.com.

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

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

- **Southwestern Vermont Medical Center**
- **Springfield Hospital**
- **The Health Center and affiliated with Community Health Pharmacy**
- **UMass Memorial Medical Center**
- **University of Vermont Medical Center and affiliated with UVMMC Outpatient Pharmacies**

vii. Integrating Family Services (IFS) Initiative

Key updates from QE0916:

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

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

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

The IFS Initiative seeks to bring state government and local communities together to ensure holistic and accountable planning, support and service delivery aimed at meeting the needs of Vermont's children, youth and families. The premise being that giving families early support, education and intervention will produce more favorable health outcomes at a lower cost than the current practice of 'waiting until circumstances are bad enough' to access funding which often results in treatment programs that are out of home or out of state. Several efforts are underway and include: performance based reimbursement projects, capitated annual budgets, and flexible choices for self-managed services. This integration is an ongoing process that is evolving into a very positive direction for children and families.

The initial IFS implementation site in Addison County 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 master grant agreement. The State has created an annual aggregate spending cap for two providers in Addison and one in Franklin/Grand Isle (this provider houses the Designated Agency and Parent Child Center). This has created a seamless system of care to ensure no duplication of services for children and families. Aa comprehensive effort continues to move the master grants towards being more integrated in regards to performance measures and alignment of language continues making significant progress to ensure the grants more effective and stream-lined.

Addison County's FY17 aggregate annual budget is approximately $3.6 million while Franklin/Grand Isle's is $5.5 million. The early successes of these two pilots include:

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

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

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

1. Accountability and Oversight: Finalized population indicators and performance measures

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

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

Additionally, this fall two new IFS work groups were launched to move the following forward:

1. **Partnering with Youth and Families**
   This workgroup will focus on developing an AHS framework for partnering with youth and families. There are two components to this goal of deepening the Agency's partnership with youth and families:
   - How service providers and staff work with children, youth, and families—i.e., what it means to put families at the center of our work using a bi-generational approach; and
   - How we embed youth and family voice into our central and regional decision-making processes.

   2. Creating Conflict Resilient Systems
   This workgroup will apply a restorative-justice lens to its goal of identifying tools and creating a set of protocols that community partners and AHS staff can use to:
   - Improve skills and standards regarding effective communication; and
   - Successfully resolve differences when they (inevitably) occur.

Continued outreach is occurring across the state to educate regions about the IFS approach and support them in their efforts to move forward. At this time, there are several regions working on the Steps to Readiness required to become an IFS region. It appears there will be multiple regions ready to move forward with IFS in July 2017. IFS is working within the larger payment reform occurring in Vermont to ensure the current successes can expand under the Medicaid Pathway.

A great deal of work has been done and will continue to be done within IFS to work on statewide health care reform and aligning approaches to achieve an integrated behavioral and physical health system. Some examples of how IFS is working to align approaches are:

- IFS is engaged in a statewide effort to look more effectively at how Vermont can increase the number of children and youth in family settings as opposed to residential treatment.
- IFS is spearheading a teaming pilot in two regions in Vermont to look at how agency departments can team to support families who have complex needs and therefore are accessing

services through a number of the agencies departments (child welfare, economic services, corrections, substance abuse, early childhood).
- Due to positions in the Agency of Education and the Agency of Human Services being eliminated, IFS is partnering with the Disabilities Division to bring together state and community leaders to strategize about how to ensure focus and services occur for children with autism diagnoses in Vermont.

viii. All Payer Model: Vermont Medicaid Next Generation Program

Key updates from QE0916:
- DVHA is seeking to establish service agreements with one (or more) Accountable Care Organization(s) (ACOs) for participation in a population-based payment model that is based on the Centers for Medicare and Medicaid Services (CMS) *Next Generation* ACO Model.
- DVHA received and reviewed bids in response to a Request for Proposals (RFP), and engaged in contract negotiations with the Apparently Successful Bidder.
- Future program implementation will be in support of Vermont's broader efforts to develop an integrated health care delivery system under an All Payer Model.

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

In this quarter, DVHA reviewed bids in response to the Request for Proposals that had been issued in the prior quarter, and identified an Apparently Successful Bidder. DVHA also began contract negotiations with the Apparently Successful Bidder during this quarter. Any ACO entering into a contractual agreement with DVHA for participation in this model will also be subject to a readiness review prior to the effective date of the agreement so that DVHA may ensure an ACO's ability to assume the roles and responsibilities outlined in the RFP. DVHA has also engaged an independent actuarial firm which is developing per member per month (PMPM) capitation rates for inclusion in a contract for the services described above.

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

ix. All Payer Model: Medicaid Pathway

Key updates from QE0916:

- Information gathering document published here requesting public feedback on proposed framework for delivery and payment models to support more integrated care for Mental Health, Substance Use Disorder and Developmental Services.

As ACO-focused delivery reforms mature under the All Payer Model, they must begin to integrate with providers that support Home and Community-Based Service in Vermont and address the social determinates of health in order to realize a fully organized and accountable system of care. The Vermont Medicaid Pathway (VMP) advances payment and delivery system reform for services not included in the initial implementation of Vermont's All Payer Model, including disability and long-term services and supports (DLTSS), mental health, and substance abuse treatment.

The ultimate goal of this multi-year planning effort is the alignment of payment and delivery system principles through both the All Payer Model and VMP to support a more integrated system of care for all Vermonters – including integrated physical health, long-term services and supports, mental health, substance abuse treatment, developmental disabilities services, and children's service providers – that can achieve the Triple Aim.

The payment model reforms start with Designated and Specialized Service Agencies (DAs and SSAs). The proposed payment model is designed to provide DAs and SSAs with a predictable, responsible, and flexible revenue stream with appropriate quality measurement to support accountability to the State and individuals served.

During the QE0916, AHS published an information gathering document that contains a preliminary framework for delivery and payment model reforms to support integrated care models among certain Medicaid community providers. The document includes:

- Principles for reform
- The Vermont Model of Care
- Defined continuum of integration and draft scope of initial VMP reforms
- Definition of governance functions
- Proposed payment model
- Quality framework

The document was published for feedback through mid-October.

VI. Financial/Budget Neutrality Development/Issues

AHS continued to work with our contracted actuarial consultant, Milliman Inc., on the pmpm rate setting process. During the Global Commitment Waiver extension negotiations, it was agreed upon that AHS could continue to use FFY16 rates for the period 10/01/2016-03/31/2017. Therefore, the work of Milliman has shifted to provide rates for the period 04/01/2017-12/31/2017, as outlined in the Waiver extension STCs.

During the Waiver extension negotiations, a few other items came up that impacted financial reporting in QE0916. CMS put forth guidance that the State of Vermont was no longer able to claim enhanced fmap on the Admin and MCO Investment allocation for the Childless New Adult

population. AHS removed this allocation from the Childless New Adult MEG effective 07/01/2016. Another topic that impacted financial reporting were the costs for the Woodside Juvenile Rehabilitation Center. CMS determined that the residents of this facility are considered inmates and therefore, no longer eligible for federal Medicaid reimbursement. This information was not finalized until late October. CMS and AHS agreed that QE0916 would be the last CMS-64 report that could include costs for Woodside.

For the QE0316, CMS Regional Office conducted a review of eligibility for VIII Group, also known as the Childless New Adult population. Vermont is entitled to receive enhanced FFP for this group of beneficiaries. The initial review found that six of the thirty individuals sampled were not eligible for the VIII Group. This resulted in a disallowance of $4,005 in FFP for the QE0316 GC claim. AHS entered this as a Prior Quarter Adjustment on the QE0916 CMS-64 report.

AHS continued to experience challenges with the QE0916 CMS-64 submission when it came to entering negative amounts for current quarter 100% ACA EPCP claims (this enhanced Match expired QE1214). MBES does not allow for entry of negative amounts in the current quarter Waiver forms. Therefore, AHS entered the amounts as a line 10B prior quarter adjustment.

VII. Member Month Reporting

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

During this quarter, there was an unusually large overall drop in enrollment with fluctuations of -7.62% across the Demonstration Populations. This decrease was primarily due to the fact that Vermont restarted Medicaid renewals this year after a multiple year hold. Because a substantial portion of the population waits until after they are closed before they respond to renewal requests, there is typically a significant degree of gaps in coverage and retroactivity. Enrollment increased in the absence of renewals, and decreased after the re-start. In addition, the increase in time between renewals led to a larger discrepancy between the information that was in the case management system and current household circumstances for individuals being redetermined. The population is expected to stabilize over time as individuals are redetermined on a yearly basis. On a secondary note, individuals renewing coverage through Vermont Health Connect for the first time were learning to navigate a new process. Vermont expects timely response rates to rise over time as individuals become comfortable with the new processes for redetermination. This, in turn, will increase the population that is enrolled at any given time.

Table 4. Number of Recipients, Change from Previous Quarter

	Q3 FFY 2016			Q4 FFY 2016		
Demonstration Population	**April 30, 2016**	**May 31, 2016**	**June 30, 2016**	**July 31, 2016**	**August 31, 2016**	**September 30, 2016**
Demonstration Population 1	35,428	33,831	32,887	30,581	29,567	28,747
Demonstration Population 2	85,567	84,214	82,228	80,045	77,715	74,899
Demonstration Population 3	64,960	63,428	60,838	60,998	59,805	57,523
Demonstration Population 4	2,965	2,909	2,865	2,985	2,934	2,877
Demonstration Population 5	1,015	1,011	1,003	1,034	1,028	1,019
Demonstration Population 6	832	823	819	821	820	797
Demonstration Population 7	7,435	7,477	7,552	7,557	7,543	7,698
Demonstration Population 8	4,259	4,240	4,263	4,224	4,207	4,235
	202,461	197,933	192,455	188,245	183,619	177,795

VIII. Consumer Issues

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

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

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

IX. Quality Improvement

Key updates from QE0916:

- The Managed Care Quality Committee finalized work on Experience of Care Survey Criteria.
- The Quality Unit and the Department of Health continued the work of a new quality improvement collaboration focused on the Medicaid population via a shared grant funded position.
- Study design work continues on the new formal CMS PIP, focused on substance use disorders. A small group from DVHA QI and the Department of Health's Alcohol and Drug Abuse Programs (ADAP) is collaborating to gather research, as well as identify best practices and barriers within the treatment system.

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

Quality Committee Updates:

The Managed Care Quality Committee met in July and August during QE0916. We continued our conversation about our beneficiaries' experience of care. In the past, discussions about how to provide oversight to this key element of our quality program has resulted in comparisons of particular surveys and/or discussion of the merits of particular survey questions. We decided to bring the conversation up to a higher level and mirror the work we had accomplished recently with our *Global Commitment to Health* performance measures. As a group, we developed and finalized a set of recommended experience of care survey criteria between June – August 2016. We can now use this Experience of Care framework to identify any current survey gaps and the criteria set can be used to guide further action.

This led us to start a conversation in August about how we, as a Committee, can do more to communicate out our activities and work products. We will continue this conversation at our October meeting and will build agreed upon communication methods into our Committee charter.

We also began a conversation in August focused on the Developmental Services, Mental Health and Substance Abuse Medicaid Pathway Measures Work Group and how the work of that group compares to the work our committee has been doing around performance measurement. The Medicaid Pathway workgroup is part of the overall health care reform work underway in Vermont. We agreed that regular updates from that work group would be provided at the Managed Care Quality Committee, as not all members sit on both groups and our work should be complementary.

The AHS Performance Accountability Committee (PAC) met monthly during the quarter. The group continued to identify organizational competencies, refine a performance action plan template, and began to identify performance monitoring best practices. The committee finalized a list of organizational competencies for each of the key elements of the AHS Performance Framework. This list was turned into an organizational competency self-assessment tool designed to support Goal Five

of the AHS Strategic Plan (i.e., reinforce accountability). In addition to the competency, the tool provides examples of what accomplishing the competency might look like, as well as a three-point rating scale meant to characterize occurrence of the competency. With the tool completed, the group will turn its attention to implementing a pilot to test the reliability and validity of the tool.

Comprehensive Quality Strategy/State Transition Plan:

During this quarter, the AHS HCBS Implementation Team met monthly to continue Vermont's Comprehensive Quality Strategy/State Transition Plan efforts. The primary focus of the group continued to be the provider self-assessment and validation activities. Members of the group continued to review and pilot the provider self-assessment with stakeholders. After an initial pilot, changes were made to the tool. The group expects to have a final tool developed by the end of the next quarter. Outstanding issues include the following: provider self-assessment sampling methodology, interpretation of conflict free case management requirement, and remediation timeline. Members of the team continue to engage stakehlders in other aspects of the CQS/STP. Vermont anticipates CMS review of their CQS/STP for initial approval after posting the modified CQS/STP, all systemic assessments and work/remedicaiton plans for a 30 day public comment period on February 1, 2017.

Global Commitment Investment Review:

During this quarter, the AHS Integrated Operations and Policy Team (IOPT) used the newly developed evaluation tool and process to review GC investments housed in the Department of Disabilities, Aging, and Independent Living, the Department of Vermont Health Access, and the Department of Mental Health. While all investments were assessed by the departments, the IOPT prioritized certain investments for the meeting presentations. To prepare for their presentation, the DVHA established an evaluation/scoring team for their investments that consisted of Quality Unit staff, the Business Manager and the Deputy Commissioner of Heath Care Services and Operations. Using the revised scoring tool, each investment was reviewed and subject matter experts were brought in where necessary in order to determine scores.

During the next quarter, the AHS Quality Improvement manager will conduct data entry and analysis activates with the anticipation of writing a summary report. In addition, separate, yet related work continues assessing current GC investments for conversion to Medicaid billable administration or services when feasible.

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

The DVHA has completed the 2016 HEDIS hybrid medical record review (MRR) on the controlling high blood pressure (CBP) and adult BMI assessment (ABA) measures. The rates were validated by our EQRO in July 2016 and will be reported to CMS as part of the Adult Core Set by the DVHA Quality Unit later this year.

Grant Funded Quality Improvement Projects:

The DVHA Quality Unit and the Vermont Dept. of Health's Health Promotion and Disease Prevention (HPDP) division have continued their partnership during QE0916. in Their shared Grant Manager position is leading cancer screening quality improvement projects (QIPs). The following QIPs are currently in progress:

- **Provider mailing:** To complement the public brochure sent to Medicaid beneficiaries in February 2016, a cover letter from Dr. Chen (the VDH Commissioner) and copies of the public and provider cancer screening brochures was sent to 5,100 Medicaid providers in April 2016.

- **Gap-in-care lists:** DVHA has committed to continuing to work with the All Payer Joint Project through 2016. Medicaid, MVP & BCBSVT are sending similarly formatted quarterly gap-in-care (GIC) reports to 29 Blueprint practices. The reports show the entire panel of female Medicaid beneficiaries ages 50-64 served at the practice and whether or not they have received a mammogram in the last 2 years. The lists were sent out mid-January,April and July 2016.

