

State of Vermont
Agency of Human Services

Global Commitment to Health
11-W-00194/1

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

Quarterly Report for the period
October 1, 2015 – December 31, 2015

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Table of Contents

I.	Background and Introduction	3
II.	Enrollment Information and Counts	4
III.	Outreach Activities	5
IV.	Operational/Policy Developments/Issues	6
V.	Expenditure Containment Initiatives	10
VI.	Financial/Budget Neutrality Development/Issues	31
VII.	Member Month Reporting	31
VIII.	Consumer Issues	32
IX.	Quality Improvement.....	33
X.	Compliance	36
XI.	Demonstration Evaluation	38
XII.	Reported Purposes for Capitated Revenue Expenditures	38
XIII.	Enclosures/Attachments	38
XIV.	State Contact(s).....	39

I. Background and Introduction

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

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

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

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

As the Single State Agency under the Global Commitment to Health Waiver, AHS designates DVHA

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

One of the Terms and Conditions of the Global Commitment Waiver requires the State to submit progress reports 60 days following the end of each quarter. *This is the fourth quarterly report for waiver year 10, covering the period from October 1, 2015 through December 31, 2015 (QE1215).*

II. Enrollment Information and Counts

Key updates from QE1215:

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

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

Table 1 is populated based on reports run the Monday after the last day of the quarter, in this case on January 4, 2015. Results yielding $\leq 5\%$ 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 QE1215 would be in Section VII: Member Month Reporting. During this quarter, there were no substantial enrollment fluctuations $> 5\%$ seen in any of the Demonstration Populations.

Table 1. Enrollment Information and Counts for Demonstration Populations*, QE1215

Demonstration Population	Current Enrollees Last Day of Qtr	Previously Reported Enrollees Last Day of Qtr	Percent Variance 9/30/2015 to 12/31/2015	Variance by Enrollee Count 9/30/2015 to 12/31/2015
	December 31, 2015	September 30, 2015		
Demonstration Population 1:	37,538	37,584	-0.12%	(46)
Demonstration Population 2:	84,772	83,453	1.58%	1,319
Demonstration Population 3:	60,317	58,457	3.18%	1,860
Demonstration Population 4:	2,819	2,799	0.71%	20
Demonstration Population 5:	929	894	3.91%	35
Demonstration Population 6:	873	905	-3.54%	(32)
Demonstration Population 7:	7,397	7,399	-0.03%	(2)
Demonstration Population 8:	4,213	4,246	-0.78%	(33)
	198,858	195,737	1.59%	

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

III. Outreach Activities

i. Member Relations

Key updates from QE1215:

- October 1, 2015 Implementation of ICD 10 Codes
- November 1, 2015, the DVHA will cover sleep studies performed in the home without prior authorization.
- Quality of Care Concerns
- Clinical Practice Guidelines.

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.

ICD-10 is a classification and coding system used by health care providers to code medical diagnoses for billing purposes. The switch from ICD-9 medical diagnosis and inpatient procedure codes to ICD-10 officially occurred on October 1, 2015. The codes were expanded from 13,000 codes for ICD 9 to 68,000 codes for ICD 10. The ICD-10 Project Team is happy to report that Vermont Medicaid, under the Department of Vermont Health Access, successfully implemented the ICD-10 code conversion.

Sleep Studies

Effective November 1, 2015, DVHA will cover sleep studies performed in the home without prior authorization.

Quality Concerns

Consistent with best practices followed by other health plans and in keeping with our mission as a CMS-approved public managed care model, DVHA is in the process of implementing a more formal process for reviewing provider quality of care. If a quality of care concern is brought to DVHA's attention, DVHA's Medical Director may request the member's medical records. After reviewing the records, DVHA's Medical Director may also request a written response from the provider(s) involved. This process will remain confidential at all times.

The Department of Vermont Health Access has completed an update of the following clinical practice guidelines:

- Diabetes Clinical Practice Guidelines
- Buprenorphine Clinical Practice Guidelines

The updated guidelines are available at: <http://dvha.vermont.gov/for-providers/initiatives>

The Medicaid and Exchange Advisory Board (MEAB) held meetings on October 26, 2015, November 23, 2015 and December 21, 2015. 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 QE1215:

- Deployed system upgrades to allow for automated renewal and self-service 2016 plan selection for QHP customers, a stark contract from the previous year which relied on manual renewal processes.
- Advanced health insurance literacy through a statewide series of Health Insurance 101 events and a new online Plan Comparison Tool to help Vermonters better understand their subsidies and assess how various plan designs and out-of-pocket costs could impact their total health care costs.

At the beginning of QE1215, Vermont Health Connect deployed a system upgrade to support automated renewal functionality for QHP customers. The upgrade also included self-service plan selection during open enrollment, self-service change reporting, and the ability to make recurring payments. When open enrollment began in November, this automated process took care of 80% of renewing households. State staff assisted with the completion of the remainder of the cases, which typically needed additional information before they could be processed into 2016 health plans.

In early November, key subcontractor Exeter announced that it was going out of business. The State quickly secured the license to Exeter's OneGate software and moved to transition key personnel to System Integrator Optum and other contractors. Prior to closing its doors, Exeter delivered code to support such additional upgrades as Medicaid redetermination integration, Department of Labor verifications, billing and payment functionality, and notices. The State and its contractors focused on testing the code and preparing multiple deployments in order to manage scope and deliver the best service for Vermonters.

Monthly redeterminations for Medicaid for the Aged, Blind and Disabled (MABD) beneficiaries restarted in November and, in December, a plan for 2016 MAGI Medicaid redeterminations was approved by CMS. The plan's schedule focused on verifying and transitioning 9,000 MAGI Medicaid households per month from the State's legacy system (ACCESS) to Medicaid or qualified health plans in the Vermont Health Connect system from January through April (a total of approximately 27,000 households), followed by 9,000 MAGI Medicaid households redeterminations per month from May through October that are already in the Vermont Health Connect system (approximately 54,000 households).

Health insurance literacy was a major focus of outreach work in the run-up to open enrollment. Vermont Health Connect partnered with community libraries and pharmacies to hold a series of "Health Insurance 101" workshops across the state. The sessions were free to the public and designed to help customers and potential customers better understand health insurance terms, financial help, and how to interact with the Vermont Health Connect system.

During open enrollment, Vermont Health Connect launched a new online Plan Comparison Tool to help Vermonters better understand their subsidies and assess how various plan designs and out-of-pocket costs could impact their total health care costs. The tool was created by the non-profit Consumers' Checkbook and was named the nation's best plan selection tool by the Robert Wood Johnson Foundation.

Maximus continues to manage the VHC Customer Support Center (call center), currently utilizing 68 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. They transfer calls to the State's Health Access Eligibility Unit for resolution and log service requests, which are escalated to the appropriate resolver group. Throughout QE1215, the system's performance continued to be stable and operated as expected. The Customer Support Center managed incoming call volume, receiving more than 100,000 calls over the quarter, with an abandon rate of 10.34% and answering nearly two out of three (65%) calls within 30 seconds.

ii. *Choices for Care*

Key updates from QE1215:

- October 2015 DAIL submitted its annual legislative report on the Adequacy of the Choices for Care Provider System.
- AHS, together with DAIL, received stakeholder input and finalized the Choices for Care HCBS Regulations systemic report and work plan for submission to CMS.

Annual Legislative Report

In Accordance with Vermont 2013 Acts and Resolves No. 50, Sec. E.308(c), DAIL, in collaboration with long-term services and supports providers, conducts an annual assessment of the adequacy of the provider system for delivery of home- and community-based services and nursing home services for the purpose of informing the reinvestment of savings during the legislative budget adjustment process. Though there are not enough Choices for Care "savings" to reinvest via the SFY2016 budget adjustment process, the report does provide valuable information of the availability of Choices for Care (CFC) services for Vermonters who need and choose them.

The report includes information obtained from the following sources:

- 2014 VT Long-Term Services and Supports HCBS Consumer Survey Report: The 2014 survey results highlighted the ***Provision of Services***, ***Staff Attributes*** and ***Consumer Choice*** as areas of the survey with the highest "potential" for improving and maintaining satisfaction. <http://ddas.vt.gov/ddas-publications/publications-cfc/evaluation-reports-consumer-surveys/ltc-consumer-satisfaction-surveys/ltc-consumer-satisfaction-survey-2014-1>
- Vermont Choices for Care: Evaluation of Years 1-9: The May 2015 evaluation results recommend a focus on ***person-centered planning***, ***quality of life*** and increased ***consumer choice***. <http://ddas.vt.gov/ddas-publications/publications-cfc/evaluation-reports-consumer-surveys/vermont-choices-for-care-evaluation-of-years-1-9-1>
- Choices for Care Policy Briefs: The 2015 Personal and Systemic Factors Leading to Nursing Facility Readmission report recommends focus on 1) ***person-centered planning***; 2) ***enhance information and referral***; 3) ***ensure appropriateness and sufficiency of services*** (such as expanding use of non-medical providers), and 4) ***enhance capacity of non-nursing facility settings***. <http://ddas.vt.gov/ddas-publications/publications-cfc/evaluation-reports-consumer-surveys/umass-policy-brief-factors-leading-to-nursing-facility-readmission-march-2015>
- Choices for Care Data: Consumer satisfaction is relatively high and total enrollment continues to increase. Nursing facility utilization continues to decline and data indicates slow growth in ***Enhanced Residential Care*** (ERC) and the new service ***Adult Family Care*** (AFC). Additionally, people continue to apply for

limited Moderate Needs funding, which adds to local agency wait lists in certain areas of the state.

- **Money Follows the Person (MFP)**: Experiences and data from the MFP grant highlights the need to **create or expand housing and care options** for people who wish to leave the nursing home and live in the community.
- **Stakeholder Survey**: The August 2015 provider stakeholder survey highlights challenges similar to the 2014 survey related to **access to services, serving people with dementia, mental health and challenging behavioral needs, and lack of residential options**.

The report concludes that there are many areas of success and strength in the Choices for Care (CFC) program including:

1. High levels of consumer satisfaction overall.
2. CFC continues to enroll more people.
3. CFC continues to offer more community-based options and to support choice and flexibility.
4. CFC implemented a nursing facility Companion Aide pilot in 2015.
5. Stakeholders indicated areas of strength such as Adult Day and Ombudsman services.

The report also indicates that there may be adequacy issues in the following areas, resulting in reduced choice and flexibility for some people:

1. Lack of consistent person-centered options counseling, assessment and planning for people who need help accessing long-term services and supports.
2. Inadequate staffing and training for home-based services (personal care, companion, respite).
3. Inadequate base funding for Moderate Needs services.
4. Inadequate funding and provider capacity for Adult Family Care and Enhanced Residential Care options.
5. Inadequate provider capacity with the expertise and willingness to care for people with dementia, mental health, traumatic brain injury and other challenging behaviors.
6. Lengthy and complicated Vermont long-term care Medicaid eligibility process.

Conclusions are being used to inform program improvement work within the Choices for Care program.

The full report may be found at: <http://ddas.vt.gov/ddas-publications/publications-cfc/publications-cfc-default-page>.

HCBS Regulations

During this reporting period, AHS, in collaboration with DAIL, completed the Choices for Care (CFC) Systemic Assessment and Work Plan as a part of Vermont's Comprehensive Quality Strategy (CQS). The assessment and plan represents the DAIL's improvement and action steps to strengthen Vermont's home and community-based services system. Planning included the following activities:

- Presentation of the State's Proposed Comprehensive Quality Strategy and its relationship to the HCBS regulations to the DAIL Advisory Board (August 13, 2015);
- A review of policies and rules governing Choices for Care operations (*Choices for Care Managed Long-Term Services and Supports Systemic-Assessment of Person-Centered Planning and Home- and Community-Based Settings Policies* (Pacific Health Policy Group, October 27, 2015; revised December 2015);
- Distribution of and a solicitation for input on a draft work plan and alignment findings (November 9, 2015);
- Positing of the draft work plan and alignment findings to the DAIL Adult Services Division and DVHA websites (November- December 2015);
- Presentation of the draft work plan and alignment findings at the DAIL Advisory Board (December 10, 2015); and

- The State’s review of stakeholder feedback and incorporation of changes in final work plan and findings report (December 18, 2015).

Based on feedback received, the State updated its findings and work plan as it relates to the Enhanced Residential Care Settings. Specifically, the State proposed additional action steps in the areas of case management and conflict of interest requirements in this Private Non-Medical Institution (PNMI) setting. Additionally, the State will initiate the provider self-assessment process earlier in the work plan timeline. Outlined on the following pages are the improvements/action steps that have been prioritized for Choices for Care settings.

A full copy of the Systemic Self-Assessment Report and Choices for Care Work Plan submitted to CMS may be found at: <http://ddas.vt.gov/ddas-projects>.

iii. Global Commitment Register

Key updates from QE1215:

- Global Commitment Register (GCR) launched in November 2015.
- Since November 2015, 10 final GCR policies have been publicly posted.

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

The GCR is a database of policy changes to and clarifications of existing Medicaid policy under Vermont's 1115 Global Commitment to Health waiver. It is based on the Federal Register Model, 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 (banners). 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, aka Health Care Policy Stakeholders 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 QE1215:

- As of November, 78,949 Medicaid beneficiaries are attributed to two accountable care organizations (ACOs) through the Vermont Medicaid Shared Savings Program (VMSSP).
- Distributed Performance Year 1 Shared Savings to both ACOs and conducted analysis on Year 1 results.
- Public notice on a VMSSP Year 3 SPA will end on January 29, 2016, after which staff will engage CMS in the Year 3 SPA process.
- Continued discussion with OneCare Vermont (OCVT) regarding their VMSSP contract amendment.

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 continues to increase as new providers are added to participating ACO entities, with 929 providers participating in the program and 78,949 total beneficiaries attributed—50,111 lives in OneCare Vermont (OCVT) and 28,838 lives in Community Health Accountable Care (CHAC).

DVHA distributed accrued shared savings to both ACOs totaling \$7.3 million, and conducted supplemental analyses of cost and utilization patterns in Performance Year 1(2014) relative to baseline years. Results were driven by an increased proportion of low-utilizing beneficiaries and decreases in utilization across several service categories in the initial performance year.

DVHA continues to work with OCVT on standard contract language sections of the VMSSP Contract Amendment Agreement, and expects to sign an amendment by the end of Q1.

In the coming year, VMSSP staff will continue to engage in implementation activities for Year 3 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 QE1215:

- The Enterprise Medicaid Management Information Systems/Care Management (MMIS/CM) VCCI Go-Live occurred on December 29, 2015. The APS Healthcare contract expired December 31, 2015 with transition of data to the new MMIS/CM vendor, eQHealth (eQH).
- The VCCI has established direct referral and communication with both Medicaid ACO's for the highest risk and cost Medicaid population in order to improve efficiency and support collaborative efforts toward common goals.
- The VCCI has piloted a project with the ACO's in 3 communities in order to enhance referrals and collaboration.

The goal of the VCCI is to improve health outcomes of Medicaid beneficiaries by addressing the increasing prevalence of chronic illness through various support and care management strategies. The VCCI uses a holistic approach of evaluating and supporting improvement in medical and behavioral health, as well as socioeconomic issues that are often barriers to sustained health improvement. The top 5% of VCCI-eligible Medicaid members account for approximately 39% of Medicaid costs. Excluded populations include dually eligible individuals, those receiving other waiver services and/or CMS-reimbursed case management. The new vendor, eQH, has instituted 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 earlier and intervene in order to track the clinical and financial improvements within the eQSuite.

The VCCI's strategy of embedding staff in high-volume hospitals and primary care sites continues to support population engagement at the point-of-need in areas of high service utilization. By targeting predicted high-cost members, resources can be allocated to areas representing the greatest opportunities for clinical improvement and cost savings. The SFY 2015 VCCI did not receive a final report from our terminating vendor, as the claims run out period was not fulfilled during their contract life cycle. However, data supports the VCCI success in continuing to reduce hospital admissions by 16.2 % and 30 day readmissions by 45%. However, for the first year since measured, the ED utilization rate among VCCI eligible members increased by a striking 25%. This increase is not entirely surprising, as there has been a significant challenge in gaining access to primary care provider (Medical Homes) given both the limited availability and the fact that many practices are 'closed' to new Medicaid members. Work with health care reform partners, including with hospitals, group practices and ACO networks is imperative to address this shift in utilization; and assure that the 'attribution' of Medicaid Members who are *not* affiliated with medical homes are factored into any shared savings efforts, such that Medicaid members are gaining access to and utilizing medical homes made available within our ACO network agreements.

The VCCI continues its collaboration with ACO partners to enhance the number of hospitals providing secure File Transfer Protocol (FTP) data feeds for its focused efforts on transitions in care and prevention of 30-day hospital readmissions. The VCCI has access to hospital data on inpatient and ED admissions through data sharing from partner hospitals. While the VCCI now receives electronic data from 6 partner hospitals, the goal is to have electronic census data from all hospitals in FFY 2016. The VCCI will continue these efforts after transition to the new eQH system. The enhanced capability of the eQHealth system will enable direct referrals to VCCI case managers based on this point in time data, and allow case managers to intervene upon discharge to lessen the risk of readmission.

The VCCI supplemented its embedded model with a nurse ‘liaison role’ given space constraints at provider and hospital sites. All 14 hospitals have a designated VCCI staff ‘liaison’ assigned who meets with hospital case managers to support the reduction of Ambulatory Care Sensitive (ACS) ED utilization 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/high cost members. DVHA leadership has been meeting regularly with ACO partners to strengthen ties and further develop referral and reporting processes. As there are many concurrent local efforts underway, there has been push back from some community providers in reviewing these reports and referral processes.

This enhanced service coordination was also a goal of the VHCIP Care Management and Care Models (CMCM) workgroup (now merged with the provider practice workgroup), which launched an integrated care management learning collaborative. These learning collaboratives were extended to additional hospital service areas in the last quarter, with the intention of having all communities participate by 2016. There is a goal of enhanced communication and coordination to prevent redundancies and with a ‘single, shared care plan’ the long term vision. This effort is an output of the SIM grant funding which includes insurance carriers, providers and community stakeholders. The Enterprise Medicaid Management Information Systems/Care Management Solution will support the work of the Learning Collaborative by offering portal capability (anticipated SFY 2017) in order to have a single, shared care plan that can be viewed across providers of services.

Medicaid Obstetric and Maternal Supports (MOMS) Care Management

The VCCI launched this pilot program for pregnancy case management services in October 2013. 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 has 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 receiving significant attention as evidenced by the increase in referrals. It is anticipated that case management will be tracked at a more detailed level in the new Care Management system.

APS Contract Termination:

APS Healthcare provided several services to support the VCCI, including supplemental professional staffing and data analytics. APS Healthcare delivered enhanced information technology and decision-support tools to assist staff in doing outreach to the most costly and complex beneficiaries (the top 5%). Additionally, APS Healthcare provided supplemental population-based reports on gaps in care to PCPs, which supported ACO providers and case managers working with patients considered high utilizers and/or at risk to become so.

To support continuity of the VCCI business operations during the Medicaid Management Information Systems (MMIS)/Care Management (CM) procurement and on-boarding process, DVHA had extended its contract with APS Healthcare through December 31, 2015. This contract extension facilitated the transition to the new enterprise level CM vendor, eQHealth. The VCCI worked proactively and successfully with APS Healthcare, to facilitate the smooth transition of the historic data to the new vendor that supported data consumption by the new system. On 12/29, DVHA VCCI went live with eQH for care management and the APS contract sunset date was 12/31/15.

