State of Vermont
Agency of Human Services

Global Commitment to Health
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Section 1115
Demonstration Year: 10
(1/1/2015 – 12/31/2015)

Quarterly Report for the period
April 1, 2015 – June 30, 2015

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I. Background and Introduction

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

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. AHS has intergovernmental agreements (IGAs) with DVHA and other AHS departments that make them part of the MCE within the framework of the Global Commitment to Health.

One of the Terms and Conditions of the Global Commitment Waiver requires the State to submit progress reports 60 days following the end of each quarter. ***This is the second quarterly report for waiver year 10, covering the period from April 1, 2015 through June 30, 2015 (QE0615).***

II. Enrollment Information and Counts

Key updates from QE0615:

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

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

Table 1 is populated based on reports run the Monday after the last day of the quarter, in this case on July 6, 2015. Results yielding ≤5% fluctuation from quarter to quarter are considered as illustrating normal deviations reflecting retroactive eligibility determinations and expected terminations. Results reflecting >5% fluctuation between quarters are reviewed by staff from DVHA and AHS to provide further detail and explanation of the changes in enrollment. The explanation of any substantial fluctuations observed in Demonstration Populations during QE0615 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*, QE0615

Demonstration Population	Current Enrollees Last Day of Qtr	Previously Reported Enrollees Last Day of Qtr	Percent Variance 3/31/2015 to 6/30/2015	Variance by Enrollee Count 3/31/2015 to 6/30/2015
	June 30, 2015	March 31, 2015		
Demonstration Population 1:	36,924	36,732	0.52%	192
Demonstration Population 2:	81,872	81,010	1.06%	862
Demonstration Population 3:	57,432	56,047	2.47%	1,385
Demonstration Population 4:	2,809	2,905	-3.30%	(96)
Demonstration Population 5:	869	877	-0.91%	(8)
Demonstration Population 6:	931	918	1.42%	13
Demonstration Population 7:	7,467	7,608	-1.85%	(141)
Demonstration Population 8:	4,257	4,344	-2.00%	(87)
	192,561	190,441	1.11%	

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

III. Outreach Activities

i. Member Relations

Key updates from QE0615:

- Member handbooks were revised, translated into seven languages in addition to English, and published online.
- The annual Timely Access Survey was completed.
- A banner was published notifying providers that enrollment applications would be accepted for Board Certified Behavior Analysts (BCBA) and Board Certified Assistant Behavior Analysts (BCaBA) beginning June 1.
- Contracts were executed with transportation brokers for July 1, 2015 to December 31, 2015.
- The Medicaid and Exchange Advisory Board met three times in this quarter.

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

Member handbooks were reviewed and updated to ensure correct and compliant information is provided to Medicaid beneficiaries. The Health Care Programs Handbook, Pharmacy Program Handbook and Enrollment Handbook were edited, revised and printed in English for distribution to new enrollees. Additionally, the handbooks were translated into seven additional languages and publicly published on the Green Mountain Care website for members and advocates to access as needed. Member handbooks can be viewed here: http://www.greenmountaincare.org/member_information/handbooks.

A Timely Access survey was sent to 258 primary care providers (PCPs), selected as a random sample of 80% of PCPs who have been enrolled in Vermont Medicaid for a minimum of two years and see at least 25 unique members. The survey addressed adherence to access to care and waiting time standards, published in the Provider Manual. Of the 258 surveys distributed, 110 surveys were returned; a return rate of about 43%. The vast majority of those surveyed meet the requirements for access to care and waiting time standards; in fact, only one provider has been asked to submit a corrective action plan (CAP) to define steps to meet the requirements. While the return rate for the survey remained consistent with recent years, the need for CAPs is the lowest ever. As a reference, six CAPs were needed in 2014.

A banner was published notifying providers that DVHA will begin accepting enrollment applications from Board Certified Behavior Analysts (BCBA) and Board Certified Assistant Behavior Analysts (BCaBA) to become enrolled as Vermont Medicaid providers starting June 1, 2015. DVHA has expanded coverage of Applied Behavior Analysis (ABA) services for beneficiaries up to the age of 21 years old, starting July 1, 2015.