- **Ladies First Direct Mail** to all female Medicaid primary beneficiaries ages 40-64 statewide
    - Women ages 40-49: Send a 1 time mailing with recommendation to talk to their PCP on when to get a mammogram based on their risk factors in October 2016
    - Women ages 50-64 who have had a screening mammogram in the last two years: Send a reminder letter to get a f/up mammogram over 12 months beginning in May 2016. Letters have been sent in May – September 2016.
    - No mailing will be sent to women ages 50-64 who have had a diagnostic mammogram in the last 2 years; these women should receive individualized follow-up from their PCP or mammogram facility.
    - Women ages 50-64 who have not had a screening or diagnostic mammogram in the last 2 years: Send a one-time mailing with educational materials urging them to get a mammogram in October 2016

- **Ladies First In-person outreach to Medicaid beneficiaries:** The Grant Program Manager & the Ladies First Outreach Specialist spoke with each of the Ladies First clinic champions in May and discussed their community outreach efforts. Their efforts, ideas, and suggestions were developed into a power point presentation and shared back to the group in a conference call on June 6th. The champions were interested in hearing what each other has been/would like to do. There has been additional networking post-call as champions move their outreach efforts forward.

- **Ladies First Two-Step Screening Reminder Project:** Ladies First implemented an ongoing two-step screening reminder project in July 2016 in an effort to increase the cardiovascular, breast & cervical cancer screening rates of its members. The first step is a reminder card based on the due date of the cardiovascular screen, and will also include the member's mammogram & pap test due date (as applicable). These cards will be sent monthly. The second step is a motivational follow up call from a Clinic Champion to the member if the member isn't current on all three screens 60 days after the reminder card is sent. The first round of calls were made in September 2016.

Follow-Up After Hospitalization for Mental Illness Quality Improvement Work:

The CMS reporting cycle for our AHS-wide Performance Improvement Project (PIP) on Follow-up After Hospitalization (FUH) for Mental Illness came to a close during QE0616. The DVHA QI Administrator submitted the 2016-2017 PIP Summary for validation to our vendor, Health Services Advisory Group (HSAG), on 6/29/16. HSAG provided us with their draft evaluation report at the end of September 2016. The DVHA scored 100% for the Design elements of the PIP, 89% for Implementation and Evaluation, 33% for Outcomes, and an overall score for all Critical Elements of

90%. Our overall validation Status was "not met" due to the fact that we weren't able to demonstrate statistically significant improvement in our FUH rates over baseline during the PIP cycle. We did, however, learn a lot about this system of care during the life of this PIP; learning that will serve us well in future projects (see below). We also confirmed through this scoring that the DVHA Quality Unit staff are competent in leading and designing a strong project framework.

As mentioned above, the DVHA QI Administrator continued to work with the project coordinator for the Vermont Program for Quality in Healthcare (VPQHC) who has recently been asked to manage a joint payer project between Vermont Blue Cross Blue Shield and MVP focused on improving their FUH HEDIS rates. The DVHA Quality Unit agreed to join this effort. The project team met twice during QE0916. A data collection tool was developed and data sharing and analysis is continuing. Again, this may become an unexpected, yet welcome, avenue to sustain and build upon the work of our PIP.

Substance Abuse Quality Improvement Project (formal CMS PIP)):

The topic of substance use disorders has risen to the top as a focus area for our next formal PIP. A small group of staff from the DVHA Quality Unit and the Vermont Department of Health's Alcohol and Drug Abuse Programs (ADAP) division have formed a team to explore inter-Agency support and interest in this project topic. To that end, we met with the Agency's Substance Abuse Treatment Committee (SATC), the Agency's Screening, Brief Intervention, Referral to Treatment (SBIRT) work group and with the Assistant Director to the Vermont Blueprint for Health between QE0316 and QE0616. All of these individuals felt that our project would dovetail well with work they had started and encouraged us to push forward.

During QE0916 our small group of ADAP and DVHA staff performed a root cause analysis and prioritized barriers. We also met with the SBIRT lead and ER Director for one of our area hospitals, the Central Vermont Medical Center. We knew from a previous meeting that this hospital has created an ongoing regional partnership meeting that has helped them unearth gaps in care and barriers to care in their region. Our PIP team wanted to explore whether there were best practices in play there that we felt could help address any of the barriers we had identified.

In fact, these regional partnerships have stood out to our team as a best practice and possible intervention for our project. We are continuing to spread the word of our PIP across the Agency. We will be meeting with the Agency's Field Service Directors and with an established group of hospital Quality Directors during QE1216 in order to take steps towards our first PIP intervention.

Consumer Assessment of Healthcare Providers and Systems Survey:

In 2015, DVHA participated in a national experience of care survey effort for the adult Medicaid population, which was coordinated by the National Opinion Research Center at the University of Chicago (NORC). Results of the 2015 adults CAHPS survey were released to states during this quarter.. The DVHA QI Administrator has pulled results from the national database and has updated our Adult Experience of Care Scorecard, which is posted on our public website.

The DVHA fielded the Children's Medicaid health plan survey in 2016. The survey process was completed and a summary report provided to the DVHA during QE0916. The DVHA QI Administrator has updated our Child Experience of Care Scorecard, which is posted on our public website.

All Payer Model:

In early 2016, the Department of Vermont Health Access (DVHA) developed and then issued a Request for Proposals (RFP) for one or more Accountable Care Organizations (ACOs) to participate in a new population-based payment model. Based on CMS' *Next Generation* ACO Model, the new payment model would pay an ACO a prospective, all-inclusive population-based payment (AIPBP) for providing an array of services to its assigned beneficiary population. The model would hold the ACO accountable for both the cost and quality of health care provided, as measured by a set of quality metrics that the DVHA Quality Unit staff were integral in helping to develop. Additionally, the Quality Unit staff advised on a quality reporting matrix to be used for monitoring and oversight. Contract negotiations are ongoing during QE0916 and the Quality Unit is participating in internal DVHA readiness review preparations.

X. Compliance

Key updates from QE0916:

- 2016 EQRO audit completed
- New Workplan and Compliance Plan updates

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

External Quality Review (EQR):

The 2016 EQRO Compliance was conducted on July 26-27, 2016 and focused on the following Access standards:

I. Availability of services: This standard includes a review of the adequacy of DVHA's provider network, the availability of women's health services, direct access to specialists, the use of treatment plans (when appropriate), opportunities for members to seek a second opinion and processes to ensure the delivery of specialized services not available in our network.
II. Furnishing of Services: This standard included a review of the timeliness of the services delivered by DVHA's network, including appointment wait times, access to after-hours assistance and the processes for monitoring and correcting issues related to this standard.
III. Cultural Competence: In this standard, DVHA needed to demonstrate how services and messages are delivered with regard to members' cultural needs/preferences and the languages they speak/sign and read.
IV. Coordination of Care: This standard relates to the processes DVHA and its network of providers use to ensure that care is coordinated across provider types and with care coordinators and program administrators.
V. Coverage and Authorization of Services: In this standard, DVHA demonstrated the

processes used to authorize services that require prior approval. DVHA also demonstrated that the services covered are appropriate in amount, duration, and scope, and that DVHA does not arbitrarily deny covered services without a sound clinical reason for doing so. This standard required a review of the written procedures for coverage and authorizations and a demonstration of DVHA's coordination with clinicians to ensure that only qualified personnel are making clinical decisions. Finally, this standard required that DVHA demonstrate adherence to statutory processes around providing timely notices to members about coverage decisions (and their rights to appeal decisions).

VI. Emergency and Post-Stabilization Services: DVHA demonstrated its procedures for ensuring that emergency and post-emergency stabilization services are covered and not arbitrarily limited (including instances where an emergency happens out-of-state and care is rendered by a non-network provider).

VII. Enrollment and Disenrollment Requirements: In this standard, the auditors reviewed DVHA's practices around enrollment and disenrollment with a focus on the materials and information provided to new enrollees.

A brief overview of findings is highlighted here:

- PIP Validation - 85% of the PIP evaluation elements were *Met*. However, DVHA did not achieve improvement in their study rates, therefore the critical elements related to real improvement were *Not Met* and resulted in an ultimate validation status of *Not Met*. The EQRO's recommendations for next steps will be taken into consideration during the next quarter.
- Review of Compliance with Standards – the standards under review were Availability/Furnishing of Services, Cultural Competence, Coordination and Continuity of Care, Coverage and Authorization of Services, Emergency and Post-Stabilization of Services, and Enrollment and Disenrollment. Overall, Vermont received a compliance score of 97.0%. During the review, the auditors discovered three potential findings. They would like to see more outreach to members on the prevention, identification and reporting of elder abuse and neglect. DVHA needs to add language to notices sent to guardians of children in state custody (Note: this has already been implemented, but was not presented to the auditors in time to avoid a finding). DVHA will also need to improve the frequency of our network mapping process (which has already been corrected). DVHA also received general praise for the work done to remain in compliance with federal law and received several helpful recommendations for improving their work. A final report is expected during the next quarter and DVHA plans to work with its IGA partners to quickly implement the corrective actions and recommendations we received from this audit.
- Validation of Performance Measures – Fourteen (14) performance measures were validated by the EQRO, including two (2) hybrid measures for which DVHA staff had performed the medical record abstraction. The results on the hybrid measures were all approved, which was a great accomplishment for the DVHA Quality and Clinical teams that collaborated during this effort. The EQRO reviewers acknowledged that substantial undertaking and encouraged DVHA to continue its efforts. In addition, DVHA scored "Acceptable" on Data Integration, Data Control and Performance Measure Documentation.

During this time, the AHS Quality QIM attended both on-site EQRO reviews – and participated in numerous PIP validation calls. Once the reviews were completed – time was spent clarifying any follow up items. In addition, draft reports for each activity were reviewed by both DVHA and AHS –

with final reports being delivered by the end of the quarter. During the next quarter, the AHS QIM will work with the EQRO to develop the annual technical report.

New Workplan and Compliance Plan updates
The DVHA Compliance Director developed a new workplan for the upcoming year. The plan will focus on document updates and preparation for the 2017 EQRO audit.

The Managed Care Compliance Plan has been updated and a draft is circulating with the members of the Managed Care Compliance Committee. Updates this year are minor and mostly involve updates to responsibilities and assignments for the Compliance Officer and Committee members.

XI. Demonstration Evaluation

During this quarter, the AHS QIM reviewed the evaluation requirements contained in waiver renewal documents. Once the renewal is approved, final timelines will be established for the following evaluation items: *draft/final evaluation design, interim evaluation report of IMD expenditures, preliminary summative evaluation report of IMD expenditures, draft interim evaluation report, preliminary IMD summative evaluation report,* and the *summative evaluation report*. Also during this quarter, the AHS QIM began to plan for evaluation activity resource needs. During the next quarter, AHS needs to decide re: how best to staff the evaluation needs of the waiver. Finally, the AHS QIM continued to meet with the other members of Vermont's SIM Evaluation Steering Committee. While Medicaid is only one of the participating payers, it was thought that there might be some efficiencies realized by leveraging the GC waiver evaluation efforts with those of the SIM grant.

XII. Reported Purposes for Capitated Revenue Expenditures

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

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

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

XIII. Enclosures/Attachments

Attachment 1: Budget Neutrality Workbook

Attachment 2: Enrollment and Expenditures Report

Attachment 3: Complaints Received by Health Access Member Services

Attachment 4: Medicaid Managed Care Entity Grievance and Appeal Reports

Attachment 5: Office of the Health Care Advocate Report

Attachment 6: State Fiscal Year 2015 Managed Care Entity Investments

XIV. State Contact(s)

Fiscal:	Sarah Clark, CFO	
	VT Agency of Human Services	802-505-0285 (P)
	280 State Drive	802-241-0450 (F)
	Waterbury, VT 05671-1000	sarah.clark@vermont.gov
Policy/Program:	Selina Hickman, Director of Health Care Operations, Compliance & Improvement	
	VT Agency of Human Services	802-585-9934 (P)
	280 State Drive, Center Building	802-241-0452 (F)
	Waterbury, VT 05671-1000	selina.hickman@vermont.gov
Managed Care Entity:	Steven M. Costantino, Commissioner	
	Department of VT Health Access	802-241-0147 (P)
	280 State Drive, NOB 1 South	802-879-5962 (F)
	Waterbury, VT 05671-1010	steven.costantino@vermont.gov