Activities supported by APS included:

- Collaboration on the data transition to support data migration to the new CM vendor and prevent interruption of VCCI services to Medicaid members.
- Development of a case transition strategy between DVHA and APS VCCI staff to assure DVHA staff has low caseloads to support new system training requirements.
- An overall VCCI case reduction strategy based on loss of 6 APS/VCCI nursing staff at time of contract termination (December 2015).

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). 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.

The VCCI lost 13 clinical and analytical FTE's as a result of the contract dissolution and has restructured operations concurrent with going live efforts in the new eQH system. The VCCI was not able to secure additional state FTEs to replace the vendor staff due to State budget constraints. As a result, DVHA anticipates a decline in the number of cases that the VCCI manages.

In preparation for 'go live' the VCCI management team worked with eQHealth and the AHS Organizational Change Management staff in development of training materials, a training schedule and facilitated adoption of the eQHealth system by the VCCI staff. Training on the new eQHealth system was also extended to the DVHA's Clinical Operations Unit and the Quality Improvement Units in order to facilitate case sharing and referrals between Units. This work will continue as new features and functionality are rolled out in the coming year.

iii. Blueprint for Health

Key updates from QE1215:

- The local Unified Community Collaboratives are maturing. A notable example of investments designed to reduce inpatient readmissions for chronic conditions is described below.
- Blueprint released the second network analysis tracking the development of health neighborhood in local regions.
- In the fourth quarter of calendar year 2015, the Blueprint completed purchase of a perpetual software license for the DocSite clinical registry from the Covisint Corporation.
- The Blueprint, in collaboration with the payers, finalized the methodology for the quality composite component of the new payment system to begin Jan 1, 2016.
- The program may be reaching a saturation point in the number of primary care practices that participate in the Blueprint.
- Analytics indicate that Medicaid beneficiaries served by the Blueprint practices and community health teams have higher use of special Medicaid services.
- Enrollment in the Hub and Spoke Health Home for opioid addiction continued to grow in the quarter.
- Blueprint practices are successfully meeting the NCQA 2014 Standards.

The Blueprint combines state level strategic direction with local organization and ownership of care delivery. The state's 14 Health Service Areas (HSAs) each have an Administrative Entity such as a hospital or Federally Qualified Health Center (FQHC) that leads the Blueprint locally. Their work includes local project management, staffing of Community Health Teams (CHTs), and financial management. The Blueprint's Transformation Network includes Project Managers, hired by the Administrative Entities, who lead implementation and engage community partners. Each Administrative Entity has contributed their own financial and human resources, beyond the scope of their Blueprint grants, demonstrating their commitment to the Blueprint's sustainability and success.

The Administrative Entities in each HSA have always included local partners in guiding Blueprint implementation. That collaboration is even stronger today with the merging of Blueprint workgroups with Accountable Care Organization (ACO) workgroups. These combined groups are called Unified Community Collaboratives (UCCs). Their leadership teams include the area's Blueprint Project Manager, representatives of ACOs present in that community, local primary care leaders (including a pediatric provider), the hospital, home health or the Visiting Nurse Association, Area Agency on Aging, Designated (mental health) Agency, Designated Regional Housing Organization, and others. They meet to identify local priorities, goals, and strategies, including the configuration of the Blueprint CHT. The ultimate goal of these UCCs is to prepare each health service area (HSA) to function as an Accountable Health Community, responsible for the wellness of the whole population and its health care budget. This model supports the complete integration of high-quality medical care, mental health and substance abuse services, social services, and prevention.

Vermont's primary care practices are supported by the Blueprint in the process of achieving and maintaining recognition as Patient Centered Medical Homes (PCMHs) under the National Committee for Quality Assurance (NCQA) standards. These standards promote excellence in six (6) areas:

- patient-centered access
- team-based care
- population health management
- care management and support
- care coordination and transitions
- performance measurement and quality improvement

All Vermont insurers (Medicaid, Medicare, and major commercial insurers) support practices to do this work through per member per month (PMPM) payments to NCQA-recognized PCMHs. New performance-based payments will further promote improvement of utilization patterns and health quality. The Blueprint's Transformation Network supports practices with Practice Facilitators, professionals trained in quality improvement and change management. Each practice has access to a Facilitator, who provides technical expertise in the NCQA standards and ongoing quality improvement coaching.

Good medical care happens in a doctor's office, but good health happens in a community –the Blueprint's CHTs take on this challenge. CHTs supplement services available in PCMHs and link patients with the social and economic services that make healthy living possible for all Vermonters. CHT services include:

- population/panel management and outreach
- individual care coordination
- brief counseling and referral to more intensive mental health care as needed

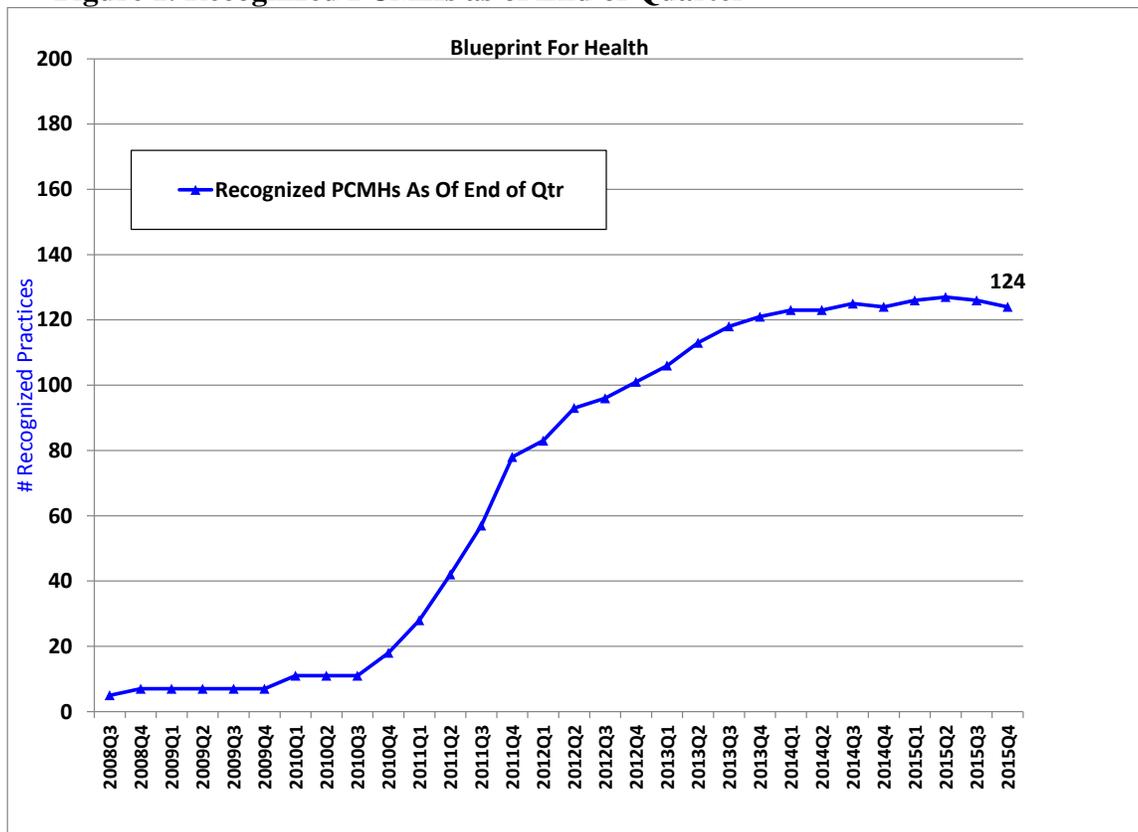
- substance abuse treatment support
- condition-specific wellness education and more

The services may be co-located with the practices (“embedded”) or centralized in the HSA. Actual service configuration, staffing, and location are determined by local leaders based on community demographics and health needs, identified gaps in available services, and the strengths of local partners. Funded by Medicaid, Medicare, and major commercial insurers, access to CHT teams is offered barrier-free to patients and practices (meaning no co-payments, no prior authorizations, and no billing).

Patient Centered Medical Homes

In the past quarter, the Blueprint for Health program has had a net decrease of two NCQA-recognized primary care practices. (Nine practices were converted or bought out, and two practices closed this past quarter.) 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 124.

Figure 1. Recognized PCMHs as of End of Quarter



Unified Community Collaboratives

One local collaborative working on reducing inpatient readmission for chronic conditions learned that a key risk factor was complicated medication regimens. The local home health agency could provide home-based medication reconciliation post discharge but was not always able to bill for these services

if the patient didn't meet certain criteria. The local FQHC offered to invest some of the shared savings earned from the Medicaid SSP to cover the costs of homebased medication reconciliation post discharge to reduce readmissions. This level of coordination and resource sharing is directly a result of the UCC structure.

The Clinical Registry

In the fourth quarter of 2015, the Blueprint completed purchase of a perpetual software license for the DocSite application from the Covisint Corporation, the host of the Blueprint Clinical Registry for the past 7 years, and in early 2016 is working to reconstitute the Blueprint Clinical Registry, to be newly hosted by Vermont Information Technology Leaders (VITL), the state's Health Information Exchange (HIE) provider. The Blueprint Clinical Registry aggregates clinical data from electronic health records for the purposes of data analysis, evaluation, and quality improvement initiatives.

New Payments Finalized:

New performance-based payments to PCMHs are effective January 1, 2016 for Medicaid and all commercial insurers. PCMHs will be eligible for up to \$0.25 PPPM for performance on healthcare quality measures, and up to \$0.25 PPPM for performance on healthcare utilization measures.

PCMH Patients Have Lower Medical Expenditures and Higher Use of Medicaid Special Services

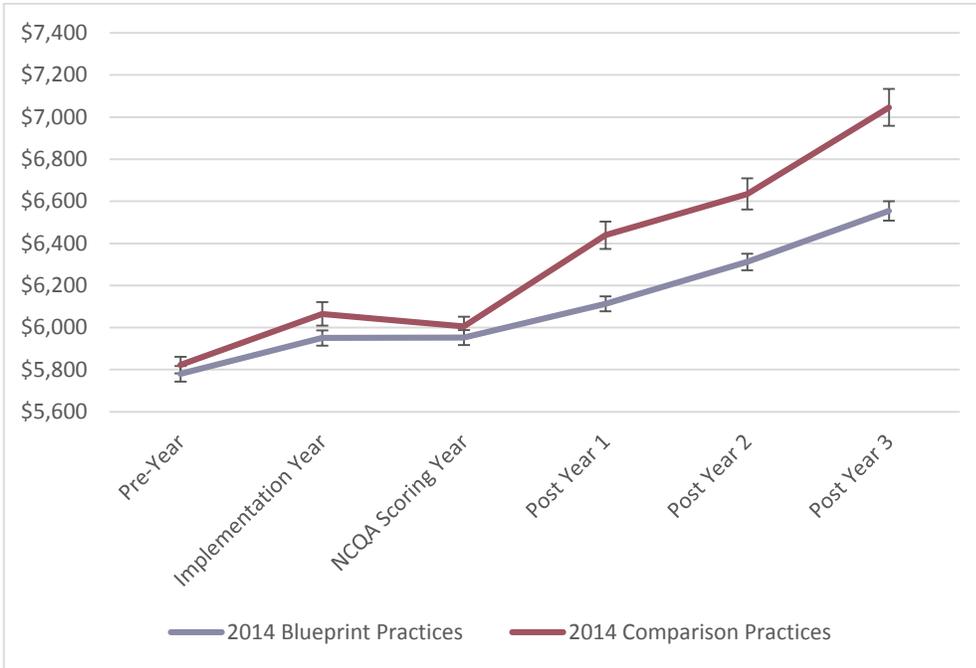
Based on the Difference in Differences (DID) analytic approach, a technique that calculates the final difference while accounting for any initial difference, the results suggest that patients receiving the majority of their care in a PCMH had reduced annual medical expenditures and utilization rates. After accounting for the initial (albeit statistically insignificant) difference between the PCMH patients and the comparison group in the Pre-Year, the expenditures for PCMH patients in Post-Year 2 practices was \$482 less per year than the comparison group.

When broken down to specific expenditure categories, the PCMH patients had significantly less inpatient expenditures (DID: \$-217.80; p-value: <0.001), and outpatient expenditures (DID: \$-154.10; p-value: <0.001). These decreases are also reflected in the utilization rates per 1,000, for which there were decreases in inpatient discharges, inpatient days, surgical specialist visits, standard imaging, advanced imaging, and echography. The DID in rates of visits to medical specialists was not significant.

One category in which there was virtually no difference between the comparison group and the PCMH patients was emergency department (ED) expenditures. The utilization rates again reflected the expenditures. The results indicate an increase, though not statistically significant, in outpatient ED visits, and a significant increase in potentially avoidable ED visits.

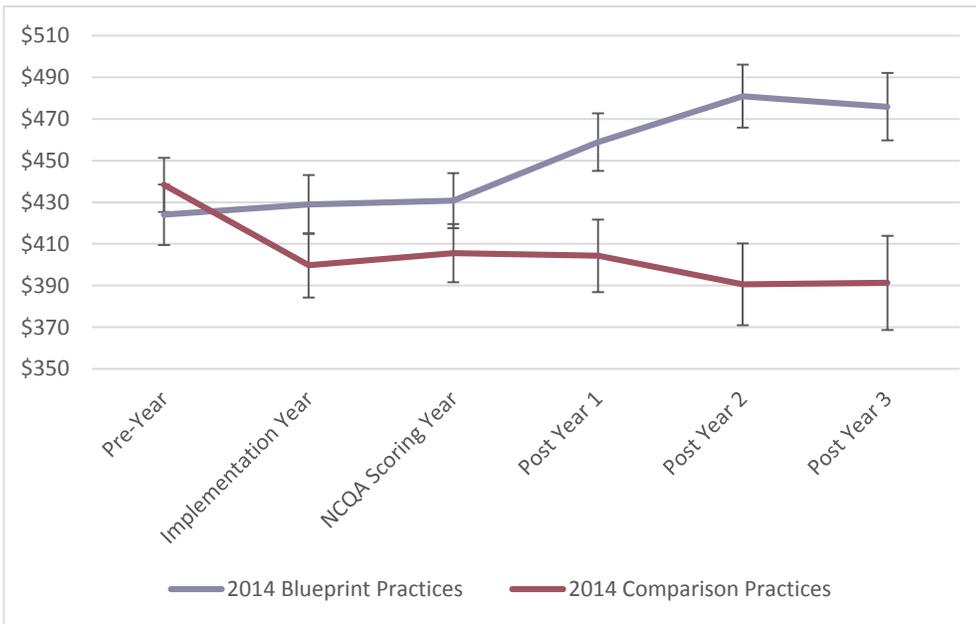
An expenditure category in which there was an increase was use of special Medicaid services (SMS). These services, covered only by Medicaid, are targeted at meeting social, economic, and rehabilitative needs (e.g., transportation, home and community-based services, case management, dental, residential treatment, day treatment, mental health facilities, and school-based services). The results indicate that DID spending on SMS for PCMH patients increased by \$56.50 (p-value: <0.001) relative to the comparison group. One explanation for the trend is that PCMHs and CHTs are better at linking their patients to social and non-medical services, although additional analysis into how communities are bridging the medical and non-medical services divide is needed for a more full explanation of the SMS expenditures. This analysis will most likely occur through the evaluation of UCC development.

Figure 2: Total Expenditure per Capita 2008-2014, All Insurers, Ages 1 Year and Older



As with the previous analysis, the SMS expenditures continued to grow Figure 3. Based on DID, PCMH patients saw their SMS annual expenditures grow by \$98.90 (p-value: <0.001) relative both to expenditures in the Pre-Year and to the Comparison patients.

Figure 3: SMS Expenditures per Capita 2008-2014, All Insurers, Ages 1 Year and Older



Mapping and Measuring Blueprint Communities Using Network Analysis

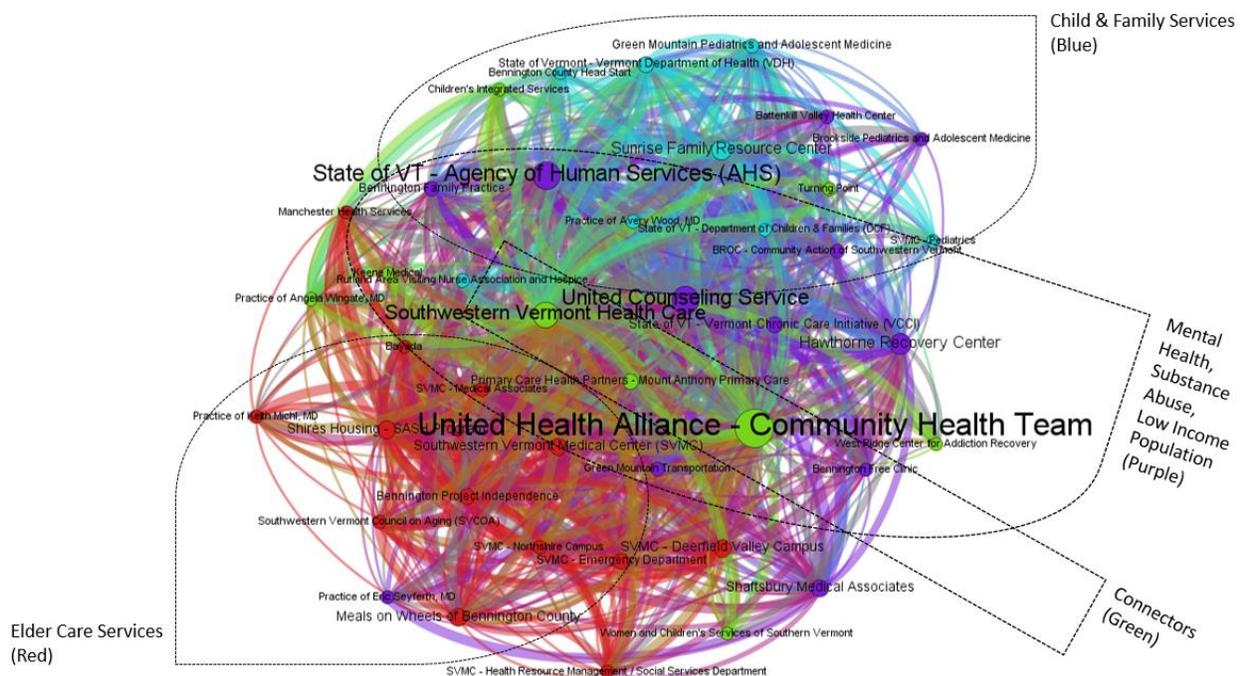
Network Analysis offers an opportunity to visualize the community networks and quantify overall connectedness and the position of key organizations. The methodology begins with a survey of

The map shown in Figure 4 includes nodes (dots) representing organizations surveyed and edges (lines) showing the relationships that connect them.

The size of the nodes indicates their relative Betweenness Centrality (larger nodes have higher Betweenness Centrality scores), a measure of how often the organization appears on the shortest path between randomly selected pairs of organizations in the network. This measure can help communities identify the organizations in their network best positioned to help connect organizations to each other, to lead coordination projects, or to rapidly disseminate critical information.