Contracts with eight transportation providers for non-emergency medical transportation (NEMT) were established for July 1, 2015 through December 31, 2015. A review of payment methodology and performance requirements is under way in preparation for the January 2016 contracts.

The Medicaid and Exchange Advisory Board (MEAB) held meetings on April 27, May 26 and June 22. 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 QE0615:

- A major system upgrade in May gave Vermont Health Connect (VHC) the technology needed to quickly process changes and integrate those changes across up to six systems.
- VHC continued to implement its pilot plan, which began in March, to transition Vermonters from the State's legacy ACCESS system to VHC to receive their MAGI Medicaid eligibility determination.
- The Customer Support Center managed incoming call volume, receiving more than 88,000 calls over the quarter, achieving an abandon rate of 0.99% and answering nearly nine out of ten calls (88%) in less than 30 seconds.

In QE0615, VHC continued to implement its pilot plan, which began in March, to transition Vermonters from the State's legacy ACCESS system to VHC to receive their MAGI Medicaid eligibility determination. The pilot consisted of 3,000 of the highest income Medicaid households. As of the end of QE0615, two out of five households in the pilot had filled out an application for coverage. Of those who applied, nearly one in five no longer had a member who qualified for Medicaid, while four out of five had at least one household member qualify for Medicaid. State staff have been closing customer cases when customers have asked for Medicaid to be closed and when customers' outreach letters have been returned with no forwarding address. The State has agreed to discuss the results with CMS and adjust renewal plans for transitioning the remaining 27,000 Medicaid for Children and Adults households from the ACCESS system accordingly.

VHC continued to utilize Optum agents to augment manual processes throughout April and the first half of May, though at a much smaller scale than in 2014. After using as many as 170 Optum agents in October and November to process both the backlog of change requests and VHC renewals, the State reduced its pool of contract resources to 30 highly trained Optum agents beginning December 31. The main reason for this decision was the complexity of the remaining manual work. These agents continued to process remaining renewals alongside state workers until May 15, 2015, when the State achieved its goal of processing renewals in advance of a major system upgrade.

This quarter, the State worked with its systems integrator, Optum, to develop two major system upgrades for 2015. The first major system upgrade deployed at the end of May and included automated processing of change requests. Focus then turned to preparing for a fall system upgrade to include self-service plan selection during open enrollment, self-service change reporting, automated noticing, and automated QHP issuer and billing integration.

Maximus continues to manage the VHC Customer Support Center (call center), currently utilizing 65 customer service representatives. The call center serves Vermonters enrolled in both public and private health insurance coverage, providing Level 1 call center support, which includes phone applications, payment, and basic coverage questions. Maximus is also the entry point for individuals requiring greater levels of assistance with case resolution. They transfer calls to the State's Health Access Eligibility Unit for resolution and log service requests, which are escalated to the appropriate resolver group. Throughout QE0615, the system's performance continued to be stable and operated as

expected. The Customer Support Center managed incoming call volume, receiving more than 88,000 calls over the quarter, achieving an abandon rate of 0.99% and answering over 88% of calls within 30 seconds.

ii. Choices for Care

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

1. Home-Based Options

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

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

2. Adult Family Care (AFC) Option

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

3. Enhanced Residential Care (ERC) Option

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

4. Nursing Home Option

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

In addition to the services offered to people who meet Highest/High Needs clinical standards (nursing home level of care), Choices for Care also provides limited funding for people with Moderate Needs. To be eligible, people must meet a modest clinical eligibility standard and a non-Medicaid financial

eligibility test with an adjusted income of up to 300% of Vermont's Supplemental Security Income (SSI) rate. Eligible participants may receive homemaker services, adult day services, and flexible funds in addition to case management services.

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

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

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

Independent Evaluation:
In May of 2015, an independent evaluation team from the University of Massachusetts Medical School (UMMS) published the Vermont Choices for Care Evaluation of Years 1-9 report. This is the final report under the old Choices for Care 1115 waiver. Future evaluations will occur under the new Global Commitment structure.