Date Submitted to CMS: November 30, 2016

ATTACHMENTS

Global Commitment Expenditure Tracking

Attachment 1 - Budget Neutrality

QE	Quarterly Expenditures	PQA: WY1	PQA: WY2	PQA: WY3	PQA: WY4	PQA: WY5	PQA: WY6	PQA: WY7	PQA: WY8	PQA: WY**9a**	PQA: WY**9b**	PQA: WY10	PQA: WY11	Net Program PQA	Net Program Expenditures as reported on 64	Excess New Adult Expenditures as reported on 64 per STC 55e	non-MCO Admin Expenses	Total columns J:K for Budget Neutrality calculation - **Includes** New Adult	Cumulative Waiver Cap - **Excluding** New Adult per 10/2/13 STCs	Variance to Cap under/(over)
1205	$ 178,493,793														$ 178,493,793					
0306	$ 189,414,365	$ 14,472,838												$ 14,472,838	$ 203,887,203					
0606	$ 209,647,618	$ (14,172,165)												$ (14,172,165)	$ 195,475,453					
0906	$ 194,437,742	$ 133,350												$ 133,350	$ 194,571,092					
WY1 SUM	$ 771,993,518	$ 434,023												$ 434,023	**$ 782,159,845**		**$ 4,620,302**	**$ 786,780,147**	**$ 841,266,663**	**$ 54,486,516**
1206	$ 203,444,640	$ 8,903												$ 8,903	$ 203,453,543					
0307	$ 203,804,330	$ 8,894,097												$ 8,894,097	$ 212,698,427					
0607	$ 186,458,403	$ 814,587	$ (68,408)											$ 746,179	$ 187,204,582					
0907	$ 225,219,267	$ -	$ -											$ -	$ 225,219,267					
WY2 SUM	$ 818,926,640	$ 9,717,587	$ (68,408)											$ 9,649,179	**$ 802,884,359**		**$ 6,464,439**	$ 809,348,797		
Cumulative																		**$ 1,596,128,945**	**$ 1,684,861,317**	**$ 88,732,372**
1207	$ 213,871,059	$ -	$ 1,010,348											$ 1,010,348	$ 214,881,406					
0308	$ 162,921,830	$ -	$ -											$ -	$ 162,921,830					
0608	$ 196,466,768	$ 14,717	$ -	$ 40,276,433										$ 40,291,150	$ 236,757,918					
0908	$ 228,593,470	$ -	$ -	$ -										$ -	$ 228,593,470					
WY3 SUM	$ 801,853,126	$ 14,717	$ 1,010,348	$ 40,276,433										$ 41,301,498	**$ 881,729,256**		**$ 6,457,896**	$ 888,187,152		
Cumulative																		**$ 2,484,316,097**	**$ 2,604,109,308**	**$ 119,793,211**
1208	$ 228,768,784		$ -	$ -										$ -	$ 228,768,784					
0309	$ 225,691,930		$ (16,984,221)	$ 38,998,635	$ (4,144,041)									$ 17,870,373	$ 243,562,303					
0609	$ 204,169,638		$ -	$ 686,851	$ 5,522,763									$ 6,209,614	$ 210,379,252					
0909	$ 235,585,153		$ -	$ 30,199	$ 34,064,109									$ 34,094,308	$ 269,679,461					
WY4 SUM	$ 894,215,505	$ -	$ (16,984,221)	$ 39,715,685	$ 35,442,831									$ 58,174,295	**$ 935,368,819**		**$ 5,495,618**	$ 940,864,437		
Cumulative																		**$ 3,425,180,534**	**$ 3,606,430,571**	**$ 181,250,037**
1209	$ 241,939,196				$ 5,192,468									$ 5,192,468	$ 247,131,664					
0310	$ 246,257,198				$ 531,141	$ 4,400,166								$ 4,931,306	$ 251,188,504					
0610	$ 253,045,787				$ 248,301	$ 5,260,537								$ 5,508,838	$ 258,554,625					
0910	$ 252,294,668			$ (115,989)	$ (261,426)	$ 3,348,303								$ 2,970,888	$ 255,265,556					
WY5 SUM	$ 993,536,849	$ -	$ -	$ (115,989)	$ 5,710,484	$ 13,009,006								$ 18,603,501	**$ 1,012,990,839**		**$ 5,939,459**	$ 1,018,930,298		
Cumulative																		**$ 4,444,110,832**	**$ 4,700,022,174**	**$ 255,911,342**
1210	$ 262,106,988				$ -	$ 6,444,984								$ 6,444,984	$ 268,551,972					
0311	$ 257,140,611													$ -	$ 257,140,611					
0611	$ 277,708,043						$ (121,416)							$ (121,416)	$ 277,586,627					
0911	$ 243,508,248						$5,528,143							$ 5,528,143	$ 249,036,391					
WY6 SUM	$ 1,040,463,890	$ -	$ -	$ -	$ -	$ 6,444,984	$5,406,727							$ 11,851,711	**$ 1,045,342,616**		**$ 6,071,553**	$ 1,051,414,168		
Cumulative																		**$ 5,495,525,000**	**$ 5,865,213,737**	**$ 369,688,737**
1211	$ 253,147,037						$ (531,744)							$ (531,744)	$ 252,615,293					
0312	$ 267,978,672						$ 3,742	$ 49,079						$ 52,821	$ 268,031,493					
0612	$ 302,958,610							$ 6,393,928						$ 6,393,928	$ 309,352,538					
0912	$ 262,406,131							$ 7,750,994						$ 7,750,994	$ 270,157,125					
WY7 SUM	$ 1,086,490,450	$ -	$ -	$ -	$ -	$ -	$ (528,002)	$ 14,194,000						$ 13,665,998	**$ 1,134,526,550**		**$ 5,751,066**	$ 1,140,277,616		
Cumulative																		**$ 6,635,802,617**	**$ 7,113,290,903**	**$ 477,488,286**
1212	$ 282,701,072							$ 3,036,447						$ 3,036,447	$ 285,737,519					
0313	$ 285,985,057							$ 991,340						$ 991,340	$ 286,976,397					
0613	$ 336,946,361							29,814,314	$ (125,679)					$ 29,688,635	$ 366,634,996					
0913	$ 286,067,548								$ 2,162,772					$ 2,162,772	$ 288,230,320					
WY8 SUM	$ 1,191,700,038	$ -	$ -	$ -	$ -	$ -	$ -	$ 33,842,100	$ 2,037,093					$ 35,879,193	**$ 1,199,887,555**		**$ 6,260,794**	$ 1,206,148,349		
Cumulative																		**$ 7,841,950,966**	**$ 8,450,684,486**	**$ 608,733,520**
1213	$ 319,939,651								$ 3,652,767					$ 3,652,767	$ 323,592,418					
WY**9a** SUM	$ 319,939,651	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 3,652,767					$ 3,652,767	$ 319,921,780		**$ 1,214,631**	$ 321,136,411		
Cumulative																		**$ 8,163,087,376**	**$ 8,955,886,798**	**$ 792,799,422**
0314	$ 288,542,475								$ 2,159,834					$ 2,159,834	$ 290,702,309					
0614	$ 288,845,927													$ -	$ 288,845,927					
0914	$ 242,449,803								$ 337,823	$ (17,871)	$ 1,466,026			$ 1,785,978	$ 244,235,780					
1214	$ 286,853,166										$ 867,215			$ 867,215	$ 287,720,381					
WY**9b** SUM	$ 1,106,691,370	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 2,497,657	$ (17,871)	$ 2,333,241			$ 4,813,027	$ 1,108,497,700		**$ 5,086,126**	$ 1,113,583,826		
Cumulative																		**$ 9,276,671,203**	**$ 10,290,338,883**	**$ 1,013,667,680**
0315	$ 321,140,737													$ -	$ 321,140,737					
0615	$ 357,677,001										$ (526,911)			$ (526,911)	$ 357,150,090					
0915	$ 309,207,552											$ 3,080,254		$ 3,080,254	$ 312,287,806					
1215	$ 348,325,098											$ 5,996,596		$ 5,996,596	$ 354,321,694					
WY10 SUM	$ 1,336,350,389	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ (526,911)	$ 9,076,850		$ 8,549,939	$ 1,348,857,571		**$ -**	$ 1,348,857,571		
Cumulative																		**$ 10,625,528,774**	**$ 11,969,357,946**	**$ 1,343,829,172**
0316	$ 370,951,068											$ (1,759,477)		$ (1,759,477)	$ 369,191,591					
0616	$ 338,344,448											$ 1,209,934	$ (13,427,019)	$ (12,217,085)	$ 326,127,363					
0916	$ 314,847,438											$ 3,979,875	$ (97,502)	$ 3,882,373	$ 318,729,811					
1216														$ -	$ -					
WY11 SUM	$ 1,024,142,954	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 3,430,332	$ (13,524,522)	$ (10,094,189)	$ 1,010,618,433		**$ -**	$ 1,010,618,433		
Cumulative																		**$ 11,636,147,206**	**$ 13,752,420,439**	**$ 2,116,273,233**
	$ 11,386,304,380	$ 10,166,327	$ (16,042,281)	$ 79,876,130	$ 41,153,315	$ 19,453,990	$4,878,725	$ 48,036,100	$ 8,187,517	$ (17,871)	$ 1,806,330	$ 12,507,182	$ (13,524,522)		**$ 11,582,785,323**	$ -	$ 53,361,884			

State of Vermont
Department of Vermont Health Access
280 State Drive, NOB 1 South
Waterbury, VT 05671-1010
http://dvha.vermont.gov

[Phone] 802-879-5900

Agency of Human Services

Medicaid Program Enrollment and Expenditures Report

Q4 SFY 2016

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

Hal Cohen, Secretary
Vermont Agency of Human Services

Steven M. Costantino, Commissioner
Department of Vermont Health Access

August 31, 2016

Glossary of Terms

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

The Department of Vermont Health Access

Caseload and Expenditure Report ~ DVHA Only Medicaid Spend

DVHA YTD '16

Monday, August 8, 2016

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

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

The Department of Vermont Health Access

Caseload and Expenditure Report ~ All AHS Medicaid Spend

All AHS YTD '16

Monday, August 8, 2016

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

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

The Department of Vermont Health Access

Caseload and Expenditure Report ~ All AHS and AoE Medicaid Spend

All AHS and AoE YTD '16

Monday, August 8, 2016

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

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

VERMONT

State of Vermont *Agency of Human Services*
Department of Vermont Health Access [Phone] 802-879-5900
312 Hurricane Lane, Suite 201 [Fax] 802-879-5651
Williston VT 05495-2807
dvha.vermont.gov

Questions, Complaints and Concerns Received by Health Access Member Services
July 1, 2016 – September 30, 2016

July 4 – July 8

- No issues to report.

July 11 – July 15

- VPharm Reviews: CSR's reviewed account and advised of renewal date.
- PCP Enrollment: CSR's assisted in finding a PCP or entering current PCP.

July 18 – July 22

- No issues to report.

July 25 – July 29

- No issues to report.

August 1 – August 5

- VPharm Closure Notices: CSR's reviewed account to determine is payment was made on time and, if so, advised of reinstatement process.

August 8 – August 12

- No issues to report

August 15 – August 19

- No issues to report.

August 22 – August 26

- VPharm payments not processed and account not reinstated: CSR's reviewed account and escalated to the PCP Team if there is an ATC issue.

August 29 – September 2

- VPharm Held Harmless letter: CSR's reviewed account and advises of held harmless rule and its change.

September 6 – September 9

- No issues to report

September 12 – September 16

- No issues to report

September 19 – September 23

- VPharm Closure Notices: CSR's reviewed account to determine is payment was made on time and, if so, advised of reinstatement process.

September 26 – September 30

- No issues to report

VERMONT

Agency of Human Services

Grievance and Appeal Quarterly Report
Medicaid Managed Care Model
All Departments Combined Data
July 1, 2016 – September 30, 2016

The Medicaid Managed Care Model is composed of various administrative areas within the Agency of Human Services (AHS). These include: the Department of Vermont Health Access (DVHA), the Department for Children and Families (DCF), the Department of Mental Health (DMH), the Department of Disabilities, Aging and Independent Living (DAIL), and the Department of Health (VDH). Also, included in the Medicaid Managed Care Model are the Designated Agencies (DA) and Specialized Service Agencies (SSA) that provide service authorizations for DMH and DAIL. Each entity should have at least one assigned grievance and appeal coordinator who enters data into the centralized grievance and appeals database. This report is based on data compiled on October 20, 2016, from the centralized database that were filed from July 1, 2016 through September 30, 2016.

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

During this quarter, there were 28 grievances filed; seventeen 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, 72% were filed by beneficiaries, 21% were filed by a representative of the beneficiary and 7% were filed by another source. Of the 28 grievances filed, DMH had 68%, DVHA had 17%, DAIL had 11% and VDH had 4%, There were no grievances filed for the DCF during this quarter.

There were no Grievance Reviews filed this quarter.

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

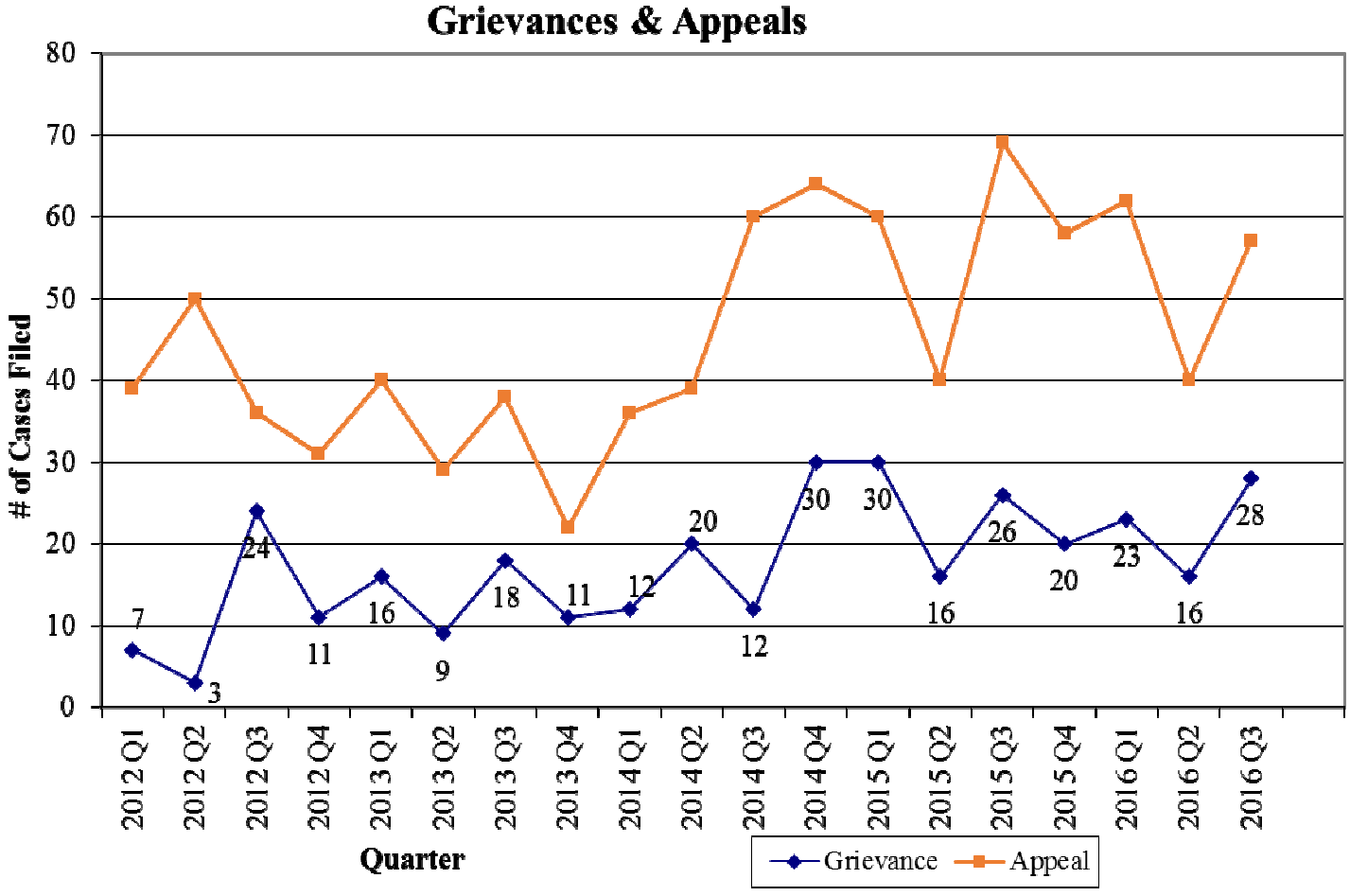
1. denial or limitation of authorization of a requested covered service or eligibility for service, including the type, scope or level of service;
2. reduction, suspension or termination of a previously authorized covered service or a service plan;
3. denial, in whole or in part, of payment for a covered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

During this quarter, there were 57 appeals filed; 20 requested an expedited decision with eleven of them meeting criteria. Of these 57 appeals, 36 were resolved (63% of filed appeals), 16 were still pending (28%), 4 were withdrawn (7%), and 1 was filed too late (2%). In fifteen cases (42% of those resolved), the original decision was upheld by the person hearing the appeal, thirteen cases (36% of those resolved) were reversed, two had a modified approval (6%) and six were approved by the applicable department/DA/SSA before the appeal meeting (16% of those resolved).

Of the 36 appeals that were resolved this quarter, 96% were resolved within the statutory time frame of 45 days, with one (4%) being extended by the beneficiary; 86% were resolved within 30 days. The average number of days it took to resolve these cases was 18 days. Acknowledgement letters of the receipt of an appeal must be sent within five days; the average was three days.