The color of the nodes shows each organization's network neighborhood membership. Organizations are more likely to be connected with other organizations marked in the same color than with the average randomly selected organization in the network. Figure 5 below shows researcher and community observations of the types of organizations that make up each neighborhood in the Bennington network. This analysis can help communities understand the basis for existing partnerships within the larger network, and help them assess whether specific types of services are adequately connected to all the populations that need them. For instance (in an example drawn from another HSA, not shown here) if elder care organizations are clustered in one part of a map, and substance abuse services treatment are clustered in another, this might raise the question of whether older community members have adequate access to substance abuse treatment services. If further local discussion and evaluation confirmed that better connected services would benefit this population, elder care and substance abuse treatment programs could work together to share more information, establish referral protocols, and develop other strategies for improving access.

Figure 5: Bennington Network Map with Network Neighborhood Observations



NCQA Patient Centered Medical Home

The most recent patient centered medical home standards (2014) are being deployed across the network and even as the standards have become more progressively rigorous, the practices assisted by facilitators, are successfully meeting the updated standards.

Figure 6. NCQA PCMH Dashboard



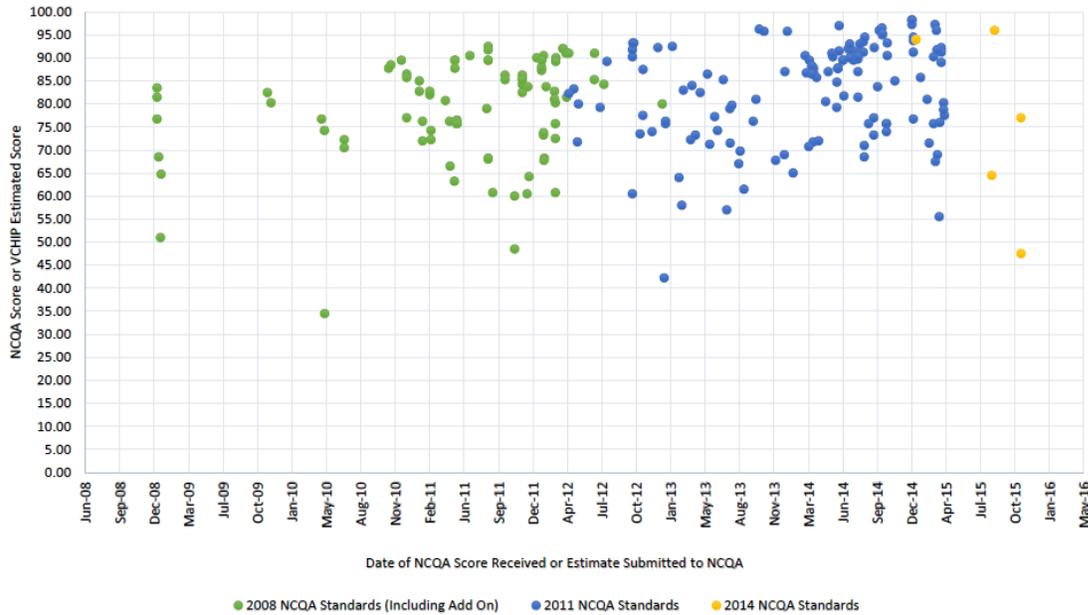
VCHIP
Vermont Child Health Improvement Program
UNIVERSITY OF VERMONT COLLEGE OF MEDICINE

NCQA PCMH Dashboard

St. Joseph's 7, UHC Campus, 1 South Prospect Street, Burlington, Vermont 05401
802 656 8210 TEL. 802 656 8368 FAX

www.vchip.org

Figure 11. NCQA Scores⁴ Over Time (by NCQA's Patient-Centered Medical Home (PCMH) Standard)



⁴Includes practices officially recognized by NCQA (at the time the dashboard was updated). Excludes closed practices. Dates reflect receipt of the final score from NCQA.

Hub and Spoke Initiative:

As part of the Blueprint, the Hub and Spoke Initiative creates a framework for integrating treatment services for opioid addiction. This initiative represents AHS and DVHA's efforts—referred to as the Alliance for Opioid Addiction—to collaborate with community providers to create a coordinated, systemic response to the complex issues of opioid addiction in Vermont. The Hub and Spoke Initiative is focused on beneficiaries receiving Medication-Assisted Treatment (MAT) for opioid addiction.

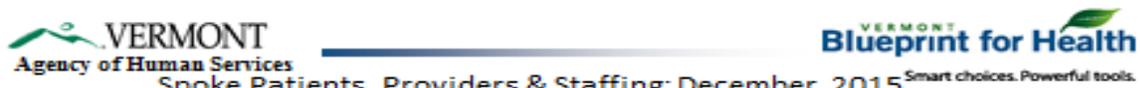
This Health Home initiative now serves 5,238 Medicaid beneficiaries in Hub and Spoke programs combined as of December 31, 2015. The following tables present the caseloads of regional Hub and Spoke staffing as of December, 2015. Spoke staffing is scaled at 1 registered nurse and 1 licensed clinician for every 100 patients receiving MAT.

Table 2. Hub Implementation as of December 31, 2015

Program	Region	Start Date	# Clients	# Buprenorphine	# Methadone
Chittenden Center	Chittenden, Franklin, Grand Isle & Addison	1/13	837	243	594
BAART Central Vermont	Washington, Lamoille, Orange	7/13	414	181	233
Habit OPCO / Retreat	Windsor, Windham	7/13	595	209	386
West Ridge	Rutland, Bennington	11/13	418	137	281
BAART NEK	Essex, Orleans, Caledonia	1/14	584	130	454
STATEWIDE			2848	900	1948

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 Patients, Providers & Staffing: December 2015



Spoke Patients, Providers & Staffing: December 2015

Region	Total # MD prescribing pts	# MD prescribing to ≥ 10 pts	Staff FTE Available	Staff FTE Funding	Staff FTE Hired	Medicaid Beneficiaries
Bennington	10	8	5.0	5.6	240	
St. Albans	13	9	7.0	5.1	339	
Rutland	10	6	5.5	4.1	267	
Chittenden	31	17	9.0	10.6	474	
Brettleboro	13	5	3.0	3.29	141	
Springfield	2	1	1.5	1.5	57	
Windsor	7	4	3.5	3.0	158	
Randolph	4	3	2.0	2.0	83	
Berre	17	7	6.5	5.5	302	
Lamoille	6	3	3.5	2.6	154	
Newport & St Johnsbury	8	4	2.0	2.0	98	
Addison	6	3	1.5	1.5	71	
Upper Valley	3	0	.5	0	5	
Total	126*	70	50.5	46.79	2,390	

Table Notes: Beneficiary count based on pharmacy claims Oct – Dec, 2015; an additional 178 Medicaid beneficiaries are served by 20 out-of-state providers. Staff hired based on Blueprint portal report 9-21-15. *4 providers prescribe in more than one region.

Table 4 below shows the number of Medicaid beneficiaries receiving treatment in the Spokes and the full-time-equivalent staff of nurses and licensed clinicians. In addition, the table shows the total number of Vermont physicians actively prescribing Buprenorphine or Vivitrol to Vermont residents for opiate addiction, and the number of these physicians who prescribe to 10 or more Medicaid beneficiaries.

Table 4. Spoke Implementation: Beneficiaries, Providers, and Staffing December 2015

Region	Total # MD prescribing pts	# MD prescribing to ≥ 10 pts	Staff FTE Available Funding	Staff FTE Hired	Medicaid Beneficiaries
Bennington	10	8	5.0	4.6	233
St. Albans	10	9	7.5	6.6	363
Rutland	10	6	5.5	4.5	259
Chittenden	30	16	9.0	9.25	434
Brattleboro	13	5	3.0	3.99	146
Springfield	2	2	1.5	1.5	67
Windsor	7	4	2.5	2.5	146
Randolph	7	3	2.0	1.4	93
Barre	18	8	5.5	5.5	231
Lamoille	7	4	3.0	2.6	147
Newport & St Johnsbury	8	4	2.0	1.0	94
Addison	6	3	1.5	1.5	66
Upper Valley	2	0	.5	0	6
Total	126*	72	49.5	44.94	2,331

Table Notes: Beneficiary count based on pharmacy claims Oct – Dec, 2015; an additional **178** Medicaid beneficiaries are served by **20** out-of- state providers. Staff hired based on Blueprint portal report 1-28-16. *4 providers prescribe in more than one region.

iv. *Behavioral Health*

- **Key updates from QE1215:**
- **Applied Behavior Analysis providers enrolling and authorizations are ongoing**
- **LADCs able to participate as Medicaid providers starting 10/1/2015**
- **Preparations for hybrid chart reviews started November 2015**

The DVHA Behavioral Health Team offers a comprehensive approach for behavioral health care coordination. The Team is responsible for concurrent review and authorization of inpatient psychiatric and detox services for Medicaid primary members as well as the utilization management activities for substance abuse residential services for Medicaid primary and uninsured Vermonters. The Team works closely with staff at the inpatient and residential facilities and, when appropriate, the Team collaborates directly with and supports collaboration between facility staff and staff from VCCI, DCF,

DMH and ADAP to ensure timely and appropriate transitions of care. The Team also manages the Team Care Program (lock-in) for Medicaid members.

The Applied Behavior Analysis (ABA) benefit was implemented July 1, 2015 and at the time of this report, there were approximately 20 individual providers enrolled representing 3 designated agencies and a number of private providers both in and out of group practices. The Autism Specialist has reviewed 45 prior authorization requests with the required clinical documentation and is preparing for the upcoming 6 month review for the authorizations that were received and completed in July 2015. The Autism Specialist continues to provide 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 final comment period for the external review of the draft Applied Behavior Analysis Clinical Practice Guideline came to a close at the end of this quarter. The Autism Specialist, who is spearheading this project, has had both verbal and written feedback from providers and will be compiling this into a draft for the Managed Care Medical Committee to review and make a final recommendation on.

Licensed Alcohol and Drug Counselors (LADCs) became eligible to enroll with Vermont Medicaid 10/1/2015 and the Quality Unit Behavioral Health Team collaborated during this Quarter with ADAP and OPR staff to review options for the responsibility of Licensure of LADCs to move to OPR from ADAP. Additionally, as a part of the ongoing collaboration between ADAP and DVHA, the Behavioral Health Team members and ADAP staff met with substance abuse residential providers to review how the current UR process is working. The providers had very positive feedback to the Team and expressed that the current UR process with DVHA staff is working well for the providers and that the process is seen as collaborative.

During this quarter, staff continued to solidify and improve the processes for enhanced collaboration with the VCCI. The Behavioral Health Team worked alongside VCCI staff as a part of the User Acceptance Testing (UAT) process for the new Care Management system which will be used by the Behavioral Health Team to communicate more effectively and efficiently with VCCI staff regarding current VCCI clients who are admitted for psychiatric or substance abuse related care and to make referrals for VCCI services for members who may be eligible but have not yet received services.

The Behavioral Health Team, in collaboration with the Clinical Operations Unit and the Quality Team has begun preparations for the upcoming medical record review which will occur throughout the next two quarters. The DVHA chose 2 measures for the upcoming review, BMI and Controlling Blood Pressure, both of which are of great interest to the Team due to the incidence of high blood pressure and obesity in the population they manage. These measures will again be validated and will inform potential performance improvement projects in the future.

v. *Mental Health System of Care*

Key updates from QE1215:

- Quality Management Unit's role in system of care
- Health Care Integration advocacy by mental health leadership

System Maturity and Quality Initiatives

As reported for the third quarter of 2015, the new policy framework of the system of care is now

maturing with all of the new facilities completed and operating. This has provided the Vermont Department of Mental Health (DMH) with the opportunity to focus on leadership and staffing for conducting a quality management program to support, measure and improve the person-centered care offered in the advanced treatment environments that Vermont has designed and built. The Department is committed to the following Quality Domain Measures:

- Access
- Practice Patterns
- Outcomes/Results of Treatment
- Administration of fully functional agencies providing care.

The Quality Management Unit is an overarching entity in that it serves adult and children's mental health programs. Organizationally, it also includes the Research and Statistics Unit given the integral role that data and measurement play in good quality work. The system of care is a network of community providers, hospitals, peer-run organizations, partnerships, and state agencies all requiring collaborative planning and implementation. Leadership of DMH monitors the system of care, reporting on a monthly basis to committees of jurisdiction and made available to the public online. The goal of the Quality Management Unit is to assure that all programs and services funded by the state are in compliance with state and federal laws and regulations, while achieving desired outcomes through the provision of high-quality services and supports. The Quality Management Unit contributes to policy development through the ongoing processes to gather accurate, valid and reliable data and continuous quality improvement activities for the leadership team and stakeholders.

The Department has been strengthened by reconstituting the Quality Management Unit in 2012 and by the hiring of a Quality Management Director. Together with Research and Statistics, the two units comprise an integral part of the Department's capacity to analyze and develop effective measures on which our system of care can be assessed and improved.

Mental Health and Health Care Integration

Organizational and staffing changes made to position the Department of Mental Health to seek its place in the great, complex environment of health care reform in Vermont reached a new level in the last quarter. For the first time, DMH sought to make its case to the Green Mountain Care Board that integration was not only essential in moving toward an all-payer system, but also to improving Vermonters' health and lowering health care costs. DMH leadership engaged the Board on the meaning of integration with mental health services as well as better linkages between primary care providers, specialty care, hospitals and other medical services. How to integrate and reimburse those services remains a topic of discussion between DMH, mental health advocates, and the Green Mountain Care Board.

Mental health, physical health and substance abuse services delivered in a coordinated way is a statutory expectation in the most recent legislation defining the Department of Mental Health's role and authority. Previously operating as a division of mental health within the Vermont Department of Health, DMH was re-established in 2007 with an expanded statutory mandate to "...centralize and more efficiently establish the general policy and execute the programs and services of the state concerning mental health, and to integrate and coordinate those programs and services with the programs and services of other departments of the state, its political subdivisions, and private agencies, so as to provide a flexible comprehensive service to all citizens of the state in mental health and related problems." Act No.15 of 2007 restored a commissioner of mental health, delineating new areas of responsibility to ensure the coordination of mental health, physical health, and substance abuse

services provided by the public and private health care delivery systems.

This re-establishment supports DMH's goal to broaden its role to include all Vermonters and to fulfill the statutorily mandated integration and coordination with other health care programs and services. As the framework for Vermont's health care reform evolved, it presented the challenge and the opportunity for DMH to focus on bringing together all of health care—physical health and mental health—within the developing systems of health reform. Research studies support the thinking that mental health has a profound impact on a person's physical health and other social determinants and, conversely, those impact mental health as well. DMH is continuing to lead the discussion regarding the role of health promotion, prevention, early intervention, and evidence-based treatment in health care reform as it relates to mental health and its integration with physical health.

DMH advocates for a range of integrated services to include:

- Strengthened collaboration among primary care practices, designated agencies, and independent mental health services providers
- Co-location between mental health providers and medical providers
- Full integration with shared systems and facilities

This range of integration would facilitate providing the right care at the right time for Vermonters, an important goal of healthcare reform.

Integration of Public Funding for Mental Health Care Services

The Department of Mental Health (DMH) and the Department of Vermont Health Access (DVHA) are engaged in a 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 publically 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.

Vermont Psychiatric Care Hospital

Planning and evaluation for development of an Electronic Health Record (EHR) solution has been ongoing. This quarter, the Department of Mental Health signed a contract with the selected vendor to provide a web-based, contractor-supported electronic medical records system for Vermont Psychiatric Care Hospital. The contracted system will integrate physical, behavioral, pharmacy, dietary, billing and lab functions into a single unified EHR solution. Technology services began on January 1, 2016, and will end on December 31, 2021, a 5-year commitment, with a provision to extend the initial contract term for two additional one-year periods. The application for a Certificate of Need (CON) issued on November 19, 2012, indicated the Department of Mental Health's intention to open the new hospital in 2014 with a fully integrated EHR system in place. The current plan for this commercial off-

the-shelf system is to go-live in October of 2016 and meet the following objectives for the Vermont Psychiatric Care Hospital:

- Integrate physical, behavioral, pharmacy, dietary and lab functionality into a single unified EHR solution.
- Streamline and standardize workflow to increase patient care and decrease clinical errors.
- Implement quality improvement and operational efficiency programs made possible through data gathered through the system.
- Improve the coordination of care by enhancing interoperability among the Vermont Psychiatric Care Hospital and external partners in care.
- Maximize the integration of behavioral health care with physical medicine.
- Meet federal Health and Human Services requirements for Meaningful Use certification as required for all healthcare technology.
- Provide interoperability with Vermont Health Information Exchange (VHIE) through Vermont Information Technology Leaders (VITL).
- Automate report generation.
- 24 x 7 x 365 support and service.

Reaching this stage of planning for an Electronic Health Record is a significant advancement in bringing the provision of psychiatric inpatient hospital care to a new level of accountability and quality for this component of this system of care.

vi. *Pharmacy and 340B Drug Discount Program*

Key updates from QE1215:

- Vermont has realized \$ 541,213.93 net cost savings for this reporting period and year to date net cost savings of \$ 2,722,492.80 through Medicaid participation of a relatively small number of eligible covered entities.

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

resources, reach more eligible patients, and provide more comprehensive services.

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

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

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

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

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

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

- Northeastern Vermont Regional Hospital
- Notch Pharmacy
- Porter Hospital
- Rutland Regional Medical Center
- **Springfield Hospital**
- **UMass Memorial Medical Center**

340B Reimbursement and Calculation of Incentive Payment:

DVHA identified the following goals in establishing its proposed 340B reimbursement methodology:

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

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

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

For the reporting period, Vermont has realized \$541,213.93 net cost savings and year to date net cost savings of \$2,722,492.80 through Medicaid participation of a relatively small number of eligible covered entities.

vii. *Integrating Family Services (IFS) Initiative*

AHS continues to act on opportunities to improve quality and access to care, within existing budgets, using managed care flexibilities and payment reforms available under 42 CFR § 438 and the GC waiver. This includes such items as: integration of administrative structures for programs serving the same or similar populations; opportunities to increase access to services by decreasing administrative

burdens on providers; reviewing pre-GC waiver operations to determine if separate administrative and Medicaid reimbursement structures can be streamlined under the waiver. Several such projects have emerged in the children's and EPSDT (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.

Annual Aggregate Budgets and Case Rates for Medicaid Children's Mental Health and Family Support Services:

The initial IFS implementation site in Addison County is in its fourth state fiscal year, and the second pilot region in Franklin and Grand Isle counties celebrated its one year anniversary on April 1, 2015. The initial pilot included consolidation of over 30 state and federal funding streams into one unified whole through one master grant agreement; the second pilot also includes consolidation of several state and federal funding streams. The State has created an annual aggregate spending cap for two providers in Addison and one in Franklin/Grand Isle (this provider houses the Designated Agency and Parent Child Center). This has created a seamless system of care to ensure no duplication of services for children and families. There is a comprehensive effort occurring to move the Designated Agency Master Grants towards being more integrated in regards to performance measures and alignment of language. These master grants are over 100 pages long and have performance measures listed throughout. There is a significant amount of work the Agency is embarking on to make these grants more effective and stream-lined.

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

- Increased service hours overall, increased number of people served, and simultaneous reduction in requests for children's mental health crisis services.

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

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

IFS is actively engaged in payment reform. Both pilot regions have met with a national Medicaid payment reform consultant, and interested providers from Washington County joined the last discussion. The goal is to work toward a model system of payment that could be replicable any place in the Agency.