The report concluded: "In the ninth year of the Choices for Care program, DAIL continues to achieve its mission to make Vermont the best state in which to grow old or to live with a disability with dignity, respect and independence. CFC enrollment increased with a larger percentage of individuals receiving services in a Home and Community Based Services (HCBS) setting. Overall data indicate that CFC improved or maintained positive gains in many domains.

As Choices for Care is folded into the Global Commitment waiver, DAIL has an opportunity to align its quality improvement efforts with the "Triple Aim" by improving the experience of care, improving the health of populations, and reducing costs (Berwick, Nolan and Whittington, 2008)."

The report provides recommendations specific to:

- Information Dissemination
- Access
- Experience with Care
- Effectiveness
- Quality of Life
- Waiting Lists
- Service Array and Amounts
- Evaluation

Recommendations will be incorporated into strategic plans where appropriate.

For the full report, go to: http://ddas.vt.gov/ddas-publications/publications-cfc/evaluation-reports-consumer-surveys/vermont-choices-for-care-evaluation-of-years-1-9-1.

Legislative Budget Change:
As a part of the state fiscal year (SFY) 2016 budget, the Vermont legislature eliminated funding for an external Choices for Care case management service to people residing in the 24/7 Enhanced Residential Care and Adult Family Care settings effective July 1, 2015.

People residing in these settings continue to receive 24/7 bundled care and services in addition to the following:

- Case management services as required by Vermont Residential Care Home regulations and Assistive Community Care Services Medicaid State Plan benefits.
- Service Coordination as required by the Choices for Care Adult Family Care home standards.
- Help with Medicaid applications through the local Area Agencies on Aging via a contract with the Vermont Department for Children and Families to help people with Medicaid applications.
- Options Counseling and Information & Referral through the local Aging and Disabilities Resource Connections.
- Help with benefit appeals and legal issues through Vermont Legal Aid.
- Help with complaints through the Vermont Long-Term Care Ombudsman program.

Participants and providers were notified June 4, 2015 of the budget elimination, including the resources available to assure continued support beyond July 1, 2015. The Department has provided training to providers via written materials, YouTube instructions, technical assistance calls and provider group meetings. The Department is also continuing to focus on quality outcomes by:

- Continuing licensing surveys of all ERC residential care home providers;
- Continuing Designation and Certification of all AFC Authorized Agencies;
- Continuing Utilization Review of all ERC and AFC service plans submitted to the State;
- Developing and implementing enhanced quality efforts in ERC and AFC to include focus on person-centered planning, quality of life, and conflict of interest policies; and
- Communicating with stakeholders on a regular basis about any unforeseen consequences of the budget elimination.

V. Expenditure Containment Initiatives

i. Medicaid Shared Savings Program

Key updates from QE0615:

- As of June, 49,000 Medicaid beneficiaries are attributed to two accountable care organizations (ACOs) through the Vermont Medicaid Shared Savings Program (VMSSP).
- Received State Plan Amendment (SPA) approval from CMS for Year 1 of the VMSSP on June 5, 2015.
- Began negotiation for Year 2 Contract Amendment with ACOs.
- Continued research into cost categories to be included in VMSSP Total Cost of Care for Performance Year 3.

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

Beneficiary attribution in the VMSSP continues to increase as new providers are added to participating ACO entities, with over 880 providers participating in the program, resulting in 49,000 total beneficiaries attributed—approximately 31,000 lives in OneCare Vermont (OCVT) and 18,000 lives in Community Health Accountable Care (CHAC).

Vermont submitted its initial SPA materials to CMS in February 2014 and worked with CMS over 15 months to respond to formal and informal questions related to various aspects of the VMSSP, particularly quality measurement and Vermont's financial trends and methodology. Vermont received SPA approval for Year 1 of the VMSSP on June 5, 2015. Vermont remains committed to working with CMS throughout the duration of the VMSSP.

In May, VMSSP staff and AHS leadership entered into negotiations with the ACOs to make amendments to the VMSSP contract for Year 2. Though the contract amendment has not been finalized, changes will be made to the following sections of the contract: program integrity, financial management, care management standards, and quality and performance measurement. VMSSP staff expects to finalize the VMSSP contract amendment next quarter.