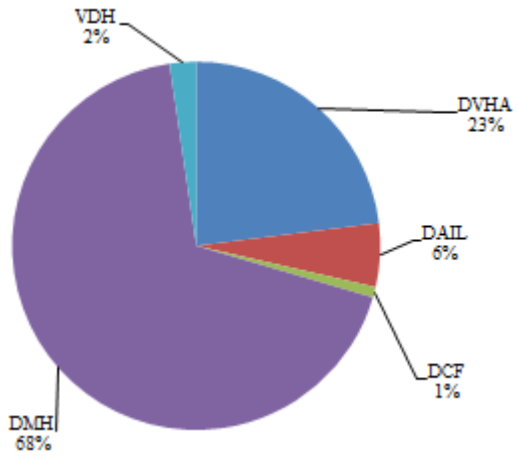
Of the 57 appeals filed, 29 were filed by beneficiaries (51%), 23 were filed by a representative of the beneficiary (40%) and 5 were filed by the provider (9%). Of the 57 appeals filed, DVHA had forty-two appeals filed (74%), DAIL had eleven (19%), DMH had three (5%) and VDH had none.

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

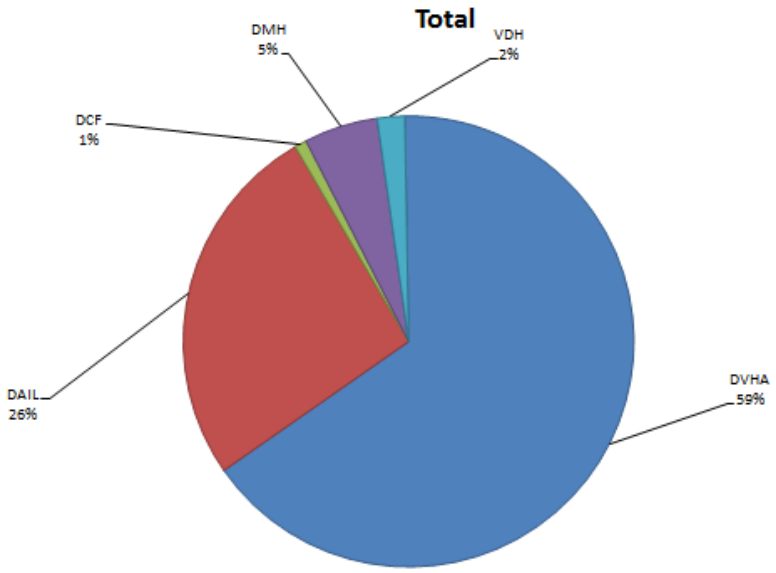


Grievance & Appeals by Department
From January 1, 2008 through September 30, 2016

Grievances



Appeals



Vermont Legal Aid

Office of the Health Care Advocate

Quarterly Report

July 1, 2016-September 30, 2016

to the

Agency of Administration

submitted by

Marjorie Stinchcombe, Staff Attorney

Office of the Health Care Advocate

October 21, 2016

Vermont Legal Aid
Working for Justice

Table of Contents

Introduction

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

The full quarterly report for July 1, 2016 – September 30, 2016 includes:

- This narrative, which contains sections on **Individual Consumer Assistance**, **Consumer Protection Activities** and **Outreach and Education**
- Seven data reports, including three based on the caller's insurance status:
  - **All calls/all coverages**: 1018 calls (compared to 1003 last quarter)
  - **Department of Vermont Health Access (DVHA) beneficiaries**: 300 calls or **29%** of total calls (compared to 241 and 24% last quarter)
  - **Commercial plan beneficiaries**: 252 calls or **24%** (294 and 29%)
  - **Uninsured Vermonters**: 132 calls or **13%** (109 and 11%)
  - **Vermont Health Connect (VHC)**: 447 calls or **44%** (511 and 51%; the VHC data report draws from the All Calls data set)
  - **Two Reportable Activities (Summary & Detail)**: 105 activities, 42 documents (174 activities and 49 documents)

Highlights

- Total hotline call volume remained steady. (1018 this quarter vs. 1003 last quarter)
- Vermont Health Connect calls dropped 13% from the previous quarter.
- Many Vermonters are still struggling with VHC billing problems. About one-third of the HCA's VHC calls involved a billing issue.
- We are resolving complex cases more quickly. The HCA escalated 181 complex cases to VHC this quarter, and 168 were resolved by the end of the quarter.
- The HCA advised on 62 appeals this quarter. Of the 62 appeals, 49 were fair hearings.
- The HCA has saved consumers $207,695.78 so far in 2016.
- In September, the Vermont Supreme Court issued a decision in the first Vermont Supreme Court appeal of a Green Mountain Care Board rate review case. The HCA represented consumers in the appeal of the Board's denial of a large rate increase requested by MVP. The Court ruled that the state rate review statute is constitutional, but sent the MVP case back to the Board for findings of fact that related to the standards in the statute.
- In another Vermont Supreme Court case this quarter, the HCA filed a brief and presented an oral argument, with the consent of the self-represented consumer in a Vermont Health Connect appeal. The Human Services Board granted Advanced Premium Tax Credits (APTC) to the spouse of an individual receiving Medicaid because he was a former foster child, and VHC appealed the decision. The spouse seeking APTC was unrepresented.
- The HCA represented the public at the hearings on the 2017 Vermont Health Connect plans and submitted memos arguing for more affordable rates.

- The number of people who used our website to find information and guidance on health care issues continued a pattern of strong growth with 48% more pageviews this quarter, compared with the same period in 2015.
- The number of people seeking information from our website about *dental services* increased significantly (142%) compared with the same period last year. This is the sixth quarter that the number of dental services pageviews has increased significantly over the previous year. Our Vermont Dental Clinics Chart was again the third most frequently downloaded of all PDFs downloaded from the Vermont Law Help website and the top health PDF download.
- An increasing number of Vermonters are seeking out information about MCA Medicaid and Dr. Dynasaur on our website. Half of the top 20 health topics focused on Medicaid or long-term care Medicaid (Choices for Care).

Individual Consumer Assistance

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, *www.vtlawhelp.org/health*. We have a team of advocates located in Vermont Legal Aid's Burlington office which provides this help to any Vermont resident free of charge, regardless of income.

The HCA received 1018 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:

- **19.72%** (201) about **Access to Care**
- **15.11%** (154) about **Billing/Coverage**
- **01.07%** (11) about **Buying Insurance**
- **10.89%** (111) about **Consumer Education**
- **31.40%** (320) about **Eligibility** for state and federal programs
- **21.68%** (221) were categorized as **Other**, which includes Medicare Part D, communication problems with providers or health benefit plans, access to medical records, changing providers or plans, confidentiality issues, and complaints about insurance premium rates, as well as other issues.

We have a customized case management system that allows us to track more than one issue per case. This enables us to see the total number of calls that involved a particular issue. For example, although 320 of our cases had eligibility for state health care programs as the primary issue, there were actually a total of 863 cases that had some eligibility issue.

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

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

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.

Top Problem Areas

A. The HCA's overall call volume was about the same as last quarter, and very close to the call volume during the same quarter in 2015. It is 39% higher than pre-VHC volume.

Total call volume was just slightly higher than last quarter. (1018 vs. 1003) It is also almost equal to the call volume compared to the same quarter last year. (1018 vs. 1015) Our call volume is usually highest from January to March because most health care plans end on December 31, with a new plan year starting on January 1. The renewal process can trigger problems. The call volume remains significantly higher than pre-VHC call volume. (1018 this quarter vs 735 calls for the same quarter in 2013)

All Cases (2006-2016)											
	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
January	313	280	309	240	218	329	282	289	428	470	411
February	209	172	232	255	228	246	233	283	304	388	511
March	192	219	229	256	250	281	262	263	451	509	416
April	192	190	235	213	222	249	252	253	354	378	333
May	235	195	207	213	205	253	242	228	324	327	325
June	236	254	245	276	250	286	223	240	344	303	339
July	183	211	205	225	271	239	255	271	381	362	304
August	216	250	152	173	234	276	263	224	342	346	343
September	181	167	147	218	310	323	251	256	374	307	372
October	225	229	237	216	300	254	341	327	335	311	--
November	216	195	192	170	300	251	274	283	306	353	--
December	185	198	214	161	289	222	227	340	583	369	--
Total	2583	2560	2604	2616	3077	3209	3105	3257	4526	4423	3354

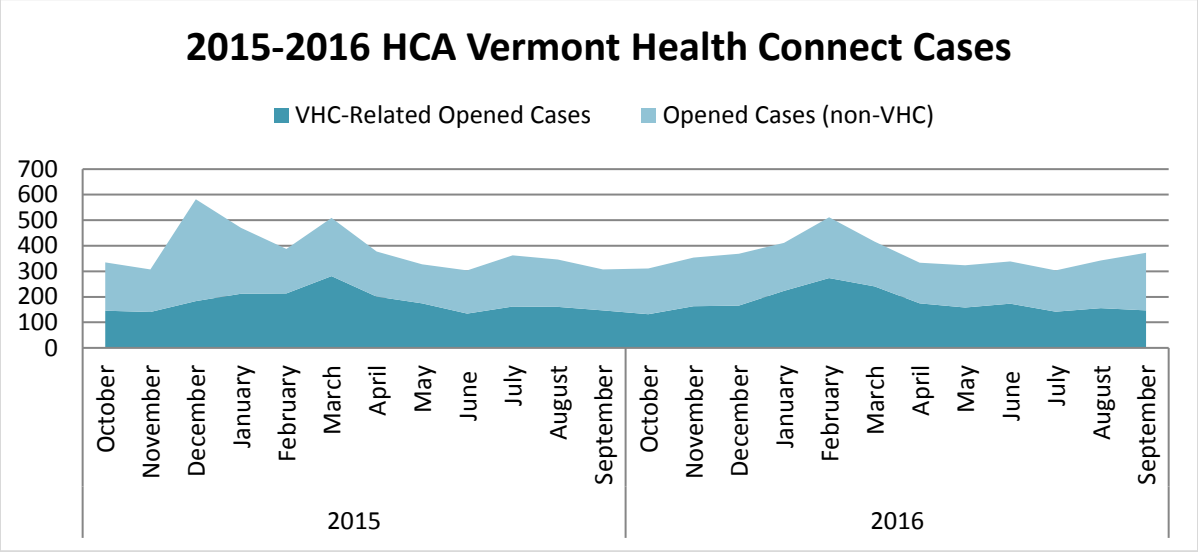
B. Vermont Health Connect call volume dropped by 14% compared with last quarter. The new escalation path is resolving complex cases more quickly and efficiently.

VHC call volume this quarter was 14% lower than last quarter. (447 vs. 511), and there was a small drop (5%) compared with the same quarter last year. (447 for 2016 vs 470 for 2015)

Even though VHC call numbers dropped, consumers are still having significant problems. VHC cases represent 44% of the HCA's total calls. Of all VHC cases, 45% require complex interventions that take more than two hours of an advocate's time to resolve. (199 complex interventions out of 447 total VHC cases)

During this quarter, VHC launched a new escalation path for the HCA's complex cases. The process allows the HCA to work directly with a Tier 3 HAEU worker, who is trained to resolve all aspects of complex cases. In addition, the HCA meets with VHC each week to discuss cases. During the first quarter of this year, before the new escalation path was launched, the HCA was carrying 75-80 complex cases

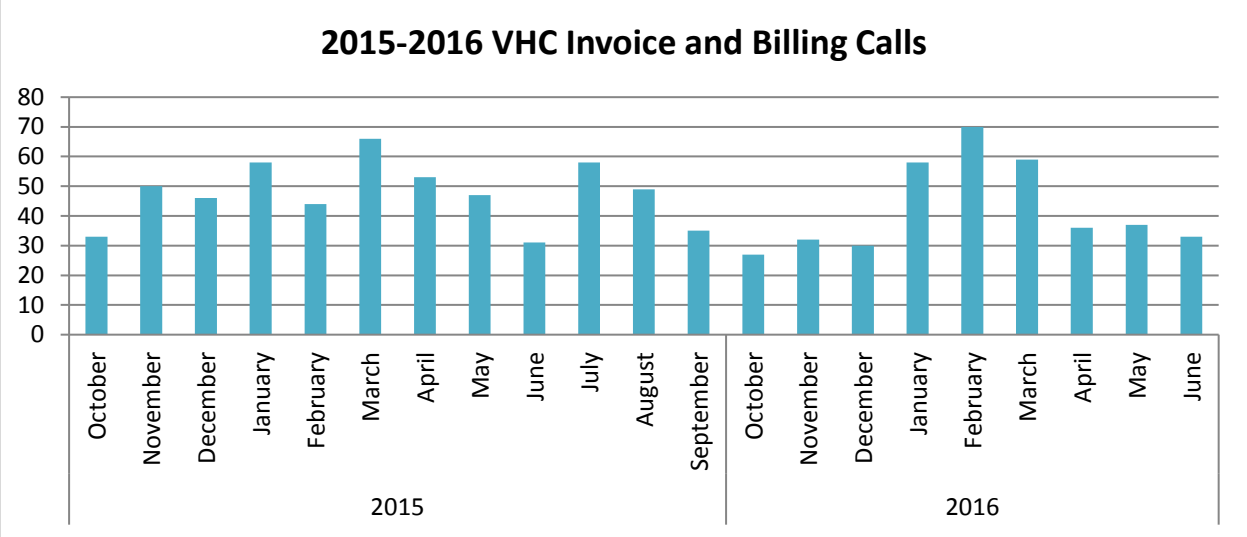
per week. That number gradually decreased to 40-50 per week and now, because the new escalation process allows complex cases to be resolved more quickly and efficiently, the HCA generally carries fewer than 20 unresolved complex cases per week. This quarter, the HCA escalated 181 cases, and 168 cases were resolved.