With the continued interest in moving IFS statewide, there has been great efforts made through five work groups to reach clarity about the IFS financing model, data and outcomes to be collected, prevention and promotion efforts and how the state in IFS regions has consistent supports and services available to families so that regardless of where they reside in the state they have access to similar service provision. These work groups are made up of state and community partners to ensure multiple perspectives are present at the table.

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 SFY2018. Some may be ready during the FY2017 time period, however, lessons learned from bringing on a region on mid-fiscal year indicates this may not be the most fiscally effective decision.

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

align approaches are:

- IFS is engaged in a statewide effort to look more effectively at how Vermont uses residential treatment for children and youth.
- IFS is creating a teaming pilot in four 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.

VI. Financial/Budget Neutrality Development/Issues

AHS received the final actuarially certified Global Commitment capitated rates from Milliman during QE1215. Milliman's contract is due to expire March 2016. AHS posted an RFP during QE1215 to solicit bids for a new two-year contract with an option to extend for two one-year terms. The bids are due 2/12/16 and we will begin the evaluation process shortly thereafter.

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

We experienced challenges with the QE1215 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, we 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.

Table 5. Number of Recipients, Change from Previous Quarter

Demonstration Population	Q4 FFY 2015			Q1 FFY 2016		
	July 31, 2015	August 31, 2015	September 30, 2015	October 31, 2015	November 30, 2015	December 31, 2015
Demonstration Population 1	37,451	37,570	37,584	37,946	37,896	37,538
Demonstration Population 2	82,915	83,348	83,453	84,551	84,698	84,772
Demonstration Population 3	58,063	58,390	58,457	59,343	59,809	60,317
Demonstration Population 4	2,906	2,862	2,799	2,950	2,887	2,819
Demonstration Population 5	917	906	894	942	930	929
Demonstration Population 6	920	906	905	893	889	873
Demonstration Population 7	7,397	7,414	7,399	7,346	7,376	7,397
Demonstration Population 8	4,227	4,232	4,246	4,195	4,196	4,213
	194,796	195,628	195,737	198,166	198,681	198,858

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 QE1215:

- The MCE Quality Committee established a set of Quality Measure Selection Criteria.
- In 2016, the DVHA will complete a HEDIS hybrid MRR process for the CBP and ABA measures. The 2016 schedule and training materials were developed this quarter.
- Members of the implementation team for the CMS formal PIP (Follow-Up After Hospitalization for Mental Illness) presented to both senior leadership at the Dept. of Mental Health and Medicaid ACO representatives.

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

Quality Committee Updates:

The MCE Quality Committee met twice during the quarter. The Committee established a set of Quality measure selection criteria that we will use when reviewing the current *Global Commitment to Health* Core Measure set. The criteria will be used as a framework to help us identify gaps and potential new measures to be added to the core list. These performance measures are reported to AHS and then CMS annually.

The AHS Performance Accountability Committee (PAC) met monthly during the quarter. The group reviewed the Global Commitment to Health (GC) core set of performance measures. This included a review of the annual HEDIS and CHAPS results. In addition, the group shared initial thoughts re: potential performance improvement projects that might be initiated for 2016. The group will look to the MCE Quality Committee for recommended modifications to the measure set as well as improvement projects for 2016. Also during this quarter, The AHS QIM continued to work with PHPG to finalize the Choices for Care systemic assessment. In addition to reviewing rules, regulations, policies, and procedures, draft versions of the assessment were shared with stakeholders. Also, the AHS QIM supported the development of a Choices for Care HCBS Work Plan that lays out the action steps necessary to align Vermont with the new HCBS regulations. Next steps include deciding on provider self-assessment, as well as initiating systemic assessments for other Global Commitment to Health special health needs populations.

MCE Investment Review:

During this quarter, the AHS PAC discussed how best to visually display results associated with MCE Investments. The group recommended that MCE Investment performance measure reporting align with other AHS performance measure reporting requirements. Beginning next quarter, departments will begin to add MCE Investment performance measure results to their Scorecards. In addition, separate, yet related work continues on assessing current MCE investments for conversion to Medicaid billable administration or services when feasible.

External Quality Review (EQR):

During this quarter, the AHS Quality Improvement Manager (QIM) worked with the External Quality Review Organization (EQRO) to produce a final report of the Performance Improvement Project (PIP) validation activity. DVHA progressed to reporting first remeasurement data in this year's submission, and the PIP was assessed for statistically significant improvement from the baseline. The assessment for real improvement determined that improvement did not occur. Both study indicators demonstrated declines from baseline to the first remeasurement. Through causal barrier analysis, it was determined that the original intervention only had six months to take effect before the remeasurement. DVHA indicated that the Remeasurement 2 period will have a full 12 months of the intervention. In addition, DVHA added a new intervention to address a second barrier of lack of providers in some areas and possible relationship-building needed between hospital staff and area clinicians.

During this quarter, the AHS Quality Improvement Manager (QIM) also worked with the External Quality Review Organization (EQRO) to produce a final report of the Performance Measure Validation (PMV) activity. Starting last year, DVHA's quality team began reviewing performance measure rates in detail in an effort to identify mechanisms for improving the quality of care and outcomes for members. The EQRO recommended that DVHA continue this review practice and enhance it to identify rates that fall below the national 10th percentiles.

In addition, the AHS Quality Improvement Manager (QIM) worked with the External Quality Review Organization (EQRO) to produce a final report of the Compliance with Standards review activity. DVHA obtained a total percentage of compliance score across the 31 requirements of 96.8 percent. DVHA scored 100 percent in two of the standards and 90.9 percent in one standard. The one element found to be noncompliant involved validating that the clinical practice guidelines were reviewed and periodically updated as required by the DVHA Evidence-based Clinical Practice Guidelines policy and procedure.

During this quarter, the AHS Quality Improvement Manager also worked with the EQRO to develop the Annual Technical Report. This document combines the results of all three external quality review activities and identifies strengths and challenges associated with the three activities as well as making recommendations to improve the timeliness, access, and quality of services provided by the MCE.

Finally, during this quarter, AHS issued a request for proposal (RFP) to secure EQR services. The current contract is due to expire on February 14, 2016. Three vendors attended the bidder's conference – and two ended up submitting proposals. A proposal review committee, comprised of representatives from the Department of Disabilities, Aging, and Independent Living (DAIL), the Department of Vermont Health Access (DVHA), and the Agency of Human Services Secretary's Office (AHSCO), was assembled shortly thereafter. Based on the data provided by committee members via a standardized scoring tool and interviews with vendor references, the committee unanimously selected HSAG as the finalist. During the next quarter, a new contract will be developed and initiated.

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

In 2015, DVHA developed the capacity for and completed its first internal HEDIS hybrid medical record review (MRR). The results were validated by HSAG in July 2015, as mentioned above. In 2016, DVHA will complete a HEDIS hybrid MRR on the controlling high blood pressure (CBP) and adult BMI assessment (ABA) measures. In QE1215, the 2015 MRR project manager cross-trained two (2) other staff within the Quality Improvement and Clinical Integrity Unit to lead the MRR in 2016. The new project managers began working with the core MRR committee in preparing the schedule and training materials for early 2016.

Formal (Validated) Performance Improvement Project:

DVHA continues to lead an AHS-wide Performance Improvement Project (PIP) on Follow-up After Hospitalization (FUH) for Mental Illness, the study indicator for which is the HEDIS measure of the same name (FUH HEDIS). During this quarter, follow-up appointment scheduling reports were again prepared and distributed to the designated hospitals and will continue to be distributed on a quarterly basis. Due to lack of movement in the overall FUH measure rates and feedback from designated hospital partners, the FUH PIP implementation team continued to discuss an additional intervention for Year 2 of the project that would enhance the work already done in Year 1. During this reporting period, members of the FUH PIP implementation team presented an overview of our PIP to two key partners in order to continue to raise awareness and collaboration – the Department of Mental Health senior leadership team, as well as the representatives from Vermont’s two Medicaid Accountable Care Organizations (ACOs). The FUH PIP team will continue to work with the Medicaid ACO’s in subsequent quarters to implement a new system intervention. We hope to find the individuals in the FUH denominator who are also attributed to ACO’s, and outreach the appropriate providers within the ACO network to help support the individual and facility in scheduling follow-up care with a mental health practitioner.

Adult Medicaid Quality (AMQ) Grant Performance Improvement Projects:

- **Breast Cancer Screening (BCS) PIP:**

The goal of this project was to increase the overall HEDIS rate of female Medicaid beneficiaries ages 50-74 receiving a mammogram every two years. There were two interventions; one aimed at providers (sending quarterly gap in care lists) and one aimed at beneficiaries (educational materials and grocery store gift card incentive). There were two annual intervention cycles in 2014 and 2015. Intervention results for both cycles were modest, ranging from 6.5 percent to 15.7 percent. Since the AMQ Grant ended in December 2015, a third intervention cycle will not be implemented. However, the initiatives will continue in slightly different ways.

The Vermonters Taking Action Against Cancer (VTAAC) All-Payer Joint Project is picking up where the PIP provider intervention ended. MVP, BCBSVT & Medicaid are coordinating efforts to continue sending quarterly GIC lists to the 32 practices Medicaid has been sending to for the last two years. The insurers are using MVP’s format so the practices can merge and sort the three lists. The first round of joint GIC lists was sent in mid-October 2015. DVHA is pleased to be able to continue to collaborate with the private insurers as well as continue to partner with the practices in quality improvement projects.

The Vermont Department of Health (VDH) and the DVHA are partnering in getting a cancer screening brochure out to targeted Medicaid beneficiaries. A cover letter and cancer screening brochure (including screening recommendations for breast, cervical, colorectal, lung, skin and prostate cancers) will be printed and sent to male Medicaid beneficiaries ages 50-75 and female Medicaid beneficiaries ages 40-75 in February 2016.

- **Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET) PIP:**

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

The IET project’s interventions involve a two-pronged approach in those three counties aimed at primary care providers (provide them with an expanded list of substance abuse clinicians in their area) and substance abuse clinicians (enroll in a pay for performance reimbursement model). The AMQ grant no-cost extension allowed the IET PIP team to extend the project through November 30, 2015. During the intervention period, 7 clinicians provided services to 51 unduplicated clients and received a total of \$2894 in enhanced payments. The preliminary overall project results (IET HEDIS rates) will be run in May 2016.

Future Performance Improvement Projects:

The DVHA Quality Unit staff are engaging appropriate committees within the Agency, such as the Managed Care Medical Committee, the MCE Quality Committee and the Performance Accountability Committee in conversation about the need to thoughtfully research and plan for future performance improvement projects. Both PIPs that fall within the AMQ Grant (see above) ended in December 2016, and the MCE’s formal PIP cycle (Follow-Up After Hospitalization for Mental Illness) ends in June 2016. Conversations will continue and data based decisions will be made in the coming months related to new improvement projects.

Consumer Assessment of Healthcare Providers and Systems Survey:

DVHA worked with WBA Research, Inc., a NCQA-certified vendor, in 2015 and focused the CAHPS survey efforts on children. Additionally, 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 will be available by NORC in the spring of 2016. During this reporting period, the DVHA is connected with the Blueprint for Health to discuss the potential for CAHPS survey coordination. It was determined that efficiencies and cost savings could be created by using the Blueprint vendor to field a children’s Medicaid health plan survey in 2016. The details of that contract amendment are currently being worked out.

X. Compliance

Key updates from QE1215:

- 2016 EQRO audit preparation has begun
- Quarterly IGA monitoring reviews have begun

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

EQRO Audit Preparation:

During this quarter, preparation began for the 2016 EQRO audit. We have been reviewing prior year recommendations and required actions to ensure that all have been met and we have begun discussing what we will need for the document submission process, which will start in a few months.

The 2016 EQRO Compliance review will focus on the following Access standards:

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

This is, perhaps, the most complicated and involved year in our three-year EQRO cycle.

Quarterly IGA Monitoring has begun

DVHA's compliance team has scheduled quarterly reviews with each of our IGA partners. During these reviews, we will use our new monitoring tool to ensure compliance with all of our statutory, rule, plan, waiver and IGA requirements.

This new process will make future EQRO reviews much easier, as we will be preparing for each review incrementally throughout the year. The review tool closely matches the EQRO standards from recent audits.

XI. Demonstration Evaluation

During this quarter, a draft evaluation plan was submitted to CMS. The new plan takes key evaluation elements from the previous Global Commitment to Health waiver as well as the previous Choices for Care waiver. In addition, an interim evaluation report was submitted to CMS during this quarter. This document is informed by the aforementioned draft evaluation plan. Finally, the AHS QIM continued to meet with members of Vermont's SIM grant to develop its evaluation plan. While Medicaid is only one of the participating payers, it was thought that there might be some efficiencies realized by leveraging the GC waiver evaluation efforts with those of the SIM grant.

XII. Reported Purposes for Capitated Revenue Expenditures

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

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

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

XIII. Enclosures/Attachments

Attachment 1: Budget Neutrality Workbook

Attachment 2: Enrollment and Expenditures Report

Attachment 3: Complaints Received by Health Access Member Services

Attachment 4: Medicaid Managed Care Entity Grievance and Appeal Reports

Attachment 5: Office of the Health Care Advocate Report

Attachment 6: State Fiscal Year 2015 Managed Care Entity Investments

XIV. State Contact(s)

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

Date Submitted to CMS: February 29, 2016

ATTACHMENTS

Attachment 1 - Budget Neutrality Workbook

Global Commitment Expenditure Tracking

QE	Quarterly Expenditures	PQA: WY1	PQA: WY2	PQA: WY3	PQA: WY4	PQA: WY5	PQA: WY6	PQA: WY7	PQA: WY8	PQA: WY9a	PQA: WY9b	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 Expenses for Budget Neutrality calculation - Includes Excess 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	\$ 1,596,128,945	\$ 88,732,372	
Cumulative																					
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	\$ 2,484,316,097	\$ 2,604,109,308	\$ 119,793,211
Cumulative																					
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	\$ 3,425,180,534	\$ 3,606,430,571	\$ 181,250,037
Cumulative																					
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	\$ 4,444,110,832	\$ 4,700,022,174	\$ 255,911,342
Cumulative																					
1210	\$ 262,106,988	\$ -	\$ 6,444,984											\$ 6,444,984	\$ 268,551,972						
0311	\$ 257,140,611	\$ -	\$ 257,140,611											\$ -	\$ 257,140,611						
0611	\$ 277,708,043	\$ -	\$ (121,416)	\$ (121,416)										\$ (121,416)	\$ 277,586,627						
0911	\$ 243,508,248	\$ -	\$ 5,528,143	\$ 249,036,391										\$ 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	\$ 5,495,525,000	\$ 5,865,213,737	\$ 369,688,737
Cumulative																					
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	\$ 309,352,538										\$ 6,393,928	\$ 309,352,538						
0912	\$ 262,406,131	\$ -	\$ 7,750,994	\$ 270,157,125										\$ 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	\$ 6,635,802,617	\$ 7,113,290,903	\$ 477,488,286
Cumulative																					
1212	\$ 282,701,072	\$ -	\$ 3,036,447											\$ 3,036,447	\$ 285,737,519						
0313	\$ 285,985,057	\$ -	\$ 991,340	\$ 286,976,397										\$ 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	\$ 288,230,320										\$ 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	\$ 7,841,950,966	\$ 8,450,684,486	\$ 608,733,520
Cumulative																					
1213	\$ 319,939,651	\$ -	\$ 3,652,767											\$ 3,652,767	\$ 323,592,418						
WY9a SUM	\$ 319,939,651	\$ -	\$ 3,652,767											\$ 3,652,767	\$ 319,921,780		\$ 1,214,631	\$ 321,136,411	\$ 8,163,087,376	\$ 8,955,886,798	\$ 792,799,422
Cumulative																					
0314	\$ 288,542,475	\$ -	\$ 2,159,834											\$ 2,159,834	\$ 290,702,309						
0614	\$ 288,845,927	\$ -	\$ 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	\$ 287,720,381										\$ 867,215	\$ 287,720,381						
WY9b 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	\$ 9,276,671,203	\$ 10,290,338,883	\$ 1,013,667,680
Cumulative																					
0315	\$ 321,140,737	\$ -	\$ (526,911)											\$ -	\$ 321,140,737						
0615	\$ 357,677,001	\$ -	\$ (526,911)	\$ 357,150,090										\$ (526,911)	\$ 357,150,090						
0915	\$ 309,207,552	\$ -	\$ 3,080,254	\$ 312,287,806										\$ 3,080,254	\$ 312,287,806						
1215	\$ 348,325,098	\$ -	\$ 5,996,596	\$ 354,321,694										\$ 5,996,596	\$ 354,321,694						
WY10 SUM	\$ 1,336,350,389	\$ -	\$ (526,911)	\$ 9,076,850										\$ 8,549,939	\$ 1,345,427,239		\$ -	\$ 1,345,427,239	\$ 10,622,098,441	\$ 11,969,357,946	\$ 1,347,259,505
Cumulative																					
0316	\$ -	\$ -	\$ -	\$ -										\$ -	\$ -						
0616	\$ -	\$ -	\$ -	\$ -										\$ -	\$ -						
0916	\$ -	\$ -	\$ -	\$ -										\$ -	\$ -						
1216	\$ -	\$ -	\$ -	\$ -										\$ -	\$ -						
WY11 SUM	\$ -	\$ -	\$ -	\$ -										\$ -	\$ -		\$ -	\$ -	\$ -	\$ -	
Cumulative																					
	\$ 10,362,161,426	\$ 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	\$ 9,076,850	\$ -	\$ -	\$ 10,568,736,558	\$ -	\$ 53,361,884	\$ 10,622,098,441	\$ 13,752,420,439	\$ 3,130,321,998	

Attachment 2 - Enrollment & Expenditures Report
Glossary of Terms

PMPM – Per Member Per Month

MEG – Medicaid Eligibility Group

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

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

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

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

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

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

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

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

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

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

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

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

The Department of Vermont Health Access
Caseload and Expenditure Report ~ DVHA Only Medicaid Spend
DVHA YTD '16
 Tuesday, November 10, 2015

	SFY '16 Appropriated			SFY '16 Actuals thru September 30, 2015			% of Approp. Spent to Date
	Caseload	Expenses	PMPM	Caseload	Expenses	PMPM	
ABD Adult	15,680	\$ 113,165,353	\$ 601.43	16,391	\$ 24,688,975	\$ 502.08	21.82%
ABD Dual	17,978	\$ 50,051,552	\$ 232.01	18,690	\$ 13,547,958	\$ 241.63	27.07%
General Adult	15,966	\$ 90,450,192	\$ 472.09	19,676	\$ 22,035,095	\$ 373.31	24.36%
New Adult	48,985	\$ 193,377,396	\$ 328.97	58,264	\$ 60,500,482	\$ 346.13	31.29%
Exchange Premium Assistance #	18,368	\$ 8,541,105	\$ 38.75	15,646	\$ 1,360,901	\$ 28.99	15.93%
Exchange Cost Sharing #	6,034	\$ 1,522,615	\$ 21.03	5,117	\$ 326,715	\$ 21.28	21.46%
ABD Child	3,727	\$ 38,392,328	\$ 858.33	3,304	\$ 7,665,813	\$ 773.39	19.97%
General Child	57,594	\$ 132,798,298	\$ 192.15	62,468	\$ 34,220,940	\$ 182.61	25.77%
Underinsured Child	981	\$ 1,137,209	\$ 96.59	796	\$ 267,468	\$ 112.00	23.52%
SCHIP	4,417	\$ 7,417,112	\$ 139.93	4,460	\$ 1,620,937	\$ 121.15	21.85%
Pharmacy Only	12,709	\$ 6,396,479	\$ 41.94	11,639	\$ (1,487,565)	\$ (42.60)	-23.26%
Choices for Care	4,222	\$ 207,145,319	\$ 4,533.64	3,981	\$ 52,747,420	\$ 4,416.60	25.46%
Total Medicaid Claims Paid	206,663	\$ 850,394,957	\$ 342.91	220,431	\$ 217,509,582	\$ 328.92	25.58%

Exchange Premium Assistance (VPA) and Cost Sharing (CSR) PMPMs 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
 Tuesday, November 10, 2015

	SFY '16 Appropriated			SFY '16 Actuals thru September 30, 2015			% of Approp. Spent to Date
	Caseload	Expenses	PMPM	Caseload	Expenses	PMPM	
ABD Adult	15,680	\$ 191,652,985	\$ 1,018.56	16,391	\$ 43,076,855	\$ 876.03	22.48%
ABD Dual	17,978	\$ 204,497,435	\$ 947.92	18,690	\$ 49,409,218	\$ 881.22	24.16%
General Adult	15,966	\$ 99,940,148	\$ 521.63	19,676	\$ 24,282,246	\$ 411.38	24.30%
New Adult	48,985	\$ 213,500,840	\$ 363.21	58,264	\$ 66,191,530	\$ 378.69	31.00%
Exchange Premium Assistance #	18,368	\$ 8,541,105	\$ 38.75	15,646	\$ 1,360,901	\$ 28.99	15.93%
Exchange Cost Sharing #	6,034	\$ 1,522,615	\$ 21.03	5,117	\$ 326,715	\$ 21.28	21.46%
ABD Child	3,727	\$ 91,644,226	\$ 2,048.88	3,304	\$ 18,682,168	\$ 1,884.80	20.39%
General Child	57,594	\$ 249,300,505	\$ 360.71	62,468	\$ 60,675,991	\$ 323.77	24.34%
Underinsured Child	981	\$ 2,742,330	\$ 232.91	796	\$ 509,479	\$ 213.35	18.58%
SCHIP	4,417	\$ 8,720,602	\$ 164.52	4,460	\$ 1,768,362	\$ 132.16	20.28%
Pharmacy Only	12,709	\$ 6,396,479	\$ 41.94	11,639	\$ (1,487,565)	\$ (42.60)	-23.26%
Choices for Care	4,222	\$ 207,145,319	\$ 4,088.40	3,981	\$ 53,226,905	\$ 4,456.74	25.70%
Total Medicaid Claims Paid	206,663	\$ 1,285,604,589	\$ 518.40	220,431	\$ 318,023,878	\$ 480.91	24.74%

Exchange Premium Assistance (VPA) and Cost Sharing (CSR) PMPMs 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.

Questions, Complaints and Concerns Received by Health Access Member Services October 5, 2015 – January 1, 2016

October 5 – October 9

- PCP Enrollment: CSR's assisted in finding a PCP or entering current PCP.
- VPharm Non-Payment Notices: CSR's reviewed payment history, advised amount due, and reviewed the payment timeline.

October 12 – October 16

- PCP Enrollment: CSR's assisted in finding a PCP or entering current PCP.
- VPharm Non-Payment Notices: CSR's reviewed payment history, advised amount due, and reviewed the payment timeline.

October 19 – October 23

- PCP Enrollment: CSR's assisted in finding a PCP or entering current PCP.
- LIS Mailers Received and Customer believes they should Reapply: CSR's verified notice and advised what is needed in accordance.

October 26 – October 30

- PCP Enrollment: CSR's assisted in finding a PCP or entering current PCP.
- LIS Mailers Received and Customer believes they should Reapply: CSR's verified notice and advised what is needed in accordance.
- PDP Change: CSR's advised if coverage or cost would change and, if so, referred to AOA to discuss further.

November 2 – November 6

- VPharm clients reporting new information for 2016: CSR's escalated an SR.

November 9 – November 13

- VPharm clients reporting new information for 2016: CSR's escalated an SR.
- VPharm Premiums: CSR's escalated a CATN regarding the late payment for coverage to be manually reinstated.

November 16 – November 20

- VPharm clients reporting new information for 2016: CSR's escalated an SR.
- VPharm Premiums: CSR's escalated a CATN regarding the late payment for coverage to be manually reinstated.
- MSP Terminations: CSR's explained reasons for coverage termination and transferred to HAEU if further information needed.



November 23- November 27

- MSP Terminations: CSR's explained reasons for coverage termination and transferred to HAEU if further information needed.

November 30 – December 4

- VPharm payments received between the 15th and 1st: CSR's explained the reinstatement process and escalated an SR if there was an ATC issue.

December 7 – December 11

- Nothing to report.

December 14 – December 18

- Erroneous MSP Closures: CSR's reviewed account, advised accordingly, and escalates a CATN to HAEU if coverage needs to be reinstated.
- AARP MedicareRX Saver Plan Bill: CSR's advised per KB references that the plan should be \$0.00 if customer is on LIS or VPharm.

December 21 – December 25

- Nothing to report.

December 28 – January 1

- Nothing to report.

**Grievance and Appeal Quarterly Report
Medicaid MCE All Departments Combined Data
October 1, 2015 – December 31, 2015**

The MCE is composed of various administrative areas within the Agency of Human Services (AHS). These include: the Department of Vermont Health Access (DVHA), the Department for Children and Families (DCF), the Department of Mental Health (DMH), the Department of Disabilities, Aging and Independent Living (DAIL), and the Department of Health (VDH). Also included in the MCE are the Designated Agencies (DA) and Specialized Service Agencies (SSA) that provide service authorizations for DMH and DAIL. Each entity should have at least one assigned grievance and appeal coordinator who enters data into the MCE database. This report is based on data compiled on January 16, 2016, from the centralized database for grievances and appeals that were filed from October 1, 2015 through December 31, 2015.

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

During this quarter, there were 20 grievances filed with the MCE; ten were addressed during the quarter and one was withdrawn. Grievances must be addressed within 90 days of filing, so having pending cases at the end of the quarter is to be expected. Acknowledgement letters of the receipt of a grievance must be sent within five days; the average was two days. Of the grievances filed, 72% were filed by beneficiaries, 21% were filed by a representative of the beneficiary and 7% were filed by other. Of the 20 grievances filed, DMH had 60%, DVHA had 30% and DAIL had 10%. There were no grievances filed for the DCF, or VDH during this quarter.

There were no Grievance Reviews filed this quarter.

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

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

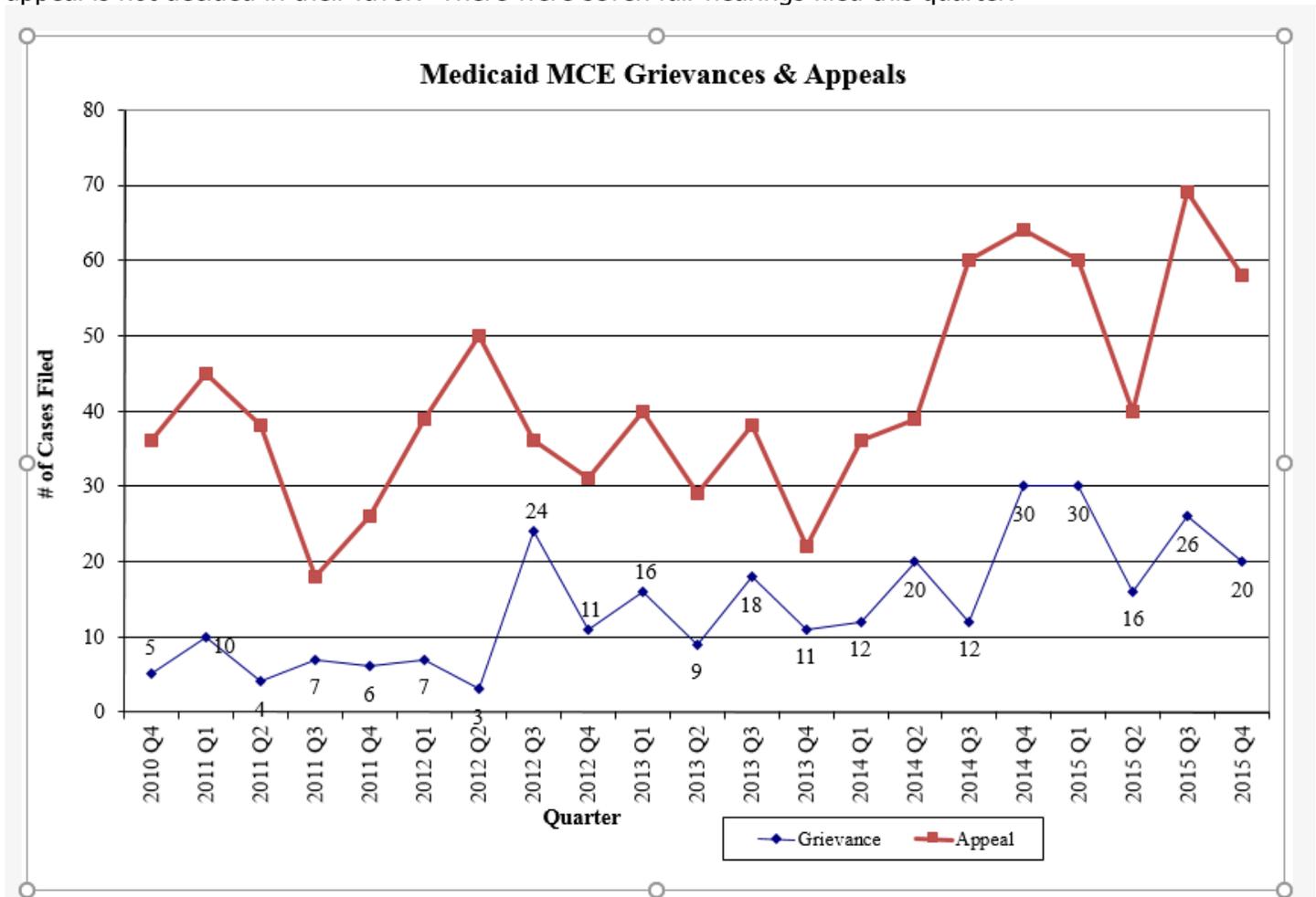
During this quarter, there were 58 appeals filed with the MCE; 43 requested an expedited decision with twenty-six of them meeting criteria. Of these 58 appeals, 42 were resolved (73% of filed appeals), 14 were still pending (24%), and 2 were withdrawn (3%). In sixteen cases (43% of those resolved), the original decision was upheld by the person hearing the appeal, and twenty cases (62% of those resolved) were reversed.

Of the 58 appeals that were resolved this quarter, 96% were resolved within the statutory time frame of 45 days, with one (4%) being extended by the beneficiary; 92% were resolved within 30 days. The average number of days it took to resolve these cases was 18 days. Acknowledgement letters of the receipt of an appeal must be sent within five days; the average was three days.

Of the 58 appeals filed, 36 were filed by beneficiaries (66%), 18 were filed by a representative of the beneficiary (31%) and 4 were filed by the provider (3%). Of the 58 appeals filed, DVHA had 95%, and DAIL had 5%.

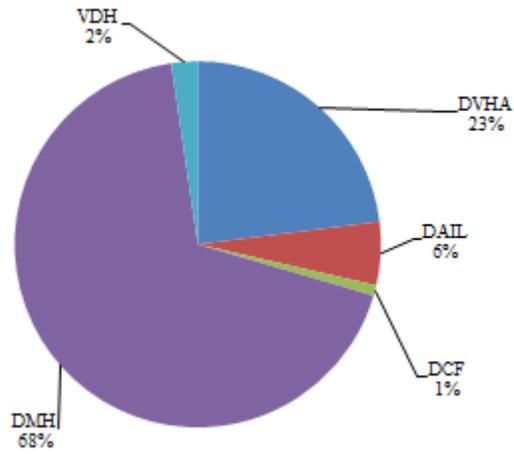
Due to the increase in appeals filed in the past year the compliance committee will review in order to determine the cause and if any remedial action is required.

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

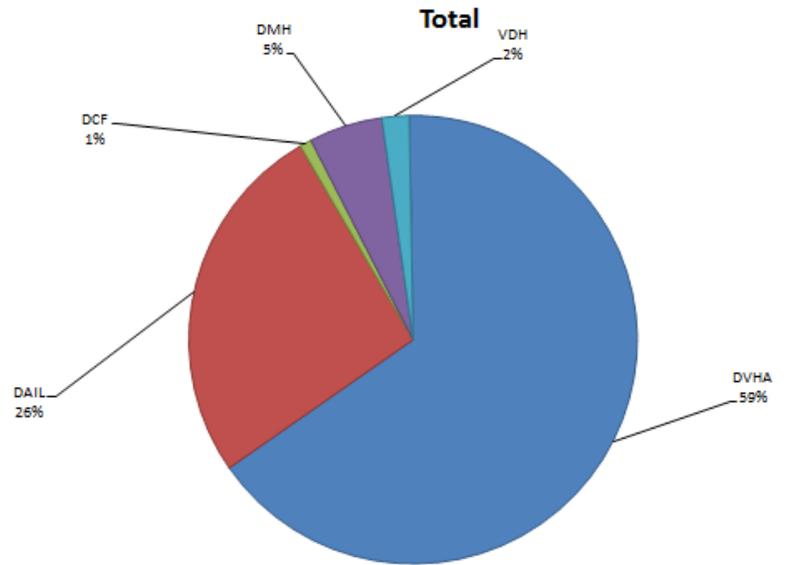


MCE Grievance & Appeals by Department From January 1, 2008 through October 31, 2015

Grievances



Appeals



VERMONT LEGAL AID, INC.

OFFICE OF THE HEALTH CARE ADVOCATE

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BURLINGTON, VERMONT 05402
(800) 917-7787 (VOICE AND TTY)
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(802) 863-2316

OFFICES:

BURLINGTON
RUTLAND
ST. JOHNSBURY

OFFICES:

MONTPELIER
SPRINGFIELD

QUARTERLY REPORT

October 1, 2015 – December 31, 2015

to the

Agency of Administration

submitted by

Trinka Kerr, Chief Health Care Advocate

January 18, 2016

NARRATIVE

I. Executive Summary

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 October 1, 2015 - December 31, 2015 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:** 1,033 calls (compared to 1,015 last quarter)
 - **Department of Vermont Health Access (DVHA) beneficiaries:** 286 calls or **28%** of total calls (compared to 289 and 28% last quarter)
 - **Commercial plan beneficiaries:** 282 calls or **27%** (276 and 27%)
 - **Uninsured Vermonters:** 145 calls or **14%** (153 and 15%)
 - **Vermont Health Connect (VHC):** 461 calls or **46%** (470 and 46%; the VHC data report draws from the All Calls data set)
 - **Two Reportable Activities (Summary & Detail):** 141 activities, 46 documents (119 and 36)

Highlights

- Total call volume was about the same as last quarter (1,033 versus 1,015), and slightly lower (16%) than the same quarter last year (1,224). In last year's fourth quarter we

The Office of the Health Care Advocate, previously named the Office of Health Care Ombudsman, is a special project of Vermont Legal Aid.

were inundated (207 calls) with calls about a VPharm notice. That did not happen this year.

- Calendar year 2015's volume was slightly lower than 2014's (2%), 42% higher than the busiest year prior to the launch of Vermont Health Connect, and more than double the volume of a decade ago.
- Vermont Health Connect (VHC) call volume has not significantly changed, despite functionality improvements. Volume was just slightly less than in the last quarter (461 compared to 470 last quarter), and just slightly less than in the same quarter in 2014 (469).
- Calls related to difficulty in making changes ("change of circumstance") through VHC decreased more than 26% over last quarter. However, after a significant drop in October, COC calls crept back up in November and December.
- Problems with Vermont Health Connect billing decreased 36%, but continued to be the top VHC problem, and the second most common complaint among all callers.
- The five most common reasons Vermonters called us were:
 - Complaints about providers
 - VHC invoice and billing problems
 - MAGI Medicaid eligibility inquiries or problems
 - Access to prescription drugs
 - VHC change of circumstance problems
- We saved Vermont consumers \$113,272 this quarter, and \$591,406 in calendar year 2015.
- The HCA represented the public before the Green Mountain Care Board in three rate reviews filed by MVP. In one, the HCA successfully argued that the rate increase of 26.9% should be denied.
- We participated in three Certificate of Need proceedings, and submitted formal questions or comments in two.
- The HCA tax attorney provided technical assistance for 68 tax questions related to the Affordable Care Act, and engaged in a significant number of additional outreach and education activities to address consumer confusion about ACA tax issues.
- In October the HCA began participating in the Accountable Care Organization (ACO) Payment Subcommittee convened by the Green Mountain Care Board to discuss and outline the governance structure, provider payment policies, and related parameters for an all-payer ACO model for Vermont. The group produced a document, *Vermont All-Payer Model Framework*, which outlines a vision for an all-payer model in Vermont from the perspective of the group's original members (GMCB staff, providers, ACOs, and commercial payers). The *Framework* document will be presented to the Board in the next quarter. The HCA had negligible input on this document, which does not include many of our priorities for such a model. Our position is outlined in our policy paper, [Consumer Principles for Vermont's All-Payer Model](#).

- The number of people who used our website to find information and guidance on health care issues continued a pattern of strong growth with 36% more pageviews this quarter, compared with the same period in 2014.
- The number of people seeking information about [dental services](#) continued to increase significantly (384%) over last year, as it has the past three quarters, and our Vermont Dental Clinics Chart was the 4th most frequently downloaded PDF from the entire Vermont Law Help website.
- We had seven articles/papers published and gave six presentations primarily to community partners, lawyers, and tax professionals who serve the public. Additionally, we worked to lower the reading grade level and improve the readability score of five State communications to consumers regarding VHC and other health-related issues.

II. Individual Consumer Assistance

The HCA provides assistance to consumers through our statewide helpline (**1-800-917-7787**) and through the Online Help Request feature on our website, www.vtlawhelp.org/health. 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 1,033 calls¹ 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:

- **22.75%** (235) about **Access to Care**;
- **14.33%** (133) about **Billing/Coverage**;
- **2.71%** (28) about **Buying Insurance**;
- **12.20%** (126) about **Consumer Education**;
- **25.56%** (264) about **Eligibility** for state and federal programs; and
- **23.91%** (247) 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 264 of our cases had eligibility for state health care programs as the primary issue, there were actually a total of 702 cases that had some eligibility issue. This is because it is possible to have multiple types of issues in a single case.

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

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

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

A. The HCA’s overall call volume was about the same as last quarter and 16% lower than the same quarter last year.

Total call volume was about the same as last quarter (1,033 versus 1,015), and slightly lower (16%) than the same quarter last year (1,224). In last year’s fourth quarter we were inundated with calls about a VPharm notice. (The VPharm notice generated 207 calls in December 2014!) That did not happen this year. October’s call volume was slightly lower than last October, November’s was 15% higher than last year, and December’s was significantly lower—37%--due to the lack of VPharm notice problems.