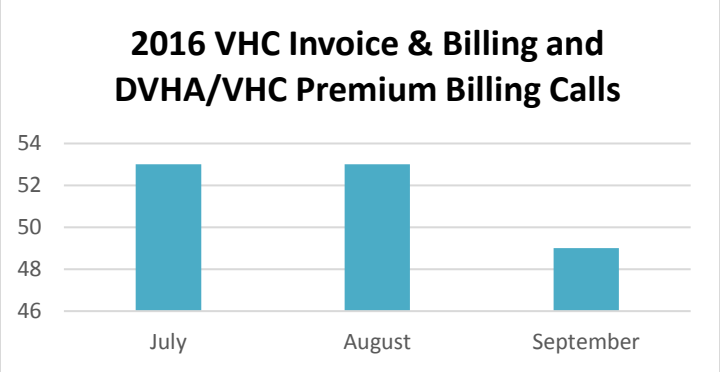


C. Vermont Health Connect invoice and premium problems decreased by 13%, but continue to be a problem for consumers.

Although the number of calls about premium problems dropped, it was still a very troublesome area for consumers. Last quarter, the HCA received a total of 181 calls about billing issues. (75 about DVHA/VHC premium issues and 106 about VHC invoice/payment/billing problems affecting eligibility) This quarter, the HCA received a total of 158 calls about billing issues. (99 about DVHA/VHC premiums issues, and 59 about VHC invoice/payment billing problems affecting eligibility) When we combine those two categories of billing issues, billing is the most common issue for the quarter.[2] The specific billing problems include: inaccurate invoices, payments not applied correctly, and payments not reflected on the invoices. The billing problems can easily turn into access to care cases when a mistake in the invoice causes a consumer's coverage to be erroneously cancelled. (See case examples)

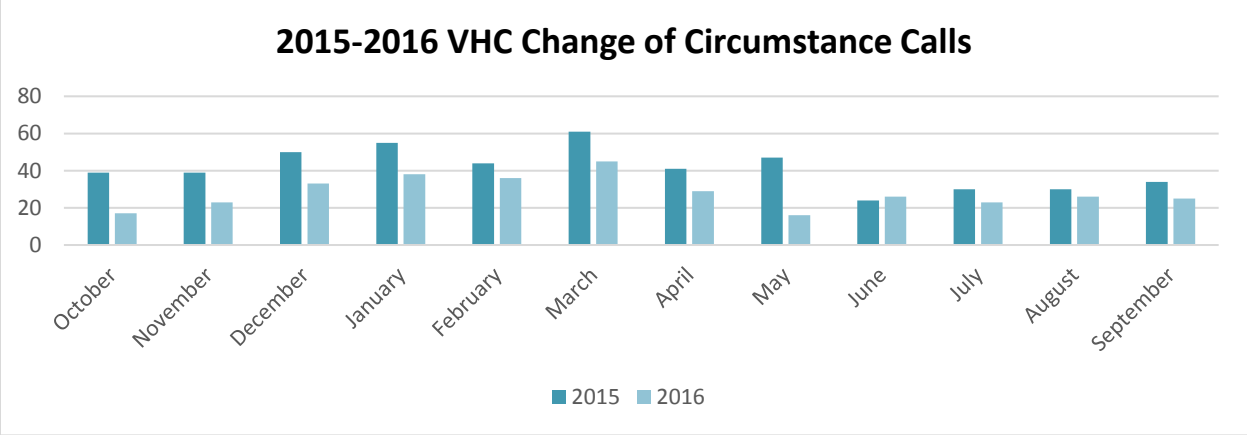
[2] This quarter the HCA revised how we code VHC billing cases. Now cases with general VHC billing problems are billed under DVHA/VHC premium issues. If the billing problem directly impacts eligibility, it is billed under VHC invoice/payment issues affecting eligibility. This change resulted in a drop in the number of cases coded for VHC invoice/billing problems affecting eligibility and an increase in the cases coded for general VHC billing problems. Both codes represent VHC billing problems. As a result, this quarter's data and that of previous quarters can no longer be represented in one chart.





D. Vermont Health Connect Change of Circumstance calls increased slightly.

The HCA received 74 Change of Circumstance calls this quarter, compared with 71 last quarter – an increase of 4%. VHC has been resolving the Change of Circumstances cases much more quickly, and we are getting fewer calls from consumers complaining about processing delays. As a result, the HCA has had to escalate far fewer Change of Circumstance cases.



E. We received 54 calls related to Medicaid reviews.

Even though the State processed thousands of Medicaid reviews each month, the HCA did not receive very many calls about Medicaid reviews. We received a total of 54 calls, which is an increase from last quarter when we received 36 calls. But it is still a relatively low number of calls compared to the number of Medicaid reviews. Of the 54 calls about Medicaid reviews this quarter, 22 were correct terminations, 13 were incorrect terminations, and 19 were seeking information about the review process.

F. Calls about Premium Tax Credit (PTC) eligibility remained steady.

The HCA received 78 calls from consumers related to their eligibility for the Premium Tax Credit, compared to 82 last quarter. These calls are relatively complex because the HCA advises consumers regarding their eligibility for PTC. If consumers are eligible, the HCA also calculates how much PTC they should be receiving. If consumers receive more PTC then they are eligible for, they may have to pay some or all of it back when they file their taxes. This process is called reconciliation. The HCA received 32 calls involving reconciliation this quarter.

G. Access to Prescription Drugs continues to be a pressing issue for consumers.

The HCA received 76 calls this quarter about access to prescription drugs, compared to 58 last quarter – an increase of 31%. Some consumers called when they went to pick up a prescription and found that their VHC plan (QHP) had been terminated or their Medicaid had been closed. With these cases, the HCA intervened to find out if the QHP had been closed in error, and if it had, the HCA worked to get it reinstated. With consumers who were Medicaid-eligible, the HCA encouraged the consumers to submit another application as quickly as possible. Other consumers called because, even with active coverage, they simply could not afford their prescriptions. In those cases, the HCA searched for prescription assistance programs that could help.

H. The top issues generating calls

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

All Calls 1018 (compared to 1003 last quarter)

1. MAGI Medicaid eligibility 126 (115)
2. DVHA/VHC premium billing 99 (75)
3. Complaints about providers 81 (82)
4. VHC Premium Tax Credit eligibility 78 (82)
5. Access to prescription drugs 76 (58)
6. VHC Change of Circumstance 74 (71)
7. Termination of insurance 64 (56)
8. VHC complaints 63 (83)
9. VHC invoice/billing problem affecting eligibility 59 (106)
10. Information/applying for DVHA programs 58 (48)
11. Medicaid eligibility (non-MAGI) 52 (39)
12. Consumer education about Fair Hearings 49 (50)
13. Special Enrollment Periods (eligibility) 49 (30)
14. Buy-in programs/Medicare Savings Programs 48 (34)
15. Confusing notice related to eligibility 45 (11)

16. Grace periods – VHC 43 (33)
17. Consumer education about Medicare 41 (30)
18. HAEU mistake 37 (34)
19. Consumer education about IRS reconciliation 32 (41)
20. VPharm eligibility 29 (13)
21. Information about VHC 27 (32)
22. Information about HCA 27 (10)

Vermont Health Connect Calls 447 (compared to 511 last quarter)

1. MAGI Medicaid eligibility 116 (107)
2. DVHA/VHC premium billing 94 (75)
3. Premium Tax Credit eligibility 75 (79)
4. Change of Circumstance 65 (67)
5. VHC complaints 62 (83)
6. VHC invoice/payment/billing problem affecting eligibility 55 (105)
7. Termination of insurance 50 (47)
8. Grace periods – VHC 43 (33)
9. Special enrollment periods 40 (29)
10. Consumer education about Fair Hearings 37 (44)
11. HAEU mistake 36 (32)
12. Access to prescription drugs 32 (21)

DVHA Beneficiary Calls 300 (compared to 241 last quarter)

1. MAGI Medicaid eligibility 46 (51)
2. Access to prescription drugs 33 (30)
3. Complaints about providers 33 (34)
4. Information/applying for DVHA programs 26 (23)
5. Medicaid eligibility (non-MAGI) 20 (16)
6. Change of Circumstance 19 (10)
7. Transportation 18 (10)
8. Medicaid Renewal/Review – Correct 14 (7)
9. Information about Medicaid Renewal/Review 14 (9)
10. Confusing notice 14 (5)
11. Consumer education about Fair Hearings 12 (8)
12. HAEU mistake 11 (3)
13. Medicaid/VHAP Managed Care Billing 11 (7)

Commercial Plan Beneficiary Calls 252 (compared to 294 last quarter)

1. DVHA/VHC premium billing 69 (53)
2. VHC invoice/payment/billing problem related to eligibility 48 (72)
3. Premium Tax Credit 46 (45)
4. Change of Circumstance 40 (45)

5. VHC complaints 37 (36)
6. Grace periods – VHC 28 (22)
7. MAGI Medicaid eligibility 23 (20)
8. Consumer education about IRS reconciliation 22 (23)
9. Confusing notice 17 (3)
10. Consumer education about IRS Penalty/ISRP 17 (12)
11. HAEU mistake 13 (19)
12. Disenrollment at consumer request 13 (14)
13. Termination of insurance 13 (13)

I. Hotline Call Volume by Type of Insurance

The HCA received 1018 total calls this quarter. The following shows the breakdown by 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"): 31% (316 calls), compared to 24% (234 calls) last quarter
- **Medicare[3] beneficiaries (**Medicare only, Medicare Advantage Plans, Medicare and a Medicare Supplemental Plan aka Medigap, Medicare and Medicaid also known as "dual eligible," Medicare and Medicare Savings Program also called Buy-In program, Medicare and Part D, or Medicare and VPharm): 26% (266 calls), compared to 14% (144) last quarter
- **Commercial plan beneficiaries** (employer-sponsored insurance, small group plans, or individual plans): **22%** (220), compared to 29% (292) last quarter
- **Uninsured: 13%** (132) of the calls, compared to 11% (108) last quarter

Recommendations

1. Continue to improve the wait times at the call center. Consumers have been experiencing long wait times to talk with a Customer Service Representative (CSR), and if their call needs to be transferred to the Eligibility Unit, they are forced to wait again. VHC has improved the wait times by adding additional CSRs. The long wait times create hardship for consumers and inhibit access to VHC.
2. Improve the accuracy of the advice at the call center. The call center is the main contact with VHC for many consumers, and they should receive accurate advice when they call. Further, if a CSR or HAEU (Health Access Eligibility Unit) worker promises to follow up with a consumer, they should do so.
3. Continue to improve the billing system to ensure that consumers receive timely and accurate invoices. Many of the incorrect terminations that we see are due to an underlying error in the billing process.
4. Emphasize the need for a timely transition to Medicare from MCA or QHPs. We are still seeing consumers who miss their initial enrollment period for Medicare Part B, which leads to long-term additional costs for them.
5. Continue to support and train navigators and assistors.

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

Case Results

A. Dispositions of Closed Cases

All Calls

We closed 1,059 cases this quarter, compared to 1,048 last quarter:

- 23% (248 cases) were resolved by brief analysis and advice
- 28% (300) were resolved by brief analysis and referral
- 26% (279) of the cases were complex interventions involving complex analysis, usually direct intervention, and more than two hours of an advocate's time
- 13% (139) were resolved by direct intervention, including calling an insurance company, calling providers, writing letters, gathering supporting medical documentation, etc.
- In the remaining cases, clients withdrew, resolved the issue on their own, or had some other outcome.

Appeals: The HCA assisted 62 people with appeals this quarter: 49 fair hearings, 7 DVHA internal MCO appeals, 5 commercial appeals, and 1 Medicare appeal.

DVHA Beneficiary Calls

We closed 315 DVHA cases this quarter, compared to 225 last quarter:

- 29% (90 cases) were resolved by brief analysis and/or advice
- 29% (90) were resolved by brief analysis and/or referral
- 25% (80) of the cases were considered complex intervention, which involves complicated analysis, usually direct intervention, and more than two hours of an advocate's time
- 12% (39) of the cases were resolved by direct intervention on the caller's behalf, including advocacy with DVHA and providers, writing letters, and gathering medical information.
- One DVHA case was resolved in the initial call.
- In the remaining cases, clients withdrew, resolved the issue on their own, or had some other outcome.

Commercial Plan Beneficiary Calls

We closed 284 cases involving individuals on commercial plans, compared to 345 last quarter:

- 22% (62 cases) were resolved by brief analysis and/or advice
- 14% were resolved by brief analysis and/or referral
- 39% (112) were considered complex intervention, which involves complicated analysis, usually direct intervention, and more than two hours of an advocate's time
- 19% (55) 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.

B. All Calls Case Outcomes

The HCA helped 79 people get enrolled in insurance plans and prevented 17 insurance terminations or reductions. We obtained coverage for services for 23 people. We got 16 claims paid, written off, or reimbursed. We estimated VHC insurance program eligibility for 37 more. We provided other billing

assistance to 38 individuals. We provided 580 individuals with advice and education. Five people were not eligible for the benefit they sought, and four were responsible for the bill they disputed. We obtained other access or eligibility outcomes for 96 more people.

The **HCA saved individual consumers $21,987.77** in cases opened this quarter and $207,695.78 total so far in 2016.

C. Case Examples

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

1. Ms. A's work hours had been reduced, and she was no longer eligible for employer-sponsored insurance (ESI). She met with a navigator who helped her apply for coverage on the Vermont Health Connect (VHC) website. The navigator told her that she was not eligible for Medicaid and that she would need to purchase a VHC plan. Medicaid eligibility is determined by the applicant's current monthly income. Ms. A was actually eligible for Medicaid, but before it could be activated she needed to "verify" her income. This meant Ms. A needed to send proof of her actual income. Ms. A sent VHC some of her pay stubs. She called the HCA because nothing seemed to happen after she sent in her pay stubs, and Ms. A's doctor was threatening to cancel her appointments if her coverage was not active. When the HCA advocate checked, VHC said they had not received the pay stubs. The HCA advocate re-sent the pay stubs and asked VHC escalate the case. Ms. A was found eligible for Medicaid just in time and was able to keep her appointment.

2. Ms. B went to her doctor's office but when she checked-in for her appointment, she was told that her Medicaid coverage was not active and that the appointment had to be re-scheduled. When Ms. B called VHC, she found that her son's Dr. Dynasaur coverage had also been cancelled. When the HCA advocate investigated, she found that Ms. B's Medicaid had closed. Earlier in the summer, VHC had reviewed her Medicaid eligibility and asked her to send in a review application by a certain date. She sent in the application. Her coverage closed, however, before the due date that VHC had given her to return the review application. When the HCA advocate checked, VHC had the application, but it had not been reviewed. The advocate intervened and requested that VHC review the application immediately. When VHC reviewed the application, they found both Ms. B and her son eligible for Medicaid. Ms. B was able to get her son to the doctor for a required check-up just in time for school to start.

3. Ms. E. called VHC to pay for her initial monthly premium for her QHP, and her bill was double what she expected. She could not afford to pay it, but she would not have active coverage until she made the first payment. When Ms. E called the HCA, the advocate investigated and found that Ms. E's Medicaid had recently closed. She had called to sign up for a QHP, and the plan was supposed to start the first day of the following month. VHC, however, had started her QHP the first day of the month that Ms. E applied. She did not need a QHP that month because she still had Medicaid. Because of the incorrect start date, Ms. E was charged for an extra month of coverage. The HCA advocate pointed out that VHC had not followed its own enrollment rules, and they agreed to move the start date up one month. As a result, Ms. E was able to make her first payment and her coverage was activated.

4. Mr. F needed his asthma medication, but he had missed the VHC open enrollment period and did not have any insurance coverage. When he called the HCA for help, the advocate discovered that he had lost his job and had no income. She told him that he was Medicaid-eligible and advised him to call VHC and apply over the phone. He called VHC and had almost completed the application when

the call was dropped. VHC called him back, but the second call was also dropped. Mr. F then called the HCA to help him find out if he had completed the Medicaid application. When the HCA advocate called VHC, they did not have a completed application. The advocate advised Mr. F that he still needed to apply and advised him to apply online. After some initial technical difficulties, he was finally able to apply online. The advocate asked VHC to rush his application because of medical urgency. His Medicaid was quickly activated, enabling him to get the asthma medication he needed.

5. Mr. G called the HCA because he could not afford to pay his Medicare Part B premiums, which were being automatically deducted from his Social Security payment. Mr. G was financially eligible for a Medicare Savings Program (MSP), which would pay the Part B premium and other out-of-pocket costs of Medicare. Before his Medicare started, Mr. G had faxed an MSP application to the State of Vermont and kept a copy of the fax confirmation showing when he had sent the application. He didn't hear anything from the State after sending the application, and Part B premiums began to be taken out of his small Social Security payment. He called the HCA, and the advocate found that the application had been temporarily lost and was scanned into the State's system over a month after he sent it. The advocate showed the State the fax documentation and argued that Mr. G's MSP start the date that he had started Medicare. The state agreed, and Mr. G was refunded the Part B premiums that had been taken out of his check when he should have been on the MSP.