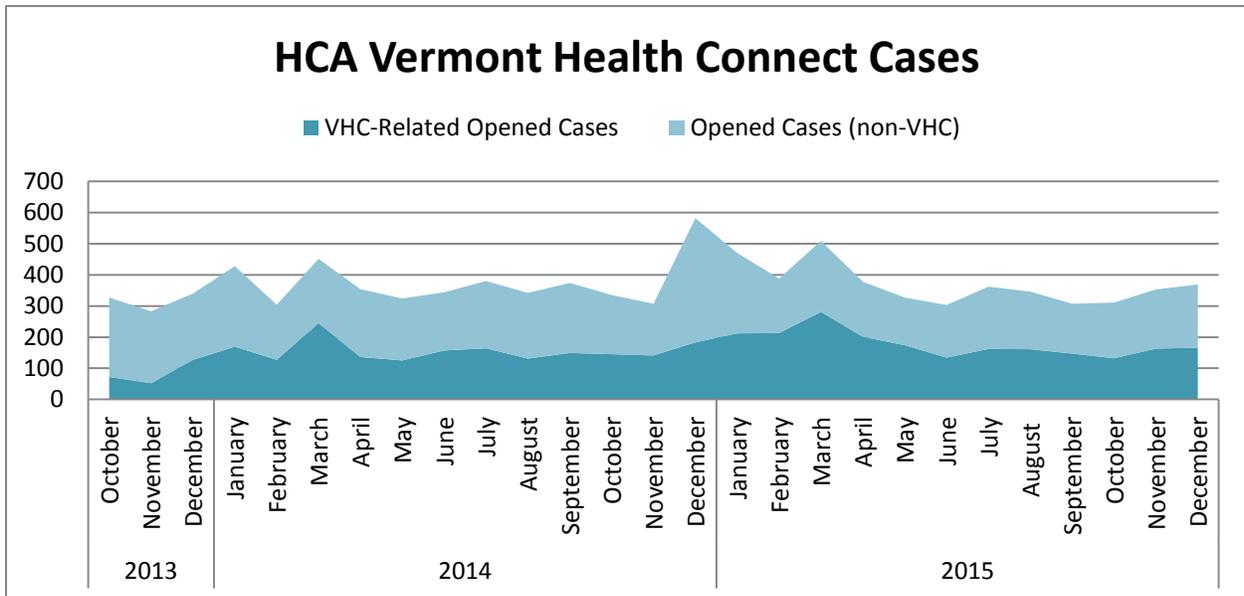
This calendar year’s volume was slightly lower than 2014’s (2%), but 42% higher than the busiest year prior to the launch of VHC and more than double the volume of a decade ago.

All Cases (2005-2015)											
	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
January	178	313	280	309	240	218	329	282	289	428	470
February	160	209	172	232	255	228	246	233	283	304	388
March	188	192	219	229	256	250	281	262	263	451	509
April	173	192	190	235	213	222	249	252	253	354	378
May	200	235	195	207	213	205	253	242	228	324	327
June	191	236	254	245	276	250	286	223	240	344	303
July	190	183	211	205	225	271	239	255	271	381	362
August	214	216	250	152	173	234	276	263	224	342	346
September	172	181	167	147	218	310	323	251	256	374	307
October	191	225	229	237	216	300	254	341	327	335	311
November	168	216	195	192	170	300	251	274	283	306	353
December	175	185	198	214	161	289	222	227	340	583	369
Total	2200	2583	2560	2604	2616	3077	3209	3105	3257	4526	4423

B. Vermont Health Connect call volume has not significantly changed despite some VHC improvements in functionality.

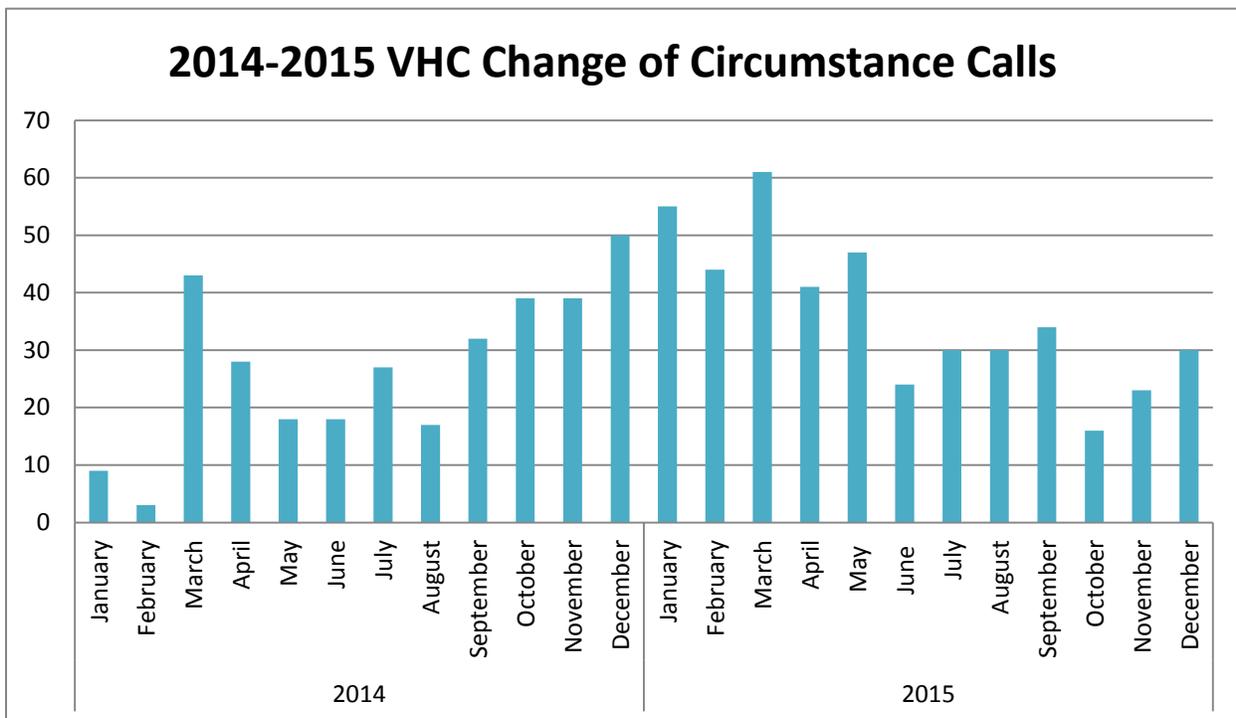
The HCA received 461 VHC calls this quarter, compared to 470 last quarter and compared to 469 and 444 for the same quarters in 2014. So, although VHC has made some functional improvements in the last six months, the volume of reported problems has not decreased.

The HCA works with VHC staff to resolve problems and escalate cases in which Vermonters need immediate access to care. We have weekly meetings with VHC staff to resolve more complex cases. When we first started these meetings last summer, our list of cases to be resolved was usually 40 to 50 each week. This quarter the complex cases dropped down to around 30 per week, but subsequently have gone back up into the 40-50 per week range.



C. Vermont Health Connect change of circumstance cases decreased in October then started creeping back up.

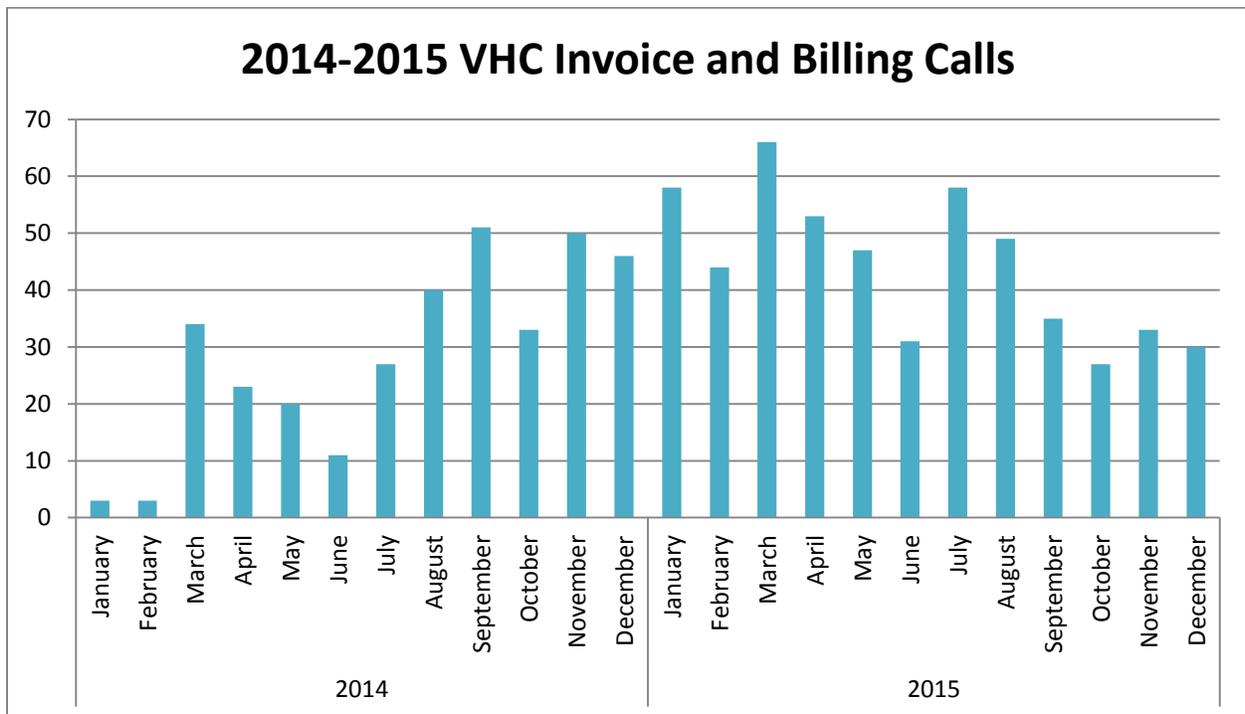
Since VHC’s May deployment of R1 in May, the number of COC’s has been declining: from 155 in the first quarter of CY 2015, to 109, then 94 last quarter, and finally to 69 in this quarter when primary and secondary issues are counted. COC calls this quarter decreased by more than 26% over last quarter. However, as can be seen in the chart below, after a drop in October, calls about COCs started going back up.



D. Problems with Vermont Health Connect billing decreased 36%, but continued to be the top VHC problem, and the second most common complaint among all callers.

Many consumers who purchased Qualified Health Plans (QHP) from VHC continued to have invoicing and billing problems. This is the number one complaint about VHC, and is the issue generating the second most calls overall. (The most common reason for calls to the HCA was complaints about providers.) The problems include: incorrect invoices; invoice amounts that are inconsistent across VHC, Benaissance and the carriers; delays in processing; delays in applying premiums to the correct account; delays in actually getting coverage; and lost payments. In some cases, the premium problems caused a consumer’s coverage to incorrectly be closed because they were not credited for payments they had actually made. Many were related to COC difficulties.

This quarter we received 90 calls involving invoices, billing and premium processing, compared to 141 last quarter, a 36% increase.



E. The top issues generating calls

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

All Calls 1,033 (compared to 1,015 last quarter)

1. Complaints about providers 93 (compared to 100 last quarter)
2. VHC Invoice/billing Problem 90 (141)
3. MAGI Medicaid eligibility 82 (60)
4. Access to Prescription Drugs 72 (82)
5. VHC Change of Circumstance 69 (94)
6. Termination of insurance 68 (57)
7. VHC Premium Tax Credit eligibility 67 (46)
8. VHC complaints 66 calls (119)
9. Information about VHC 62 (58)
10. Information about DVHA programs 40 (59)
11. Affordability issue that created an access problem 53 (59)
 - DVHA/VHC Premium billing 53 (39)
 - Consumer Education about Medicare 53 (40)
12. VHC Renewals 46 (20)
13. Disenrollment at consumer request 39 (24)
14. Buying QHPs through VHC 38 (13)
15. Consumer Education about Fair Hearings 36 (43)
16. Medicaid eligibility (non-MAGI) 34 (36)
17. Special Enrollment Periods (eligibility) 29 (35)
18. Grace Periods-VHC 28 (86)
 - IRS Penalty/ISRP 28 (10)
 - DCF/HAEU Mistake 28 (29)
19. Buy-in Programs/MSPs 27 (19)
20. Hospital billing 26 (26)
 - Communication problems: DCF/HAEU 26 (18)

Vermont Health Connect Calls 461 (compared to 470 last quarter)

1. VHC Invoice/Payment/Billing problem 89 (67)
2. MAGI Medicaid eligibility 73 (56)
3. Change of Circumstance 67 (92)
4. Premium Tax Credit Eligibility 65 (46)
5. VHC complaints 62 (118)
 - Termination 62 of insurance (50)
6. Information about VHC 60 (55)
7. DVHA/VHC Premium billing 52 (38)
8. VHC Renewals 46 (19)

9. Disenrollment at consumer request 38 (22)
10. Buying QHPs through VHC 35 (13)

DVHA Beneficiary Calls 286 (compared to 289 last quarter)

1. Complaints about Providers 39 (43)
2. Access to Prescription Drugs 27 (43)
3. MAGI Medicaid eligibility 26 (19)
4. Information about DVHA programs 24 (26)
5. Choosing/Changing Providers 18 (20)
6. Transportation 17 (18)
7. Medicaid (non-MAGI) 16 (12)
8. Balance billing-Medicaid 15 (13)
9. Durable Medical Equipment/Supplies 13 (9)
10. Consumer education about Fair Hearings 12 (9)

Commercial Plan Beneficiary Calls 282 (compared to 276 last quarter)

1. VHC invoice/payment problem 60 (84)
2. Change of Circumstance 45 (47)
3. DVHA/VHC premiums billing 39 (25)
4. VHC Renewals 37 (11)
VHC complaints 37 (66)
5. Premium Tax Credit eligibility 30 (23)
6. Information about VHC 28 (33)
7. Disenrollment at consumer request 24 (15)
8. Grace Periods-VHC 16 (44)
9. DCF/HAEU Mistake 15 (16)
10. MAGI Medicaid 15 (15)

F. Hotline call volume by type of insurance:

The HCA received 1,033 total calls this quarter. Callers had the following insurance status:

- **DVHA program beneficiaries** (Medicaid, VPharm, or both Medicaid and Medicare aka “dual eligibles”) insured **28%** (286 calls), compared to 28% (289) last quarter;
- **Medicare² beneficiaries** (Medicare only, Medicare Advantage Plans, Medicare and a Medicare Supplemental Plan aka Medigap, Medicare and Medicaid aka “dual eligibles,” Medicare and Medicare Savings Program aka Buy-In program, Medicare and Part D, or Medicare and VPharm) insured **20%** (211), compared to 16% (165) last quarter;

² Because Medicare beneficiaries can also have commercial or DVHA coverage, these Medicare numbers overlap with those figures.

- **Commercial plan beneficiaries** (employer sponsored insurance, small group plans, or individual plans) insured **27%** (282), compared to 27% (276) last quarter; and
- **Uninsured** callers made up **14%** (145) of the calls, compared to 15% (153) last quarter.
- In the remainder of calls insurance status was either unknown or not relevant.

G. Dispositions of closed cases

All Calls

We closed 945 cases this quarter, compared to 1,083 last quarter.

- 32% (304 cases) were resolved by brief analysis and advice;
- 28% (263) were resolved by brief analysis and referral;
- 22% (208) of the cases were complex interventions involving complex analysis, usually direct intervention, and more than two hours of an advocate's time;
- 11% (103) were resolved by direct intervention, including calling an insurance company, calling providers, writing letters, gathering supporting medical documentation, etc.;
- 1 case was resolved in the initial call.
- In the remaining cases, clients withdrew, resolved the issue on their own, or had some other outcome.
- Appeals: The HCA assisted 34 individuals with appeals: 3 commercial plan appeals, 19 Fair Hearings, 6 VHC expedited internal hearings, 3 DVHA internal MCO appeals and 3 Medicare appeals. Most of our cases involving VHC and DVHA problems are resolved without using the formal appeals process.

DVHA Beneficiary Calls

We closed 266 DVHA cases this quarter, compared to 309 last quarter.

- 38% (102 cases) were resolved by brief analysis and advice;
- 30% (81) were resolved by brief analysis and referral;
- 13% (35) were considered complex intervention, which involves complex analysis, usually direct intervention, and more than two hours of an advocate's time;
- 14% (36) were resolved by direct intervention on the caller's behalf, including advocacy with DVHA and providers, writing letters, and gathering medical information;
- 1 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.
- Appeals: 9 cases involved appeals on behalf of individuals who were on a DVHA program when they called us: 5 Fair Hearings, 3 internal MCO appeals, and 1 Medicare Part D appeal.

Commercial Plan Beneficiary Calls

We closed 245 cases involving individuals on commercial plans, compared to 293 last quarter.

- 29% (73 cases) were resolved by brief analysis and advice;
- 16% (38) were resolved by brief analysis and referral;
- 36% (88) were considered complex intervention, which involves complex analysis, usually direct intervention, and more than two hours of an advocate's time;
- 15% (36) were resolved by direct intervention on the caller's behalf, including advocacy with the carrier and providers, writing letters, and gathering medical information;
- No calls from a commercial plan beneficiary were resolved in the initial call.
- In the remaining cases clients withdrew, resolved the issue on their own, or had some other outcome.
- Appeals: 23 cases involved appeals for individuals on commercial plan: two Level 1 internal appeals, one Level 2 internal appeal, 14 Fair Hearings, and 6 Expedited Fair Hearings.

H. Case outcomes

All Calls

The HCA helped 87 people get enrolled in insurance plans and prevented 4 insurance terminations or reductions. We obtained coverage for services for 22 people. We got 17 claims paid, written off or reimbursed. We helped 1 person complete an application and estimated VHC insurance program eligibility for 13 more. We provided other billing assistance to 38 individuals. We provided 523 individuals with advice and education. We obtained other access or eligibility outcomes for 75 more people, many of whom we expected to be approved for medical services and state insurance.

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

In total, this quarter the **HCA saved individual consumers \$113,272.24** in cases opened this quarter. We saved Vermonters **\$591,406.66** in calendar year 2015.

I. Case Examples

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

1. An incorrect income change by VHC made premiums unaffordable. Mr. A called the HCA because he received a Qualified Health Plan (QHP) invoice from VHC that was close to his entire monthly income. He did not understand why his premium had increased so drastically. The HCA advocate investigated and found that VHC had the wrong income

listed for Mr. A. Earlier in the year, Mr. A had applied for a promotion at work, and called VHC to see how the possible increase in income would affect his insurance. VHC misunderstood his inquiry and recorded a change in his income. Mr. A did not get the promotion, his income did not increase, and he should not have lost his Advance Premium Tax Credit. While working through this case, the HCA advocate realized that not only should Mr. A not have had his premium increased but he was now in fact eligible for Medicaid due to a citizenship status change. This meant he did not owe any premiums at all, and VHC moved him from the QHP to Medicaid.

2. Despite payments to VHC, consumer had no coverage. When Ms. B went for her annual flu shot she discovered that she had no health insurance. When she called VHC about her QHP she learned that she had not had any coverage for most of the year. Ms. B was mystified. She had paid her premiums and been going to medical appointments on a regular basis. Now she needed multiple prescriptions and could not afford them, so she called the HCA. The HCA contacted VHC and found that Ms. B's coverage had closed after just one month of coverage in 2015. She had not received grace period notices warning her that her coverage was closing or any termination notice. The HCA advocate requested that Ms. B's coverage be reinstated for the whole year. VHC agreed that her coverage should not have been closed and reinstated her so she was able to get her medications.
3. Incorrect QHP start date created a gap in coverage. Mr. C's COBRA coverage expired, giving him a Special Enrollment Period to purchase a QHP through VHC outside the Open Enrollment Period. He carefully applied and enrolled in his selected QHP before the 15th of the month so his new coverage would start on the first day of the next month. He did not want any break in coverage because he was scheduled to have surgery. VHC, however, mistakenly gave him the wrong start date creating a one month gap in coverage. The HCA advocate asked VHC to escalate the case and correct the start date, which it did. The advocate also contacted the carrier to ensure that Mr. C's pharmacy coverage was in place prior to his surgery. Mr. C was able to have his surgery as scheduled, and get his post-surgery prescriptions in a timely manner.
4. Medicare enrollment triggered the loss of Medicaid. Mr. D received a notice that his Medicaid through VHC was closing. He did not understand why, as his income had not changed. The HCA advocate learned that Mr. D had recently become eligible for Medicare. She explained that because Mr. D was now on Medicare, he was no longer eligible for Medicaid for Children and Adults (MCA). He was also not eligible for the type of Medicaid that works with Medicare, Medicaid for the Aged Blind and Disabled (MABD), because his income exceeded its income limit, which is lower than the MCA limit. The advocate found, however, eligible for two other programs that could help him defray his health care costs: VPharm, to help pay for prescriptions, and a Medicare Savings Program (MSP), which could pay his Medicare Part B premium. He helped Mr. D

apply for these programs. He also got the MSP granted retroactively because Mr. D should have been screened for it when his MCA was terminated.

5. Two mistakes by a commercial drug plan delayed payment for an expensive medication. Mr. E called the HCA because he could not get his insurer to cover his medication due to a mistake. Mr. E had a commercial plan through COBRA. Under this plan, he was responsible for 20% of the cost of prescriptions. When he went to pick up his prescription, he was charged over \$800--the entire cost of the prescription. The pharmacist said his plan was not picking up its portion of the cost because he had secondary coverage. He did not have secondary coverage. He only had COBRA. The HCA advocate called the drug plan with Mr. E, and explained the situation to a supervisor. The supervisor agreed that an error had been made, and advised that Mr. E would receive a written decision about coverage in 7-10 days. When Mr. E received the decision, however, it was a denial. This time the drug plan denied coverage because it said Mr. E was not an eligible member on the date of service-- another mistake. The HCA advocate helped Mr. E file an appeal. Eventually the drug plan corrected its mistake and reimbursed Mr. E for the 80% it should have covered.

III. Consumer Protection Activities

A. Rate Reviews

The HCA monitors all insurance carrier requests to the Green Mountain Care Board for changes in premium rates, which are usually rate increases. Three rate review cases were pending at the beginning of the quarter. The HCA entered Notices of Appearance and submitted memoranda in all three. There were no new filings in the quarter.

In the first case the carrier sought approval of the manual rates, experience rating formula, and factors used to develop group-specific premium rates to be used in MVP Health Insurance Company's (MVP) Large Group AR42 product portfolio in the first and second quarters of 2016. The actuarial analysis by the Board's actuary recommended a small adjustment in the carrier's pharmacy trend to conform to the corresponding trend in MVP's 2016 Vermont Health Connect (VHC) rate filing. The HCA requested that the Board adopt this actuarial recommendation and also reduce the requested 2% contribution to surplus. The Board initially issued a decision modifying the requested rate with the pharmacy reduction and a 0% contribution to surplus (corresponding to the request in the VHC filing). However, after a Motion to Reconsider from MVP, the Board amended the decision to allow a 2% contribution to surplus.

MVP also filed a request for rate increases for small group plans grandfathered under the Affordable Care Act and renewing in the first quarter of 2016 (2.7% increase) and the second quarter of 2016 (2.3% increase). These rates affect approximately 281 policyholders and 2,107 covered lives, and membership in this closed block of business is declining. The issues in this filing were similar to those in the Large Group filing and again the Board modified the pharmacy

trend. It initially reduced the contribution to surplus to 0% but on reconsideration allowed the requested 2% contribution to surplus.

The third filing was a rate request for five plans offered by the Agriservices Association, an association for farmers. Agriservices uses MVP's large group Minimum Premium Plan (MPP) funding arrangement for these grandfathered plans with a contract renewing with a December 1, 2015 effective date. MVP had told the Board in its prior filing that Agriservices intended to discontinue the plans after November 2015, but another request for premium increases was filed in September 2015. The average annual increase requested was 26.9%. The HCA asked the Board to disapprove the rate request given the size of the requested increase and the history of the 2014 filing. The Board's Decision disapproved the requested rate increase and "encourage[d] the carrier to evaluate the plan's continued viability and affordability prior to any future request for additional rate increases."

B. Certificate of Need Applications

The HCA monitors all CON proceedings before the Board. This quarter we focused primarily on the University of Vermont Medical Center's Inpatient Bed proposal, Northwestern Medical Center's plans for expanded private beds and for a medical office project, and Copley Hospital's application for Surgical Suite Construction.

- UVM Medical Center's Inpatient Bed project: The HCA submitted formal questions to the applicant regarding its alternative financing plans and participated in the hospital's meeting with the Board reviewing the plans.
- Northwestern Medical Center's Private Room Expansion and medical office project: The HCA reviewed all materials and attended the Board's hearing on Northwestern's two active CONs.
- Copley Surgical Suite Construction: The HCA submitted comments to the Board describing our concerns about the hospital's financial reliance on its specialized orthopedic practice, financial projections, and allocation of resources to address identified community needs.

C. Hospital Budgets

Last summer, the HCA assessed all Vermont hospitals' financial assistance policies. In this quarter, we submitted a formal request asking the Board to include in its upcoming hospital budget guidance a requirement for hospitals to show how they will comply with new federal rules on hospital financial assistance policies. We expect the Board to develop its upcoming hospital budget guidance in the next quarter.

D. Other Green Mountain Care Board Activities

In the last quarter, we submitted formal comments to the Board outlining consumer principles for the all-payer model being considered by the Board and the administration which we based on our policy paper, [Consumer Principles for Vermont's All-Payer Model](#).

In addition, we attended the following Board events:

- Weekly GMCB meetings (9)
- Monthly Data Governance Meetings (2)
- Additional meetings with Staff (2) – one general meetings and one specifically focusing on the topic of the Board's work towards an all-payer model
- GMCB Advisory Committee (1)

E. Vermont Health Care Innovation Project

The HCA continues to participate in the Vermont Health Care Innovation Project (VHCIP), which is funded by a federal State Innovation Model (SIM) grant. This quarter the VHCIP changed its structure by eliminating some work groups, changing the names and scopes of work for others, and adjusting the meeting schedule for others to a quarterly basis.

This quarter we:

- Participated in 2 meetings as a member of the VHCIP Steering Committee
- Participated, along with representatives from other projects of Vermont Legal Aid, as “active members” in 5 of the 6 VHCIP work groups:
 - Payment Model Design and Implementation Work Group
 - Practice Transformation Work Group
 - Health Data Infrastructure Work Group
 - Disability and Long Term Services and Supports Work Group
 - Population Health Work Group
- Attended 9 VHCIP work group meetings
- Attended 2 meetings of the VHCIP Core Team as an interested party
- Attended 1 meeting of the SIM Self-Evaluation Committee
- Submitted formal comments to the Health Data Infrastructure Work Group
- Submitted formal comments to DVHA as part of the Payment Model Design and Implementation Work Group's review of the proposed Episodes of Care payment model
- Met with work group staff about Learning Collaboratives and Shared Care Plan release forms
- Reviewed and commented on 2 draft Shared Care Plan release forms

F. Affordable Care Act Tax-related Activities

During this quarter, the HCA continued its tax-related advocacy and outreach efforts to ensure that consumers maintain access to affordable health care. Consumers who lack an understanding of how the tax system interacts with the health insurance system, or who have difficulty navigating the tax filing process, are in danger of losing access to subsidized health insurance. This quarter we closely monitored the QHP renewal process to ensure that notices were clear and consumers did not lose tax subsidies through no fault of their own. VHC continues to process 2016 renewals as of the date of this report. HCA is monitoring this issue closely.

In this quarter we continued to assist consumers with problems related to 2014 forms 1095-A from VHC. We also continued to work on 2015 account problems that, if not fixed, will affect those consumers' tax returns in 2016. For example, we advocated with VHC to correct errors in its Modified Adjusted Gross Income calculations. The HCA helped many consumers get account changes made and, where appropriate, get amended tax forms from VHC.

During this quarter, the HCA continued to employ a half-time tax attorney, who also staffs the Low Income Taxpayer Project at VLA. This allowed the HCA to stay up to date on tax law developments and support our staff to effectively field calls related to the ACA and VHC. The tax attorney consulted with HCA advocates when particularly difficult IRS-related issues arose in individual HCA cases. Technical assistance on tax issues remains an important part of the HCA's work in this area. During this quarter the tax attorney advised the HCA on 24 technical assistance questions. She also responded to 42 technical assistance questions from assisters, VHC personnel, tax preparers, the IRS Taxpayer Advocate Service, and legal services attorneys in other states.

HCA continued to communicate with VHC regarding tax issues as they arose. One issue we discussed this quarter was whether VHC could include the benchmark plan information on Form 1095-A for consumers who did not get subsidies. While the IRS regulations permit VHC to omit this information from the form, the IRS computer system is programmed to stop these tax returns and require verification if the consumer claims a Premium Tax Credit. Many tax refunds were held up because of this issue, and those consumers had to fight through a frustrating IRS process to receive their refunds.

To address consumers' confusion and misunderstanding of the tax implications of the Affordable Care Act, the HCA engaged in a significant number of outreach and education activities. They are detailed below in the Outreach and Education section.

G. Other Activities

Rule 09-03 Work Group

This quarter the HCA continued to be actively involved in this work group which was set up in Act 54 of the 2015 legislative session. The work group's purpose is to help the Agency of

Administration, the Green Mountain Care Board and the Department of Financial Regulation evaluate the necessity of maintaining provisions for regulating insurers in Rule 09-03, which contains consumer protection and quality requirements for managed care organizations, and other regulations governing quality and consumer protection. The group is also assessing which state entity is the appropriate one to be responsible for functions set forth in the regulations. The group met five times during the quarter.

2017 Qualified Health Plan 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 Qualified Health Plans offered on Vermont Health Connect in 2017. The group met once during the quarter.

Legislative Activities

This quarter the HCA monitored the activities of the few legislative committees that took up issues related to health care and health reform while the legislature was not in session.

This quarter, we:

- Attended 1 meeting of the Health Reform Oversight Committee
- Attended 1 meeting of the House Appropriations Committee
- Attended 1 meeting of the Joint Fiscal Committee
- Attended 2 meetings of the Senate Judiciary Committee
- Attended 2 meetings of the House Health Care Committee
- Submitted formal comments to the Senate Judiciary Committee on the Health Care Privacy section of S.18
- Testified before the House Health Care Committee 2 times
- Met and collaborated with other advocates on legislative initiatives

Administrative Advocacy

This quarter, the HCA:

- Submitted formal comments on VHC notices, including renewal forms and tax form cover letters.
- Submitted proposed language for a draft DVHA rule on direct enrollments and QHP certification.
- Submitted formal comments to HHS on a proposed rule implementing the ACA's anti-discrimination provisions.
- Submitted concerns and suggestions to the National Taxpayer Advocate's senior attorney advisor for ACA issues.
- Submitted concerns and suggestions to the Department of the Treasury's legislative policy office for health care.
- Met with representatives from the IRS ACA Office and the Center on Budget and Policy Priorities to discuss issues of concern for the 2016 tax filing season. The HCA suggested

improvements that could be made to Form 1095-B to assist consumers and tax preparers in filing accurate tax returns.

- Advocated with AHS and the IRS Stakeholder Liaison to add benchmark plan information to Forms 1095-A for consumers with unsubsidized plans. Currently those consumers are unable to claim a Premium Tax Credit without undergoing additional review and verification by the IRS, which can be time-consuming.
- Participated in 2 meetings about VHC fair hearings
- Corresponded with the Human Services Board (HSB) about its VHC appeal form
- Corresponded with DVHA about VPharm annual notices
- Participated in 4 meetings about VHC notices
- Participated in 5 meetings about the VHC case escalation path
- Participated in 1 meeting about VHC and Medicare
- Participated in 1 meeting about VHC regulations
- Submitted formal comments on VHC regulations
- Submitted four complaints and suggestions to VHC
- Submitted a letter to DVHA requesting changes to its Hepatitis C treatment criteria
- Submitted comments to AHS on the Secretary of Administration's budget presentation
- Submitted comments to the Agency of Administration on the draft Universal Primary Care Study
- Submitted comments on Vermont's Global Commitment Comprehensive Quality Strategy to CMS and HHS

Other Boards, Task Forces, and Work Groups

In February 2015 the staff of the Green Mountain Care Board convened the ACO Payment Subcommittee to discuss and outline the governance structure, provider payment policies, and related parameters for an all-payer Accountable Care Organization model for Vermont. The HCA staff became aware of these meetings in August, asked to participate, and were told we could not. In September we made another request to participate to the GMCB Chair and in mid-October we were invited to participate. HCA staff attended the final nine meetings of the work group from mid-October through December. The group produced a document, *Vermont All-Payer Model Framework*, which outlines a vision for an all-payer model in Vermont from the perspective of the group's original members (GMCB staff, providers, ACOs, and commercial payers). The *Framework* document will be presented to the Board in the next quarter. The HCA had negligible input on this document, which does not include many of our priorities for such a model. Our position is outlined in our policy paper, [Consumer Principles for Vermont's All-Payer Model](#). In addition, we participated in the following sub groups of the ACO Payment Subcommittee: ACO Rostering Subgroup (3 meetings); and All-Payer Model Quality Measurement Subgroup (3 meetings).

Additionally, this quarter the HCA participated in:

- 5 Rule 09-03 Review Work Group meetings
- 1 Qualified Health Plan Stakeholder Work Group meeting

- 2 Medicaid and Exchange Advisory Board (MEAB) meetings
- 1 MEAB Improving Access Work Group meeting (a subgroup of the MEAB which works on improving access to Medicaid services, which the Chief Health Care Advocate Chairs)
- 1 VHC Consumer Experience Work Group meeting
- 2 meetings of the Oral Health Care for All Coalition
- 1 UVM Medical Center Mental Health Program Quality Committee meeting
- 2 42 CFR Part 2 Advisory Group meetings

Collaboration with other organizations

The HCA worked with the following organizations this quarter:

- Alliance for a Just Society
- American Bar Association Tax Section Pro Bono and Tax Clinics Committee
- American Civil Liberties Union
- Community of Vermont Elders
- Connecticut Health Policy Project
- Department of Vermont Health Access
- Disability Rights Vermont
- Families USA
- Health*first*
- IRS Taxpayer Advocate Service
- National Health Law Program
- New Haven Legal Assistance Association
- Procedurally Taxing
- Vermont Association of Hospitals and Health Systems
- Vermont Council of Developmental and Mental Health Services
- Vermont Information Technology Leaders
- Vermont Medical Society
- Vermont Oral Health Care for All Coalition
- Vermont Low Income Advocacy Council
- Vermont Public Interest Research Group
- Villanova University Tax Clinic
- Voices for Vermont's Children

Trainings

The HCA participated in the following trainings:

- 10/1: VITL Summit
- 10/16: Consumers Union – Health Care Price Transparency: Who's Looking? Webinar
- 10/26: CBPP Webinar – Basic VITA Certification Topics: Minimum Essential Coverage, Exemptions & the Shared Responsibility Payment
- 10/29: CBPP Webinar – ACA Exemptions and Penalties
- 11/2: CBPP Webinar – Advanced VITA Certification Topic: Premium Tax Credits and Reconciliation

- 11/17: The Vermont Community Foundation – 2015 Grantseeker Webinar
- 11/23: CBPP Webinar: Comprehensive ACA Examples and Wrap Up

IV. Outreach and education

A. Website

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

- The total number of health pageviews increased by 36% in the reporting quarter ending December 31, 2015 (6,207 pageviews), compared with the same quarter in 2014 (4,570 pageviews).
- The number of people seeking information about [dental services](#) continued to increase significantly (384%) over the same quarter last year, as it has the past three quarters. (276 pageviews this quarter, compared with 57 in the same period last year)
- This quarter, again like the previous two quarters, showed a large increase over last year in the number of people seeking information about [Medicaid income limits](#) (1,732 pageviews this quarter, compared with 768 in the same quarter in 2014, an increase of 126%). The consistently high numbers indicate that search engines are delivering this page as a high-ranking source of information about Medicaid income limits.
- The [health home page](#) again had the second largest number of pageviews (843), an increase of 32% over last year's 640. 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 total pageviews focused on Medicaid or long-term care Medicaid (Choices for Care). These topics accounted for 44% of all health page views.
- Other popular topics included:
 - [Health Insurance, Taxes and You](#) (New this year/no comparative data)
 - [Medical Decisions, Advance Directives and Living Wills](#) (+33%)
 - [Federally Qualified Health Centers \(FQHCs\)](#) (+533%)
- The number of people searching for information about things to consider before making [Complaints](#) against a provider) increased by 61%, while the number of people seeking help with [Buying Prescription Drugs](#) fell 22%.

PDF Downloads

Forty out of 78 or 51% of the unique PDFs downloaded from the Vermont Law Help website were on health care topics. Of those health-related PDFs:

- 21 were created for consumers. The top consumer-focused downloads were the same as last quarter:
 - Advance directive, short and long forms
 - Vermont dental clinics chart
 - Blue Cross Blue Shield of VT Annual Report 2014
 - Vermont Medicaid Coverage Exception Request – 10 Standards and Provider Request Form
- 11 were prepared for lawyers, advocates and assisters who help consumers with health care matters, including tax issues related to the Affordable Care Act. The top advocate-focused downloads were:
 - Low-Income Taxpayers and the Affordable Care Act
 - IRS Late-Payment Penalty Waiver Request Form and Instructions
- 8 covered topics related to health policy. The top policy-focused downloads were:
 - Consumer Principles for Vermont’s All-Payer Model
 - Vermont ACO Shared Savings Program Quality Measures

Our [Vermont Dental Clinics Chart](#) was the fourth 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.

Papers, Articles

We published a white paper, [Consumer Principles for Vermont’s All-Payer Model](#), in November. The paper looks at the all-payer model through a consumer lens and highlights seven key principles for the model based on current information. The principles, along with a link to the paper, were also published in the December 3, 2015 issue of Community Catalyst’s biweekly newsletter, The Dual Agenda.

We wrote two articles for the Fall 2015 issue of Vermont Legal Aid’s newsletter, *Justice Quarterly*. One article provided an overview of Vermont Health Connect open enrollment for people who are enrolling for the first time, those who have a VHC plan but want to change to a different one, and for those who simply want to renew the plan they have. The article also reminds readers to refer people who have a problem with a VHC plan to call the HCA. The other

article provided a link to proposed regulations banning discrimination in health care and information on how to comment.

Our tax attorney wrote a review of the first tax year of the Affordable Care Act as well as a look toward what lies in the future as guest blogger for Procedurally Taxing, a popular national blog. The thorough analysis was published in three parts in mid-December and was also referenced in a consulting firm blog's tax roundup.