6. Mr. H called the HCA when he found out that his family plan on VHC had been cancelled back to the end of January. He had discovered the cancellation when he took his children to the doctor and was told that they had no coverage. The HCA advocate looked into the issue and found that he had been terminated for non-payment. When Mr. H's payment record was reviewed, though, it showed that all of his premiums for 2015 and 2016 had been paid. The family had dropped their dental coverage in 2015, which had created an error in the billing system that ultimately caused him to be terminated in January 2016, even though he was up-to-date with his payments. Because there was no basis for a non-payment termination, the HCA advocate asked that the family's coverage for all of 2016 be reinstated, and VHC agreed.

Back to Table of Contents

Consumer Protection Activities

A. Rate Reviews

The HCA monitors all insurance carrier requests to the Green Mountain Care Board for changes in premium rates requested by commercial insurance carriers. These are usually rate increases. Three new rate review cases were filed during the quarter.

The two significant new rate review cases decided during the quarter were rate requests for products to be offered on the Vermont health insurance exchange, Vermont Health Connect (VHC), in 2017. BCBSVT's filing requested an average 8.2% increase for its 2017 plans, which have 70,423 members. MVP's filing requested an average increase of 8.8% for its plans with 6,614 members. The Board's actuary, the firm of Lewis and Ellis (L & E) reviewed the filings and requested additional information from the insurers. The HCA and its independent actuary also analyzed the two filings and suggested questions for L & E to pose to the insurers. Hearings were held on July 20 and July 21, 2016, and the HCA and the insurers submitted memoranda summarizing their arguments. The HCA's actuary filed an expert

report and testified in the hearing on the BCBSVT filing. The Board issued its decisions on August 9, 2016.

The Board issued a 3-2 decision in the BCBSVT VHC filing directing the company to lower its price increase from the requested 8.2 percent to 7.3 percent. The Board's reduction was based on assumptions that BCBSVT's increased utilization amount could be reduced and that hospital commercial rate increases would be lower than the increases assumed by the carrier. The HCA had argued for a rate decrease based on lowering the insurer's requested contribution to surplus. BCBSVT filed a Motion for Reconsideration of the Board's decision, and that Motion was denied in August.

The Board reduced MVP's requested rate increase of 8.8% to 3.7% based on a revised risk adjustment factor recommended by the Board's actuaries, L & E. This decision was consistent with the HCA's argument that the Board should adopt the L & E recommendation for rate modification.

MVP filed three new rate review cases during the quarter. The HCA has entered appearances to participate as a party in the first two filings. The Board's actuaries and DFR evaluated both filings during the quarter. The first shows the premium rate development for MVP's large group EPO/PPO products for the first and second quarters of 2017 including high deductible health plans and non-high deductible plans. The proposed rates in this filing will affect approximately 2,234 Vermonters. The second filing shows proposed quarterly rate increases for MVP's small group grandfathered EPO/PPO product portfolio. This is a closed block of business. As of June 2016 1,933 members were enrolled in the plans affected by this rate filing. The proposed filing would result in 9% annual rate increases for 1st quarter 2017 group renewals and 10.5% increases for 2nd quarter group renewals.

The third filing is a manual rate filing for MVP's 2017 Large Group HMO products. There are currently no members enrolled in these products because members have shifted to the Large Group EPO/PPO products. The HCA did not enter an appearance for this filing due to the lack of membership.

The HCA was a party in the Vermont Supreme Court's review of the Board's December 2015 decision disapproving the rate request for five plans offered by the Agriservices Association. Agriservices, an association for farmers, uses MVP's large group Minimum Premium Plan funding arrangement for grandfathered plans with a contract renewing with a December 1, 2015 effective date. MVP requested a very large average annual rate increase of 26.9%. The HCA asked the Board to disapprove the requested rates and the Board's December 2015 decision disapproved the increase. In January, MVP asked the Board to reconsider its decision. The HCA opposed this request and the Board refused to change its initial decision. MVP then appealed the Board's decision to the Vermont Supreme Court. MVP claimed that the criteria used by the Board in denying the rate increase were unconstitutionally vague or in the alternative that the Board's findings of fact and conclusions were not consistent with the standards in the rate review statute. The insurer, the HCA and the solicitor General on behalf of the Green Mountain Care Board filed briefs in March and April 2016. The HCA asked the Supreme Court to find the statute constitutional and uphold the Board decision, and the Solicitor General also asked the Court to affirm the Board's decision. MVP, the HCA and the Solicitor General all participated in oral argument in front of the Supreme Court in June. The Supreme Court issued its decision on September 23, 2016. It found the rate review statute constitutional but agreed with MVP's argument that the Board's conclusions of law were not supported by specific findings of fact that related to the statutory criteria. The Court sent the case back to the Board for new findings.

B. Certificate of Need

In the past quarter, the HCA participated in a public hearing on whether there should be an emergency certificate of need process for the acquisition of Burlington Labs. We questioned the applicant at the

hearing regarding allegations that the previous owners had committed Medicaid fraud and asked the Board to clarify the emergency review process. The Board decided to proceed with the emergency application process and did not hold a hearing on the application or allow parties to intervene.

In addition, we submitted a notice of appearance for Southwestern Medical Center's certificate of need application to create a new dental clinic. We are currently reviewing the information on this application as it comes in.

C. Other Green Mountain Care Board Activities

Hospital Budget Review

The HCA took advantage of a new opportunity in 2016 to protect consumer interests through an expanded role in the Green Mountain Care Board's Hospital Budget Review process. This new role developed from changes to Act 152, which gave the HCA the right to pose written questions to Green Mountain Care Board staff and to the hospitals regarding the hospitals' budget submissions and to ask questions and provide testimony at the Hospital Budget hearings, in addition to providing written comments after the hearings. In the last quarter, we began the process by meeting with Board staff to coordinate the exchange of hospital budget documents between the Board, the HCA, and the hospitals. We then worked with an independent expert in hospital budget accounting to advise us on the hospitals' submissions. Together, we reviewed the information we received from the Board and the hospitals, and submitted a list of questions to each hospital in writing before the hearings. We then questioned each hospital during the four days of hospital budget hearings, and we submitted formal comments after we had assessed the answers we received to our questions and the information provided at the hearings. In our role, we focused on the hospitals' community benefit activities, health care reform work to lower costs and improve quality, services related to substance abuse and mental health support, and justifications for their requested budget increases.

In addition, in the past quarter, the HCA attended six Board meetings.

D. All-Payer Model

The Green Mountain Care Board, Agency of Administration, and Agency of Human Services are in the process of negotiating an all-payer model (APM) agreement for the state, which would be implemented by a unified Accountable Care Organization (ACO). The HCA has been monitoring the planning process for the proposed APM and unified ACO for potential consumer protection concerns.

During the last quarter, we attended a meeting convened by the Green Mountain Care Board to gather stakeholder input on proposed state-level population health measures for the APM. At the very end of the quarter (September 29), the state released a draft APM agreement with the federal government. During the last two days of the quarter we began reviewing the draft agreement and related materials.

E. Vermont Health Care Innovation Project (SIM Grant)

The HCA continues to participate in the Vermont Health Care Innovation Project (VHCIP), which is funded by a federal State Innovation Model (SIM) grant. The Chief Health Care Advocate was a member of the VHCIP Steering Committee until her retirement on August 31. The Steering Committee met once this quarter, in September, and the HCA's policy analyst attended the meeting in the Chief's absence. The HCA participated, along with representatives from other projects of Vermont Legal Aid, as "active members" in five of the six VHCIP work groups: Payment Model Design and Implementation, Practice Transformation, Health Data Infrastructure, Disability and Long Term Services and Supports, and Population Health. This quarter we participated in five VHCIP work group meetings.

We continued to monitor the activities of the VHCIP Core Team and attended one Core Team meeting as an interested party. The HCA is a participant in the VHCIP Self-Evaluation Committee and attended one meeting with the project's evaluation consultant this quarter. The HCA is also a participant in the newly formed VHCIP Sustainability Planning Group. We were unable to attend the first meeting, but provided our perspective to the group's consultant on a different date. We attended the group's second meeting this quarter.

F. Affordable Care Act Tax-related Activities

The HCA continued tax-related assistance, advocacy, and outreach efforts. We commented on VHC's implementation of a federal requirement to provide notice to employers when an employee is granted advance payments of the Premium Tax Credit (APTC). The HCA received and escalated cases with VHC involving APTC reconciliation and forms 1095-A.

The HCA employed 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 support our staff to effectively field calls related to the ACA and VHC as HHS and IRS release new federal guidance and regulations affecting VHC and Vermont consumers. The HCA submitted comments to the IRS on proposed changes to the Premium Tax Credit regulations. (See Administrative Advocacy below.) The proposed changes to federal rules would have a significant impact on Vermont consumers.

As in prior quarters, the HCA's tax attorney consulted with HCA advocates when particularly difficult IRS-related issues arose in HCA cases. The tax attorney advised the HCA on 11 technical assistance questions. She also responded to 40 technical assistance questions from assisters, Vermont tax preparers, and legal services attorneys in other states. The most common topic of technical assistance was IRS safe harbor rules for incorrect APTC determinations. HCA also responded to technical assistance requests on IRS procedures and consumer rights after a tax return is filed.

The HCA continued to participate in the *In Re J.H.* case before the Vermont Supreme Court involving eligibility for premium subsidies through VHC. The HCA supports J.H.'s eligibility for premium subsidies because she does not have the ability to enroll in employer-sponsored insurance unless her husband changes his mind and decides to also enroll. On July 1 the HCA filed a legal brief as *amicus curiae*, friend of the court. The HCA subsequently alerted the Court to new draft IRS guidance relevant to the case. The Supreme Court heard oral arguments on September 29. The HCA presented an oral argument with the consent of the self-represented consumer.

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

G. Other Activities

Litigation

- **In Re: J.H.**

As described above under **Affordable Care Act Tax-Related Activities**, the HCA participated as *amicus curiae* in a Vermont Supreme Court appeal involving eligibility for QHP subsidies under federal tax law. The Court's decision is pending.

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

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

Administrative Advocacy

✧ Controlled Substance and Pain Management Advisory Council

Act 173 of 2016 created this council to advise the Commissioner of Health on matters related to the Vermont Prescription Monitoring System, the appropriate use of controlled substances in treating pain, and preventing prescription drug abuse, misuse, and diversion. This quarter the council had its first meeting regarding rulemaking for opiate prescribing, which the HCA attended. At the meeting, the Commissioner of Health solicited comments from council members prior to the filing of the rule. The HCA submitted a set of comments and also suggested edits to a patient information form about opiates.

✧ HIT Plan Interim Governance Team

The state's HIT Plan creates an Interim Governance Team responsible for developing recommendations for the Secretary of Administration to provide to the next Administration. The HCA is participating in this group, which includes state employees and stakeholders. We attended two meetings of the governance team this quarter and submitted written accountability recommendations for private and public HIT entities.

✧ Health Care Administrative Rules (HCAR)

In September VLA's Disability Law Project and the HCA submitted formal comments on proposed Health Care Administrative Rules (HCAR) as part of the Administrative Procedure Act's formal rulemaking process. We asked for changes to the proposed rules for Specialized Services and Programs and for the definition of Early Periodic Screening, Diagnostic and Treatment services and argued against the elimination of some non-eyewear aids to vision.

✧ IRS Premium Tax Credit Notice of Proposed Rulemaking VI

In September the HCA collaborated with VLA's Low-Income Taxpayer Clinic and Southeastern Ohio Legal Services to comment on proposed changes to the federal Premium Tax Credit rules. HCA supported simplification of the rules for calculating benchmark plans when family members reside apart. HCA also supported giving consumers 120 days to pay the premiums for a retroactive enrollment allowed by an HSB decision. Currently, there is no exception to the rule that consumers must pay all premiums by April 15 following the plan year. The comments by HCA also raised fairness concerns with proposed changes to the APTC reconciliation safe harbor rules. HCA suggested different approaches the IRS could take to better accommodate federal exchange rules and Medicaid agency practices.

✧ Qualified Health Plan (QHP) Rule

In May 2016 the HCA submitted formal comments on a pre-rulemaking draft of DVHA's QHP certification and direct enrollment rule, *Standards for Issuers Participating in the Vermont Health Benefits Exchange*. The HCA's comments emphasized the need for the rule to be written in plain language so that it will be accessible to consumers and assisters as well as health insurance issuers. The HCA also advocated limiting consumer and issuer liability for mistakes made by VHC and creating a formal guidance system so that sub-regulatory guidance is accessible to consumers and the public.

After submitting comments, the HCA attended a follow-up stakeholder meeting with DVHA and AHS to discuss the rule. DHVA accepted several changes suggested in the HCA's comments. DVHA began the

formal APA rulemaking process this quarter. The HCA submitted written comments in August. DVHA made changes to the final proposed version of the rules based on these comments, including a rule change that will allow more consumers who transfer from one plan to another in the middle of a year to transfer payments made toward their deductibles in the old plan to the new plan. LCAR will review the rules in October. In addition, the HCA has been participating in two workgroups that were formed to discuss retroactive account changes and billing and enrollment.

✧ 2018 Qualified Health Plan (QHP) Work Group

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

✧ Rule 09-03 Work Group

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

The HCA advocated for provisions in the statute and rule that would maintain regulatory protections for consumers in commercial health care plans, would improve the reports insurers provide about denied claims and would require DFR to file quarterly reports showing how many complaints are filed about violations of the consumer protection standards in Rule 09-03. The Administration presented proposed language for statutory changes to implement the work group's proposals in S.255, and the HCA testified about this bill. DFR and the HCA negotiated a compromise section requiring annual reports about the complaints DFR receives about violations of the rule, aggregated for all insurers. After S.255 passed during the legislative session, the work group met to discuss the rule before the Administration began the formal rule-making process under the Administrative Procedures Act. The formal rule was filed during the quarter. The HCA did not have any issues with the rule as filed. The Legislative Committee on Administrative Rules will review the rule during the next quarter.

✧ Vermont Health Connect Escalation Path

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

✧ Comments on Vermont Health Connect Notices

At VHC's request, the HCA commented on three 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

The Chief Health Care Advocate was an active participant in Vermont's Medicaid and Exchange Advisory Board (MEAB) until her retirement at the end of August. The Chief attended two meetings of the MEAB this quarter. The HCA attended one additional meeting of the MEAB in September after the Chief's retirement.

✧ 42 C.F.R. Part 2 Advisory Group

We continue to participate in the 42 C.F.R. Part 2 advisory group started by DVHA. This group is working on ways the Vermont Health Information Exchange (VHIE) can protect patient privacy in compliance with federal rules on substance abuse information in medical records without excluding these patients' records from the Exchange. The group did not meet this quarter.

✧ Vermont Hepatitis Task Force

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

Legislative Activities

This quarter the HCA monitored the activity of joint committees that took up issues related to health care. We attended two meetings of the Health Reform Oversight Committee and one meeting of the Joint Fiscal Committee.

Collaboration with Other Organizations

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

- American Bar Association Section of Taxation
- American Cancer Society of Vermont
- American Civil Liberties Union of Vermont (ACLU-VT)
- Champlain Valley Office of Economic Opportunity (CVOEO) Financial Futures Program
- Community Catalyst
- Families USA
- Iowa Legal Aid
- OneCare Vermont
- Southeastern Ohio Legal Services
- University of South Dakota Low Income Tax Clinic
- Vermont CARES
- Vermont Council of Developmental and Mental Health Services
- Vermont Health Connect
- Vermont Oral Health Care for All Coalition
- Vermont Program for Quality in Health Care
- Vermont Public Interest Research Group (VPIRG)

Back to Table of Contents

Outreach and Education

A. Website

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

Google Analytics Statistics

- The total number of health pageviews increased by 48% in the reporting quarter ending September 30, 2016 (8,645 pageviews), compared with the same quarter in 2015 (5,857 pageviews). This is particularly noteworthy because the total number of pageviews for the entire Vermont Law Help website was only slightly higher (5.5%) compared with the same period last year.
- The number of people seeking help finding *dental services* increased significantly (142%) compared with the previous year, as it has **the past six quarters**. (525 pageviews this quarter, compared with 217 in the same period last year). The number of pageviews decreased slightly (<5%) this quarter (525) compared with last quarter (552).
- The number of people who visited our *Health Insurance, Taxes and You* page increased by 111% this quarter, with 279 pageviews compared to last year's 132. This statistic is particularly interesting since the regular tax season ended in mid-April, and the number of pageviews is slightly higher than it was last quarter (275).
- This quarter, like the previous four quarters, we saw a large increase in the number of people seeking information about *Medicaid income limits* (3,130 pageviews this quarter, compared with 1,301 in the same quarter in 2015, an increase of 141%). The consistently high numbers indicate that search engines are delivering this page as a high-ranking source of information about Medicaid income limits, as well as the increasing age of Vermont's population.
- The *health home page* again had the second largest number of pageviews (919), slightly higher than last year's 887. The home page tells consumers how we can help them and provides several ways to contact us including an online form that can be filled out and submitted 24/7.
- Half of the 20 health topics with the largest number of pageviews focused on Medicaid or long-term care Medicaid (Choices for Care). There is almost no information about MCA Medicaid or Dr. Dynasaur available on the state websites, but there is clearly a need for information on these topics.
- While the total number is small, the number of people looking for information about *Medical Debt* is steadily increasing (62 pageviews, +130%). This number is 59% higher than last quarter, which was 160% higher than last year.
- Other popular topics included:
    - *Vermont Choices for Care* (256 pageviews, +35%)
    - *Medical Marijuana Registry – Patient Form* (161 pageviews, +152%)
    - *Medicaid and Medicare (Dual Eligible)* (157 pageviews, +41%)
    - *Federally Qualified Health Centers (FQHCs)* (115 pageviews, +37%)
    - *Medicare Savings/Buy In Programs* (114 pageviews, +148%)

PDF Downloads

Thirty-eight out of 74 or 51% of the **unique PDFs** downloaded from the Vermont Law Help website were on health care topics. Of those unique health-related PDF titles:

- 18 were created for consumers. The top five consumer-focused PDF downloads were the same as the last two quarters:
  - *Vermont Dental Clinics Chart* (134 downloads)
  - *Advance directive, short form* (53 downloads)
  - *Blue Cross Blue Shield of VT Annual Report 2014* (20 downloads)
  - *Vermont Medicaid Coverage Exception Request – 10 Standards and Provider Request Form* (16 downloads)
  - *Advance directive, long form* (12 downloads)
- 13 were prepared for lawyers, advocates and assisters who help consumers with tax issues related to the Affordable Care Act. The top advocate-focused downloads were:
  - *Magi 2.0 (it's complicated)* (5 downloads)
  - *Low-Income Taxpayers and the Affordable Care Act – November 2014* (4 downloads)
- 7 covered topics related to health policy. The top policy-focused downloads were:
  - *BCBSVT 2016 Exchange Filing – Plain Language Summary* (3 downloads)
  - *Vermont ACO Shared Savings Program Quality Measures* (3 downloads)

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

B. Education

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

We gave presentations directly to approximately 44 individuals, many of whom serve populations that are likely to benefit from the information and education provided. We reached several hundred more through outreach events and publications.

Outreach Events

Here to Help Clinic (September 24, 2016)

HCA's brochure was distributed at the Here to Help Clinic held at First United Methodist Church in Burlington. 97 low-income people, including many who are experiencing homelessness, attended the event.

CVOEO Financial Futures Program (August 26, 2016)

The HCA's tax attorney provided information and brochures at CVOEO's Financial Wellness Day, an event designed to provide information about financial and community resources for New Americans. Approximately 150 New Americans attended the event.

Publications

American Bar Association Tax Manual – Chapter Update (August 2016)

Vermont Legal Aid's tax attorney co-wrote a 2016 update to Chapter 29, Understanding the Affordable Care Act and Its Impacts on Low-Income Taxpayers, which originally appeared in the 6th edition of the ABA Tax Manual - Effectively Representing Your Client Before the IRS. The updated chapter can't be shared publicly, but it is available on our intranet as a reference for the HCA advocates, and it was provided for free to all Low-Income Tax Clinics nationwide. The manual and the 2016 ACA chapter update are also available to the public for purchase from the ABA.

Justice Quarterly (August 19, 2016)

Two health care articles were published in the Summer issue of VLA's quarterly newsletter, Justice Quarterly. The first article urged Medicaid patients who are having problems getting to medical appointments to let us know so we can work on those problems. The second article informed readers about the Vermont District Court ordering CMS to develop a corrective action plan to provide additional education to make it clear to providers and contractors that an improvement standard cannot be used to deny Medicare coverage.

Presentations

Vermont Tax Practitioners Association (September 20, 2016)

The HCA's tax attorney gave a presentation entitled ACA Refresher to 34 tax preparers who attended the Vermont Tax Practitioners Association's September meeting. The presentation included affordability exemptions and PTC safe harbors. Participants took all 10 HCA brochures that were available at the meeting, and we mailed 34 more later to those who requested them. We posted the presentation and handouts on our *ACA for Assisters* web page.

Ladies First (July 19, 2016)

The HCA presented information about the Office of the Health Care Advocate and what we do, along with a basic intro to Obamacare and Vermont Health Connect, to approximately 10 staff members from Ladies First and the Vermont Department of Health. Ladies First helps eligible women get free health screenings and, in some cases, diagnostic screenings. The program also provides support and guidance to help women through health challenges and to help them make positive lifestyle changes.

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:

- Rewrote VHC video scripts encouraging insureds to use preventive services 8-31-16
- Suggested extensive revisions to VDH Opioid Patient Information 8-24-16
- Suggested language for HHS to use for VT employer appeal 7-28-16
- Provided extensive plain language edits and edits/comments to improve comprehension of message and ability to resolve the problem being addressed in the following notices/letters:
    - ADM710-MM VPharm Wrong App sent 9-16-16
    - ADM709-MM VPharm Held Harmless Change Notice 8-8-16
    - FAQs: Billing, Premium Payment, Grace Period 8-8-2016

- RE005EP-MM VMR 2016 VHC Renewal Notice of Decision 7-15-16
- SYS709-MM Dr D Premium Change letter 7-13-16
- ADM708-MM VPharm Annual Review Change Notice VLA 7-13-16