Another article by our tax attorney, ACA Update: New Challenges for 2016, was published in the December issue of Tax Newsletter, sponsored by the Pro Bono and Tax Clinics Committee of the American Bar Association Tax Section. In addition to the subscribers to the Tax Newsletter, the article was distributed to the National Health Law Program's advocate listserv and to the Vermont Tax Practitioners Association.

Promoting Plain Language in Health Communications

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

- Suggested revisions to the APTC re-calculation explanation to be added to the Advance Premium Tax Credit page on the VHC portal. In addition, we provided suggested revisions to the APTC page.
- Provided extensive comments and revisions to Shared Care Release forms
- Provided general feedback, identified possible inaccurate results and offered suggested text revisions to VHC's plan comparison/OOP calculator tool created by Consumer Checkbook in collaboration with VHC
- Suggested extensive revisions to the MCA Legacy renewal notice
- Suggested revisions to the format and language of the Reasons for Appeal form used by the Human Services Board to help triage VHC cases.

Presentations

During this quarter, the HCA provided education directly to several hundred individuals, many of whom serve populations that will likely benefit from the information and education provided.

Vermont Tax Practitioners Association Meeting (October 20)

The HCA's tax attorney collaborated with the Department of Vermont Health Access's health attorney to present a 2016 ACA Update for CPAs, enrolled agents and unenrolled tax preparers. The presentation covered new issues and developments (2016 VHC open enrollment, Medicaid reviews, Form 1095 procedures for 2016), the small business health care tax credit, IRS

assessment and collection procedure updates, and premium tax credit examples. Following the webinar, the presentation was distributed to the VTPA listserv, making the extensive information available to more than 100 Vermont tax practitioners.

Guen Gifford Advocate Training (October 30)

The HCA presented Open Enrollment and Renewal on Vermont Health Connect, which covered Vermont's health programs, VHC open enrollment, renewal and advance premium tax credits, steps to take before renewing a qualified health plan, VHC payment issues and grace periods and Medicaid renewals.

2015 UVM Income Tax School (November 10-11, November 17-18)

Our tax attorney taught the Affordable Care Act workshop at both the Essex and Killington sessions of the UVM Tax School. The tax school was presented by UVM Extension in cooperation with the IRS, Vermont Department of Taxes, and Vermont Tax Practitioners Association to provide up-to-date information and continuing education credits to Vermont tax professionals.

National Health Law Program (NHeLP) Conference (December 6)

The HCA's tax attorney teamed with an NHeLP staff attorney to present Getting MAGI Right to approximately 75 advocates at the annual NHeLP conference in Washington DC. The presentation covered MAGI FAQs (household rules, what income counts), reconciliation and IRS forms (premium tax credits (PTC), exemptions, penalties), PTC complications (shifting enrollees, allocation, alternative marriage calculation), and IRS collections and due process. The HCA attorney created a handout using case studies to demonstrate the impact of filing status on aspects of the Affordable Care Act.

Annual Low-Income Taxpayer Clinic Grantee Conference (December 8)

The HCA's tax attorney was featured on a panel discussion titled, The Affordable Care Act: Big Issues in the 2015 Filing Season, What Taxpayers Can Expect in 2016 and Advocacy Tips. The panel covered issues including the premium tax credit, individual shared responsibility payment, changing circumstances, filing requirements and forms.

MCO Investment Expenditures

Department	Criteria	Investment Description	SFY11 Actuals	SFY12 Actuals	SFY13 Actuals	SFY14 Actuals	SFY15 Actuals	Investment Criteria #	Rationale
DOE	2	School Health Services	\$ 4,478,124	\$ 11,027,579	\$ 9,741,252	\$ 10,454,116	\$ 10,029,809		
AOA	4	Blueprint Director	\$ -	\$ -	\$ -	\$ -	\$ -	1	Reduce the rate of uninsured and/or underinsured in Vermont
AOA			\$ -	\$ -	\$ -	\$ -	\$ 639,239		
GMCB	4	Green Mountain Care Board	\$ -	\$ 789,437	\$ 1,450,717	\$ 2,360,462	\$ 2,517,516	2	Increase the access of quality health care to uninsured, underinsured, and Medicaid beneficiaries
DHR	2	Health Care Administration	\$ 1,898,342	\$ 1,897,997	\$ -	\$ -	\$ -		
DVI	4	Vermont Information Technology Leaders	\$ -	\$ -	\$ -	\$ -	\$ -	3	Provide public health approaches and other innovative programs to improve the health outcomes, health status and quality of life for uninsured, underinsured, and Medicaid-eligible individuals in Vermont
VVH	2	Vermont Veterans Home	\$ 1,410,956	\$ 1,410,956	\$ 1,410,956	\$ 410,986	\$ 410,986		
VSC	2	Health Professional Training	\$ 405,407	\$ 405,407	\$ 405,407	\$ 405,407	\$ 409,461	4	Encourage the formation and maintenance of public-private partnerships in health care, including initiatives to support and improve the health care delivery system.
UVM	2	Vermont Physician Training	\$ 4,006,156	\$ 4,006,156	\$ 4,006,156	\$ 4,006,156	\$ 4,046,217		
VAAF	3	Agriculture Public Health Initiatives	\$ -	\$ 90,278	\$ 90,278	\$ 90,278	\$ 90,278		
AHSCO	2	Designated Agency Underinsured Services	\$ 2,510,099	\$ 5,401,947	\$ 6,232,517	\$ 7,184,084	\$ 6,894,205		
AHSCO	4	2-1-1 Grant	\$ 415,000	\$ 415,000	\$ 415,000	\$ 499,792	\$ 499,667		
VDH	2	Emergency Medical Services	\$ 333,488	\$ 274,417	\$ 378,168	\$ 498,338	\$ 480,027		
VDH	2	AIDS Services/HIV Case Management	\$ -	\$ -	\$ -	\$ -	\$ -		
VDH	2	TB Medical Services	\$ 36,284	\$ 39,173	\$ 34,046	\$ 59,872	\$ 28,571		
VDH	3	Epidemiology	\$ 315,135	\$ 329,380	\$ 766,053	\$ 623,363	\$ 872,449		
VDH	3	Health Research and Statistics	\$ 289,420	\$ 439,742	\$ 497,700	\$ 576,920	\$ 715,513		
VDH	2	Health Laboratory	\$ 1,912,034	\$ 1,293,671	\$ 2,885,451	\$ 2,494,516	\$ 3,405,659		
VDH	4	Tobacco Cessation: Community Coalitions	\$ 94,089	\$ 371,646	\$ 498,275	\$ 632,848	\$ 702,544		
VDH	3	Statewide Tobacco Cessation	\$ 507,543	\$ 450,804	\$ 487,214	\$ 1,073,244	\$ 1,148,535		
VDH	2	Family Planning	\$ 275,803	\$ 420,823	\$ 1,574,550	\$ 1,556,025	\$ 1,390,410		
VDH	4	Physician/Dentist Loan Repayment Program	\$ 900,000	\$ 970,000	\$ 970,105	\$ 1,040,000	\$ 900,000		
VDH	2	Renal Disease	\$ 13,689	\$ 1,752	\$ 28,500	\$ 3,375	\$ 10,125		
VDH	2	Newborn Screening	\$ -	\$ -	\$ -	\$ -	\$ -		
VDH	2	WIC Coverage	\$ 36,959	\$ -	\$ 77,743	\$ 317,775	\$ 1,824,848		
VDH	4	Vermont Blueprint for Health	\$ 752,375	\$ 454,813	\$ 875,851	\$ 713,216	\$ 703,123		
VDH	4	Area Health Education Centers (AHEC)	\$ 500,000	\$ 540,094	\$ 496,176	\$ 547,500	\$ 543,995		
VDH	4	Community Clinics	\$ 640,000	\$ 600,000	\$ 640,000	\$ 688,000	\$ -		
VDH	4	FOHC Lookalike	\$ 87,900	\$ 102,545	\$ 382,800	\$ 160,200	\$ 97,000		
VDH	4	Patient Safety - Adverse Events	\$ 16,829	\$ 25,081	\$ 42,169	\$ 38,731	\$ 34,988		
VDH	4	Coalition of Health Activity Movement Prevention Program (CHAMPPS)	\$ 290,661	\$ 318,806	\$ 345,930	\$ 326,184	\$ 396,229		
VDH	2	Substance Abuse Treatment	\$ 1,693,198	\$ 2,928,773	\$ 2,435,796	\$ 2,363,671	\$ 2,913,591		
VDH	4	Recovery Centers	\$ 648,350	\$ 771,100	\$ 864,526	\$ 1,009,176	\$ 1,299,604		
VDH	2	Immunization	\$ -	\$ 23,903	\$ 457,757	\$ 165,770	\$ 253,245		
VDH	2	DMH Investment Cost in CAP	\$ 752	\$ 140	\$ -	\$ -	\$ -		
VDH	4	Poison Control	\$ 115,710	\$ 213,150	\$ 152,250	\$ 152,433	\$ 105,586		
VDH	4	Challenges for Change: VDH	\$ -	\$ 309,645	\$ 353,625	\$ 288,691	\$ 426,000		
VDH	3	Fluoride Treatment	\$ -	\$ 43,483	\$ 75,081	\$ 59,362	\$ 55,209		
VDH	4	CHIP Vaccines	\$ -	\$ 196,868	\$ 482,454	\$ 707,788	\$ 557,784		
VDH	4	Healthy Homes and Lead Poisoning Prevention Program	\$ -	\$ -	\$ 101,127	\$ 479,936	\$ 421,302		
DMH	2	Special Payments for Treatment Plan Services	\$ 134,791	\$ 132,021	\$ 180,773	\$ 168,492	\$ 152,047		
DMH	2	MH Outpatient Services for Adults	\$ 522,595	\$ 974,854	\$ 1,454,379	\$ 2,661,510	\$ 3,074,989		
DMH	2	Mental Health Elder Care	\$ -	\$ -	\$ -	\$ -	\$ -		
DMH	4	Mental Health Consumer Support Programs	\$ 582,397	\$ 67,285	\$ 1,649,340	\$ 2,178,825	\$ 1,132,931		
DMH	2	Mental Health CRI Community Support Services	\$ 1,935,344	\$ 1,886,140	\$ 6,047,450	\$ 11,331,235	\$ 282,071		
DMH	2	Mental Health Children's Community Services	\$ 1,775,120	\$ 2,785,090	\$ 3,088,773	\$ 3,377,546	\$ 3,706,864		
DMH	2	Emergency Mental Health for Children and Adults	\$ 2,309,810	\$ 4,395,885	\$ 8,719,824	\$ 6,662,850	\$ 4,148,197		
DMH	2	Respite Services for Youth with SED and their Families	\$ 543,635	\$ 541,707	\$ 823,819	\$ 749,943	\$ 931,962		
DMH	2	CRT Staff Secure Transportation	\$ -	\$ -	\$ -	\$ -	\$ -		
DMH	2	Recovery Housing	\$ 512,307	\$ 562,921	\$ 874,194	\$ 985,098	\$ 463,708		
DMH	2	Transportation - Children in Involuntary Care	\$ -	\$ -	\$ -	\$ -	\$ -		
DMH	2	Vermont State Hospital Records	\$ -	\$ -	\$ -	\$ -	\$ -		
DMH	4	Challenges for Change: DMH	\$ 229,512	\$ 945,051	\$ 819,069	\$ -	\$ -		
DMH	2	Seriously Functionally Impaired: DMH	\$ 68,713	\$ 160,560	\$ 1,151,615	\$ 721,727	\$ 392,593		
DMH	2	Acute Psychiatric Inpatient Services	\$ -	\$ 12,603,067	\$ 5,268,556	\$ 3,011,307	\$ 2,423,577		
DMH	2	Institution for Mental Disease Services: DMH	\$ -	\$ -	\$ 10,443,654	\$ 7,194,964	\$ 25,371,245		
DVHA	4	Vermont Information Technology Leaders/HIT/HIE/HCR	\$ 646,220	\$ 1,425,017	\$ 1,517,044	\$ 1,549,214	\$ 2,915,149		
DVHA	4	Vermont Blueprint for Health	\$ 2,616,211	\$ 1,841,690	\$ 2,002,798	\$ 2,490,206	\$ 1,987,056		
DVHA	1	Buy In	\$ 50,605	\$ 24,000	\$ 17,878	\$ 17,728	\$ 27,169		
DVHA	1	Visiting Expanded	\$ -	\$ -	\$ -	\$ -	\$ -		
DVHA	1	HIV Drug Coverage	\$ 39,176	\$ 37,452	\$ 39,881	\$ 26,540	\$ 10,072		
DVHA	1	Civil Union	\$ 999,084	\$ 1,215,109	\$ 1,112,119	\$ 760,819	\$ (50,085)		
DVHA	1	Vtgham	\$ -	\$ -	\$ -	\$ -	\$ -		
DVHA	4	Hospital Safety Net Services	\$ -	\$ -	\$ -	\$ -	\$ -		
DVHA	2	Patient Safety Net Services	\$ 36,112	\$ 73,487	\$ 2,394	\$ 363,489	\$ 335,420		
DVHA	2	Institution for Mental Disease Services: DVHA	\$ -	\$ -	\$ 6,214,805	\$ 6,948,129	\$ 7,792,709		
DVHA	2	Family Supports	\$ -	\$ -	\$ 4,015,491	\$ 3,723,521	\$ 2,982,388		
DCF	2	Family Infant Toddler Program	\$ 624	\$ -	\$ -	\$ -	\$ -		
DCF	2	Medical Services	\$ 64,496	\$ 47,720	\$ 37,164	\$ 33,514	\$ 32,299		
DCF	2	Residential Care for Youth/Substitute Care	\$ 7,853,100	\$ 9,629,269	\$ 10,131,790	\$ 11,137,225	\$ 10,405,184		
DCF	2	AABD Admin	\$ -	\$ -	\$ -	\$ -	\$ -		
DCF	2	AABD	\$ -	\$ -	\$ -	\$ -	\$ -		
DCF	2	Aid to the Aged, Blind and Disabled CCL Level III	\$ 2,661,246	\$ 2,563,226	\$ 2,621,786	\$ 2,611,499	\$ 2,864,727		
DCF	2	Aid to the Aged, Blind and Disabled Res Care Level III	\$ 136,466	\$ 137,833	\$ 124,731	\$ 89,159	\$ 77,196		
DCF	2	Aid to the Aged, Blind and Disabled Res Care Level IV	\$ 265,812	\$ 273,662	\$ 269,121	\$ 183,025	\$ 160,963		
DCF	2	Essential Person Program	\$ 736,479	\$ 775,278	\$ 783,860	\$ 801,658	\$ 707,316		
DCF	2	GA Medical Expenses	\$ 492,079	\$ 352,451	\$ 275,187	\$ 253,939	\$ 219,973		
DCF	2	CUPS/Early Childhood Mental Health	\$ 112,619	\$ 165,016	\$ 45,491	\$ -	\$ -		
DCF	2	VCRHYP/Vermont Coalition for Runaway and Homeless Youth Program	\$ -	\$ -	\$ -	\$ -	\$ -		
DCF	2	HBKF/Healthy Babies, Kids & Families	\$ -	\$ -	\$ -	\$ -	\$ -		
DCF	1	Catamount Administrative Services	\$ -	\$ -	\$ -	\$ -	\$ -		
DCF	2	Children's Integrated Services Early Intervention	\$ -	\$ -	\$ -	\$ 200,484	\$ -		
DCF	2	Therapeutic Child Care	\$ 570,493	\$ 596,406	\$ 557,599	\$ 543,196	\$ 605,419		
DCF	2	Lund Home	\$ 196,159	\$ 354,528	\$ 181,243	\$ 237,387	\$ 405,034		
DCF	2	GA Community Action	\$ 199,762	\$ 338,275	\$ 420,359	\$ 25,181	\$ -		
DCF	3	Prevent Child Abuse Vermont: Shaken Baby	\$ 44,119	\$ 74,250	\$ 86,969	\$ 111,094	\$ 54,125		
DCF	3	Prevent Child Abuse Vermont: Nurturing Parent	\$ -	\$ 107,184	\$ 186,916	\$ 54,231	\$ 195,124		
DCF	4	Challenges for Change: DCF	\$ 50,622	\$ 196,378	\$ 197,426	\$ 207,286	\$ 189,378		
DCF	2	Strengthening Families	\$ -	\$ 465,343	\$ 429,154	\$ 399,841	\$ 370,003		
DCF	2	Lamoille Valley Community Justice Project	\$ -	\$ 162,000	\$ 216,000	\$ 402,685	\$ 83,315		
DCF	3	Building Bright Futures	\$ -	\$ -	\$ 398,201	\$ 594,070	\$ 514,225		
DDAIL	2	Elder Coping with MMA	\$ -	\$ -	\$ -	\$ -	\$ -		
DDAIL	2	Mobility Training/Other Svcs.-Elderly Visually Impaired	\$ 245,000	\$ 245,000	\$ 245,000	\$ 245,000	\$ 245,000		
DDAIL	2	DS Special Payments for Medical Services	\$ 757,070	\$ 1,498,083	\$ 1,299,613	\$ 1,271,148	\$ 385,896		
DDAIL	2	Flexible Family/Respite Funding	\$ 1,103,748	\$ 1,103,749	\$ 1,088,889	\$ 2,868,218	\$ 1,400,997		
DDAIL	4	Quality Review of Home Health Agencies	\$ 103,598	\$ 128,399	\$ 84,139	\$ 51,697	\$ 44,682		
DDAIL	4	Support and Services at Home (SASH)	\$ -	\$ 773,192	\$ 773,192	\$ 1,013,671	\$ 1,026,155		
DDAIL	4	HomeSharing	\$ -	\$ -	\$ 310,000	\$ 317,312	\$ 327,163		
DDAIL	4	Self-Neglect Initiative	\$ -	\$ -	\$ 150,000	\$ 200,000	\$ 265,000		
DDAIL	2	Seriously Functionally Impaired: DAIL	\$ -	\$ -	\$ 1,270,247	\$ 859,371	\$ 333,331		
DOC	2	Intensive Substance Abuse Program (ISAP)	\$ 591,000	\$ 458,485	\$ 400,910	\$ 547,550	\$ 58,280		
DOC	2	Intensive Sexual Abuse Program	\$ 70,002	\$ 60,585	\$ 69,311	\$ 19,322	\$ 15,532		
DOC	2	Intensive Domestic Violence Program	\$ 174,000	\$ 164,218	\$ 86,814	\$ 64,970	\$ 169,043		
DOC	2	Women's Health Program (Tapestry)	\$ -	\$ -	\$ -	\$ -	\$ -		
DOC	2	Community Rehabilitative Care	\$ 2,221,448	\$ 2,242,871	\$ 2,500,085	\$ 2,388,327	\$ 2,539,161		
DOC	2	Return Home	\$ -	\$ -	\$ 399,999	\$ 399,999	\$ 343,592		
DOC	2	Northern Lights	\$ 40,000	\$ -	\$ 393,750	\$ 335,587	\$ 354,909		
DOC	4	Challenges for Change: DOC	\$ -	\$ 687,166	\$ 524,594	\$ 433,910	\$ 539,727		
DOC	4	Northeast Kingdom Community Action	\$ -	\$ -	\$ 548,825	\$ 287,662	\$ 267,025		
DOC	2	Pathways to Housing	\$ -	\$ -	\$ 802,488	\$ 830,936	\$ 830,338		
			\$ 56,275,877	\$ 89,836,470	\$ 123,669,882	\$ 127,103,459	\$ 128,924,888		

Attachment 6 - MCE Investments SFY15