Back to Table of Contents

Office of the Health Care Advocate

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

http://www.vtlegalaid.org/health

Attachment 6 - MCO Investments SFY 2016

MCO Investment Expenditures

Department	Criteria	Investment Description	SFY06 Actuals - 3/4 SFY	SFY07 Actuals	SFY08 Actuals	SFY09 Actuals	SFY10 Actuals	SFY11 Actuals	SFY12 Actuals	SFY13 Actuals	SFY14 Actuals	SFY15 Actuals	SFY16 Actuals
AOE	2	School Health Services	$ 6,397,319	$ 8,956,247	$ 8,956,247	$ 8,956,247	$ 8,956,247	$ 4,478,124	$ 11,027,579	$ 9,741,252	$ 10,454,116	$ 10,029,809	$ 10,472,205
AOA	4	Blueprint Director	$ -	$ -	$ 70,000	$ 68,879	$ 179,284	$ -	$ -	$ -	$ -		
AOA	4	Green Mountain Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 639,239	
GMCB	4	Green Mountain Care Board	$ -	$ -	$ -	$ -	$ -	$ -	$ 789,437	$ 1,450,717	$ 2,360,462	$ 2,517,516	$ 2,188,901
DFR	2	Health Care Administration	$ 983,637	$ 914,629	$ 1,340,728	$ 1,871,651	$ 1,713,959	$ 1,898,342	$ 1,897,997	$ 659,544	$ 165,946		
DII	4	Vermont Information Technology Leaders	$ 266,000	$ 105,000	$ 105,000	$ 339,500	$ -	$ -	$ -	$ -	$ -		
VVH	2	Vermont Veterans Home	$ 747,000	$ 913,047	$ 913,047	$ 881,043	$ 837,225	$ 1,410,956	$ 1,410,956	$ 1,410,956	$ 410,986	$ 410,986	$ 410,986
VSC	2	Health Professional Training	$ 283,154	$ 391,698	$ 405,407	$ 405,407	$ 405,407	$ 405,407	$ 405,407	$ 405,407	$ 405,407	$ 409,461	$ 629,462
UVM	4	Vermont Physician Training	$ 2,798,070	$ 3,870,682	$ 4,006,152	$ 4,006,156	$ 4,006,152	$ 4,006,156	$ 4,006,156	$ 4,006,156	$ 4,006,156	$ 4,046,217	$ 4,046,217
VAAFM	3	Agriculture Public Health Initiatives	$ -	$ -	$ -	$ -	$ -	$ -	$ 90,278	$ 90,278	$ 90,278	$ 90,278	$ 90,278
AHSCO	2	Designated Agency Underinsured Services	$ -	$ -	$ -	$ -	$ -	$ 2,510,099	$ 5,401,947	$ 6,232,517	$ 7,184,084	$ 6,894,205	$ 5,632,253
AHSCO	4	2-1-1 Grant	$ -	$ -	$ -	$ 415,000	$ 415,000	$ 415,000	$ 415,000	$ 415,000	$ 499,792	$ 499,667	$ 453,000
VDH	2	AIDS Services/HIV Case Management	$ 152,945	$ -	$ -	$ -	$ -	$ -	$ -	$ -		$ -	
VDH	2	Newborn Screening	$ 74,899	$ 166,795	$ 136,577	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
VDH	2	DMH Investment Cost in CAP	$ -	$ -	$ -	$ 64,843	$ -	$ 752	$ 140	$ -	$ -	$ -	
VDH	2	Renal Disease	$ 15,000	$ 7,601	$ 16,115	$ 15,095	$ 2,053	$ 13,689	$ 1,752	$ 28,500	$ 3,375	$ 10,125	$ 13,500
VDH	2	TB Medical Services	$ 27,052	$ 29,129	$ 15,872	$ 28,359	$ 41,313	$ 36,284	$ 39,173	$ 34,046	$ 59,872	$ 28,571	$ 9,738
VDH	4	Immunization	$ -	$ -	$ -	$ 726,264	$ -	$ -	$ 23,903	$ 457,757	$ 165,770	$ 253,245	$ 109,373
VDH	2	Emergency Medical Services	$ 174,482	$ 436,642	$ 626,728	$ 427,056	$ 425,870	$ 333,488	$ 274,417	$ 378,168	$ 498,338	$ 480,027	$ 442,538
VDH	2	Family Planning	$ 365,320	$ 122,961	$ 169,392	$ 300,876	$ 300,876	$ 275,803	$ 420,823	$ 1,574,550	$ 1,556,025	$ 1,390,410	$ 1,193,215
VDH	3	WIC Coverage	$ 161,804	$ 1,165,699	$ 562,446	$ 86,882	$ -	$ 36,959	$ -	$ 77,743	$ 317,775	$ 1,824,848	$ 1,201,498
VDH	2	Substance Abuse Treatment	$ 1,466,732	$ 2,514,963	$ 2,744,787	$ 2,997,668	$ 3,000,335	$ 1,693,198	$ 2,928,773	$ 2,435,796	$ 2,363,671	$ 2,913,591	$ 2,169,074
VDH	2	Health Laboratory	$ 1,369,982	$ 1,908,982	$ 2,012,252	$ 1,522,578	$ 1,875,487	$ 1,912,034	$ 1,293,671	$ 2,885,451	$ 2,494,516	$ 3,405,659	$ 3,294,240
VDH	3	Fluoride Treatment	$ -	$ -	$ -	$ -	$	$	$ 43,483	$ 75,081	$ 59,362	$ 55,209	$ 75,916
VDH	3	Health Research and Statistics	$ 276,673	$ 403,244	$ 404,431	$ 217,178	$ 254,828	$ 289,420	$ 439,742	$ 497,700	$ 576,920	$ 715,513	$ 1,195,231
VDH	3	Epidemiology	$ 326,708	$ 427,075	$ 416,932	$ 204,646	$ 241,932	$ 315,135	$ 329,380	$ 766,053	$ 623,363	$ 872,449	$ 750,539
VDH	3	Statewide Tobacco Cessation	$ -	$ -	$ -	$ 230,985	$ 484,998	$ 507,543	$ 450,804	$ 487,214	$ 1,073,244	$ 1,148,535	$ 257,507
VDH	4	Community Clinics	$ -	$ -	$ -	$ 640,000	$ 468,154	$ 640,000	$ 600,000	$ 640,000	$ 688,000	$ -	
VDH	4	Patient Safety - Adverse Events	$ -	$ -	$ 190,143	$ 100,509	$ 44,573	$ 16,829	$ 25,081	$ 42,169	$ 38,731	$ 34,988	$ 35,033
VDH	4	FQHC Lookalike	$ -	$ -	$ 30,000	$ 105,650	$ 81,500	$ 87,900	$ 102,545	$ 382,800	$ 160,200	$ 97,000	$ 6,000
VDH	4	Poison Control	$ -	$ -	$ -	$ -	$ 176,340	$ 115,710	$ 213,150	$ 152,250	$ 152,433	$ 105,586	$ 85,586
VDH	4	Coalition of Health Activity Movement Prevention Program (CHAMPPS)	$ -	$ 100,000	$ 291,298	$ 486,466	$ 412,043	$ 290,661	$ 318,806	$ 345,930	$ 326,184	$ 395,229	$ (26,262)
VDH	4	Healthy Homes and Lead Poisoning Prevention Program	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 101,127	$ 479,936	$ 421,302	$ 187,784
VDH	4	Challenges for Change: VDH	$ -	$ -	$ -	$ -	$ -	$ -	$ 309,645	$ 353,625	$ 288,691	$ 426,000	$ 784,155
VDH	4	Area Health Education Centers (AHEC)	$ -	$ 35,000	$ 310,000	$ 565,000	$ 725,000	$ 500,000	$ 540,094	$ 496,176	$ 547,500	$ 543,995	$ 562,000
VDH	4	CHIP Vaccines	$ -	$ -	$ -	$ -	$ -	$ -	$ 196,868	$ 482,454	$ 707,788	$ 557,784	$ 578,183
VDH	4	Tobacco Cessation: Community Coalitions	$ 938,056	$ 1,647,129	$ 1,144,713	$ 1,016,685	$ 535,573	$ 94,089	$ 371,646	$ 498,275	$ 632,848	$ 702,544	
VDH	4	Vermont Blueprint for Health	$ 92,049	$ 1,975,940	$ 753,087	$ 1,395,135	$ 1,417,770	$ 752,375	$ 454,813	$ 875,851	$ 713,216	$ 703,123	$ 757,576
VDH	4	Physician/Dentist Loan Repayment Program	$ 810,716	$ 439,140	$ 930,000	$ 1,516,361	$ 970,000	$ 900,000	$ 970,000	$ 970,105	$ 1,040,000	$ 900,000	$ 770,000
VDH	4	Recovery Centers	$ 171,153	$ 287,374	$ 329,215	$ 713,576	$ 716,000	$ 648,350	$ 771,100	$ 864,526	$ 1,009,176	$ 1,299,604	$ 1,354,104
DMH	2	Special Payments for Treatment Plan Services	$ 101,230	$ 131,309	$ 113,314	$ 164,356	$ 149,068	$ 134,791	$ 132,021	$ 180,773	$ 168,492	$ 152,047	$ 158,316
DMH	2	MH Outpatient Services for Adults	$ 775,899	$ 1,393,395	$ 1,293,044	$ 1,320,521	$ 864,815	$ 522,595	$ 974,854	$ 1,454,379	$ 2,661,510	$ 3,074,989	$ 4,446,379
DMH	2	Mental Health Elder Care	$ 38,563	$ 37,682	$ 38,970	$ -	$ -	$ -	$ -	$ -	$ -		
DMH	4	Mental Health Consumer Support Programs	$ 451,606	$ 546,987	$ 673,160	$ 707,976	$ 802,579	$ 582,397	$ 67,285	$ 1,649,340	$ 2,178,825	$ 1,132,931	$ 470,222
DMH	2	Mental Health CRT Community Support Services	$ 2,318,668	$ 602,186	$ 807,539	$ 1,124,728	$ -	$ 1,935,344	$ 1,886,140	$ 6,047,450	$ 11,331,235	$ 282,071	$ 5,866,297
DMH	2	Mental Health Children's Community Services	$ 1,561,396	$ 3,066,774	$ 3,341,602	$ 3,597,662	$ 2,569,759	$ 1,775,120	$ 2,785,090	$ 3,088,773	$ 3,377,546	$ 3,706,864	$ 4,379,820
DMH	2	Emergency Mental Health for Children and Adults	$ 1,885,014	$ 1,988,548	$ 2,016,348	$ 2,165,648	$ 1,797,605	$ 2,309,810	$ 4,395,885	$ 8,719,824	$ 6,662,850	$ 4,148,197	$ 2,528,751
DMH	2	Respite Services for Youth with SED and their Families	$ 385,581	$ 485,586	$ 502,237	$ 412,920	$ 516,677	$ 543,635	$ 541,707	$ 823,819	$ 749,943	$ 931,962	$ 1,286,154
DMH	2	CRT Staff Secure Transportation	$ -	$ -	$ 52,242	$ -	$ -	$ -	$ -	$ -	$ -		
DMH	2	Recovery Housing	$ -	$ -	$ 235,267	$ -	$ 332,635	$ 512,307	$ 562,921	$ 874,194	$ 985,098	$ 463,708	$ 914,858
DMH	2	Transportation - Children in Involuntary Care	$ 4,768	$ 1,075	$ -	$ -	$ -	$ -	$ -	$ -	$ -		
DMH	2	Vermont State Hospital Records	$ -	$ -	$ -	$ -	$ 19,590	$ -	$ -	$ -	$ -		
DMH	4	Challenges for Change: DMH	$ -	$ -	$ -	$ -	$ -	$ 229,512	$ 945,051	$ 819,069	$ -		
DMH	2	Seriously Functionally Impaired: DMH	$ -	$ -	$ -	$ -	$ -	$ 68,713	$ 160,560	$ 1,151,615	$ 721,727	$ 392,593	$ 246,049
DMH	2	Acute Psychiatric Inpatient Services	$ -	$ -	$ -	$ -	$ -	$ -	$ 12,603,067	$ 5,268,556	$ 3,011,307	$ 2,423,577	$ 3,145,476
DMH	2	Institution for Mental Disease Services: DMH	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 10,443,654	$ 7,194,964	$ 25,371,245	$ 22,335,938
DVHA	4	Vermont Information Technology Leaders/HIT/HIE/HCR	$ -	$ -	$ -	$ -	$ 339,500	$ 646,220	$ 1,425,017	$ 1,517,044	$ 1,549,214	$ 2,915,149	$ 1,887,543
DVHA	4	Vermont Blueprint for Health	$ -	$ -	$ -	$ -	$ -	$ 2,616,211	$ 1,841,690	$ 2,002,798	$ 2,490,206	$ 1,987,056	$ 2,594,329
DVHA	1	Buy-In	$ 4,594	$ 314,376	$ 419,951	$ 248,537	$ 200,868	$ 50,605	$ 24,000	$ 17,878	$ 17,728	$ 27,169	$ 29,447
DVHA	1	Vscript Expanded	$ 1,695,246	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
DVHA	1	HIV Drug Coverage	$ 31,172	$ 42,347	$ 44,524	$ 48,711	$ 38,904	$ 39,176	$ 37,452	$ 39,881	$ 26,540	$ 10,072	$ 8,484
DVHA	1	Civil Union	$ 373,175	$ 543,986	$ 671,941	$ 556,811	$ 627,976	$ 999,084	$ 1,215,109	$ 1,112,119	$ 760,819	$ (50,085)	$ (585)
DVHA	1	Vpharm	$ -	$ -	$ -	$ 278,934	$ 210,796	$ -	$ -	$ -	$ -	$ -	
DVHA	4	Hospital Safety Net Services	$ -	$ -	$ 281,973	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
DVHA	2	Patient Safety Net Services	$ -	$ -	$ -	$ -	$ -	$ 36,112	$ 73,487	$ 2,394	$ 363,489	$ 335,420	$ 573,050
DVHA	2	Institution for Mental Disease Services: DVHA	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 6,214,805	$ 6,948,129	$ 7,792,709	$ 7,839,519
DVHA	2	Family Supports	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 4,015,491	$ 3,723,521	$ 2,982,388	$ 273,177
DCF	2	Family Infant Toddler Program	$ -	$ 199,064	$ 326,424	$ 335,235	$ 81,086	$ 624	$ -	$ -	$ -	$ -	
DCF	2	Medical Services	$ 69,893	$ 91,569	$ 120,494	$ 65,278	$ 45,216	$ 64,496	$ 47,720	$ 37,164	$ 33,514	$ 32,299	$ 55,400
DCF	2	Residential Care for Youth/Substitute Care	$ 9,181,386	$ 10,536,996	$ 10,110,441	$ 9,392,213	$ 8,033,068	$ 7,853,100	$ 9,629,269	$ 10,131,790	$ 11,137,225	$ 10,405,184	$ 10,238,115
DCF	2	AABD Admin	$ 988,557	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -		$ 135,517
DCF	2	AABD	$ 2,415,100	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -		
DCF	2	Aid to the Aged, Blind and Disabled CCL Level III	$ 96,000	$ 2,617,350	$ 2,615,023	$ 2,591,613	$ 2,827,617	$ 2,661,246	$ 2,563,226	$ 2,621,786	$ 2,611,499	$ 2,864,727	$ 2,753,853
DCF	2	Aid to the Aged, Blind and Disabled Res Care Level III	$ -	$ 143,975	$ 170,117	$ 172,173	$ 137,356	$ 136,466	$ 137,833	$ 124,731	$ 89,159	$ 77,196	$ 80,830
DCF	2	Aid to the Aged, Blind and Disabled Res Care Level IV	$ 210,989	$ 312,815	$ 349,887	$ 366,161	$ 299,488	$ 265,812	$ 273,662	$ 269,121	$ 183,025	$ 160,963	$ 190,066
DCF	2	Essential Person Program	$ 542,382	$ 675,860	$ 614,974	$ 620,052	$ 485,536	$ 736,479	$ 775,278	$ 783,860	$ 801,658	$ 707,316	$ 667,102
DCF	2	GA Medical Expenses	$ 254,154	$ 339,928	$ 298,207	$ 380,000	$ 583,080	$ 492,079	$ 352,451	$ 275,187	$ 253,939	$ 211,973	$ 181,835
DCF	2	CUPS/Early Childhood Mental Health	$ -	$ -	$ 52,825	$ 499,143	$ 166,429	$ 112,619	$ 165,016	$ 45,491	$ -		
DCF	2	VCRHYP/Vermont Coalition for Runaway and Homeless Youth Program	$ -	$ -	$ 1,764,400	$ -	$ -	$ -	$ -	$ -	$ -		
DCF	2	HBKF/Healthy Babies, Kids & Families	$ -	$ -	$ 318,321	$ 63,921	$ -	$ -	$ -	$ -	$ -		
DCF	1	Catamount Administrative Services	$ -	$ -	$ -	$ 339,894	$ -	$ -	$ -	$ -	$ -		
DCF	2	Children's Integrated Services Early Intervention									$ 200,484		$ 371,836
DCF	2	Therapeutic Child Care	$ -	$ -	$ -	$ 978,886	$ 577,259	$ 570,493	$ 596,406	$ 557,599	$ 543,196	$ 605,419	$ 712,884
DCF	2	Lund Home	$ -	$ -	$ -	$ 325,516	$ 175,378	$ 196,159	$ 354,528	$ 181,243	$ 237,387	$ 405,034	$ 261,081
DCF	2	GA Community Action	$ -	$ -	$ -	$ -	$ -	$ 199,762	$ 338,275	$ 420,359	$ 25,181		
DCF	3	Prevent Child Abuse Vermont: Shaken Baby	$ -	$ -	$ -	$ -	$ -	$ 44,119	$ 74,250	$ 86,969	$ 111,094	$ 54,125	$ 54,125
DCF	3	Prevent Child Abuse Vermont: Nurturing Parent	$ -	$ -	$ -	$ -	$ -	$ -	$ 107,184	$ 186,916	$ 54,231	$ 195,124	$ 126,365
DCF	4	Challenges for Change: DCF	$ -	$ -	$ -	$ -	$ -	$ 50,622	$ 196,378	$ 197,426	$ 207,286	$ 189,378	$ 202,488
DCF	2	Strengthening Families	$ -	$ -	$ -	$ -	$ -	$ -	$ 465,343	$ 429,154	$ 399,841	$ 370,003	$ 426,417
DCF	2	Lamoille Valley Community Justice Project	$ -	$ -	$ -	$ -	$ -	$ -	$ 162,000	$ 216,000	$ 402,685	$ 83,315	$ 216,000
DCF	3	Building Bright Futures	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 398,201	$ 594,070	$ 514,225	$ 531,283
DDAIL	2	Elder Coping with MMA	$ 441,234	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
DDAIL	2	Mobility Training/Other Svcs.-Elderly Visually Impaired	$ 187,500	$ 250,000	$ 250,000	$ 250,000	$ 245,000	$ 245,000	$ 245,000	$ 245,000	$ 245,000	$ 245,000	$ 270,171
DDAIL	2	DS Special Payments for Medical Services	$ 394,055	$ 192,111	$ 880,797	$ 522,058	$ 469,770	$ 757,070	$ 1,498,083	$ 1,299,613	$ 1,277,148	$ 385,896	$ 1,904,880
DDAIL	2	Flexible Family/Respite Funding	$ 1,086,291	$ 1,135,213	$ 1,341,698	$ 1,364,896	$ 1,114,898	$ 1,103,748	$ 1,103,749	$ 1,088,889	$ 2,868,218	$ 1,400,997	$ 1,919,377
DDAIL	4	Quality Review of Home Health Agencies	$ -	$ 77,467	$ 186,664	$ 126,306	$ 90,227	$ 103,598	$ 128,399	$ 84,139	$ 51,697	$ 44,682	$ 35,203
DDAIL	4	Support and Services at Home (SASH)	$ -	$ -	$ -	$ -	$ -	$ -	$ 773,192	$ 773,192	$ 1,013,671	$ 1,026,155	$ 1,013,283
DDAIL	4	HomeSharing	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 310,000	$ 317,312	$ 327,163	$ 339,966
DDAIL	4	Self-Neglect Initiative	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 150,000	$ 200,000	$ 265,000	$ 276,830
DDAIL	2	Seriously Functionally Impaired: DAIL	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 1,270,247	$ 859,371	$ 333,331	$ 120,997
DOC	2	Intensive Substance Abuse Program (ISAP)	$ 382,230	$ 299,602	$ 310,610	$ 200,000	$ 591,004	$ 591,000	$ 458,485	$ 400,910	$ 547,550	$ 58,280	
DOC	2	Intensive Sexual Abuse Program	$ 72,439	$ 46,078	$ 85,542	$ 88,523	$ 68,350	$ 70,002	$ 60,585	$ 69,311	$ 19,322	$ 15,532	$ 6,375
DOC	2	Intensive Domestic Violence Program	$ 109,692	$ 134,663	$ 230,353	$ 229,166	$ 173,938	$ 174,000	$ 164,218	$ 86,814	$ 64,970	$ 169,043	$ 88,152
DOC	2	Women's Health Program (Tapestry)	$ 460,130	$ 487,344	$ 487,231	$ 527,956	$ -	$ -	$ -	$ -	$ -	$ -	
DOC	2	Community Rehabilitative Care	$ 1,038,114	$ 1,982,456	$ 2,031,408	$ 1,997,499	$ 2,190,924	$ 2,221,448	$ 2,242,871	$ 2,500,085	$ 2,388,327	$ 2,539,161	$ 2,639,580
DOC	2	Return House	$ -	$ -	$ -	$ 51,000	$ -	$ -	$ -	$ 399,999	$ 399,999	$ 343,592	$ 342,084
DOC	2	Northern Lights	$ -	$ -	$ -	$ -	$ 40,000	$ 40,000	$ -	$ 393,750	$ 335,587	$ 354,909	$ 768,289
DOC	4	Challenges for Change: DOC	$ -	$ -	$ -	$ -	$ -	$ -	$ 687,166	$ 524,594	$ 433,910	$ 539,727	
DOC	4	Northeast Kingdom Community Action	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 548,825	$ 287,662	$ 267,025	$ 220,436
DOC	2	Pathways to Housing	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 802,488	$ 830,936	$ 830,336	$ 1,018,229
			$ 45,455,809	$ 55,495,719	$ 59,918,097	$ 62,419,988	$ 55,554,314	$ 56,275,877	$ 89,836,470	$ 123,669,882	$ 127,103,459	$ 128,924,888	$ 126,882,102

Last Updated: 9/15/16