Over the course of the three-year program, the VMSSP seeks to expand the scope of accountability in care to go beyond traditional medical services. This expansion aims to include pharmacy, non-emergency transportation, long term care services and supports, mental health and substance abuse services, and other social services that are commonly sought by Medicaid beneficiaries. The ACOs did not elect to take on optional cost categories (including pharmacy and non-emergency medical transportation) for Year 2 of the VMSSP. VMSSP staff presented their research and analysis on the potential impacts of including additional cost categories into the Year 3 Total Cost of Care (TCOC) to the Payment Models working group of the Vermont Health Care Innovation Project (VHCIP) in June, and is currently holding an open comment period for stakeholders to submit comments and questions. Inclusion of additional cost categories chosen by VMSSP staff for Year 3 is mandatory. VMSSP staff will notify the ACOs of selected additional cost categories no later than September 1, 2015.

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

ii. Vermont Chronic Care Initiative (VCCI)

Key updates from QE0615:

- The Enterprise Medicaid Management Information Systems/Care Management (MMIS/CM) contract was approved by CMS with the new vendor, eQHealth (eQH) starting in June 2015 with an anticipated go live date in the first quarter of FFY 2016.
- The APS Healthcare contract was extended for 6 months to support continuity of business operations during the onboarding of the new MMIS/CM vendor, eQHealth.
- The VCCI field staff are becoming members of the ACO 'regional clinical planning committees' (RCPCs). Concurrently, efforts are underway between DVHA and ACO leadership to develop systems and processes to identify and manage members in common and minimize redundancies.
- The VCCI launched the Medicaid Obstetrical and Maternal Supports (MOMS) program for at risk pregnant women in April 2015.

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

The VCCI uses a holistic approach of evaluating and supporting improvement in medical and behavioral health, as well as socioeconomic issues that are often barriers to sustained health improvement. 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 VCCI's strategy of embedding staff in high-volume hospitals and primary care sites continues to support population engagement at the point-of-need in areas of high service utilization. By targeting predicted high-cost members, resources can be allocated to areas representing the greatest opportunities for clinical improvement and cost savings. The VCCI's SFY 2014 final report validates its approach, demonstrating a reduction of 30% in hospital admissions, a 31% reduction in 30-day readmissions and a 15% reduction in Emergency Department (ED) usage among members in the top 5% as compared to SFY 2013. These reductions in utilization, along with related improvement in evidence based chronic disease management, resulted in a net savings of $30.5 million over anticipated expenses in SFY 2014. SFY 2015 results will not be available until the 6 month claims run-out.

The VCCI is also continuing its collaboration with ACO partners to enhance the number of participating hospitals providing File Transfer Protocol (FTP) data feeds for its focused efforts on transitions in care and prevention of 30-day hospital readmissions. The VCCI has access to hospital data on inpatient and ED admissions through data sharing from partner hospitals. While the VCCI currently receives electronic data from 5 partner hospitals, the goal is to have electronic census data

from all hospitals in FFY 2015. While some hospitals have not supported these strategies in the past, the advent of Medicaid ACOs may help facilitate new relationships based on common goals and financial incentives. The VCCI has requested that its ACO partners facilitate this with member hospitals, and internal DVHA partners in the Blueprint for Health are also helping to facilitate this via local hospital grants.

The VCCI supplemented its embedded model with a nurse 'liaison role' given space constraints at provider and hospital sites. All 14 hospitals have a designated VCCI staff 'liaison' assigned who meets with hospital case managers to support the reduction of ACS ED utilization 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. Although these efforts have facilitated more robust communication, referral and support of mutual goals of the VCCI, more work is required. DVHA leadership has been meeting regularly with ACO partners to strengthen ties and further develop referral and reporting processes.

This enhanced service coordination is a goal of the VHCIP Care Management and Care Models (CMCM) workgroup, which has launched an integrated care management learning collaborative in 3 pilot locations—Rutland, Burlington and St. Johnsbury—in which the VCCI participates along with other community service providers. The pilot, launched in QE0315, will run for one year. New communities are being on-boarded starting QE0915, using SIM grant funding to support the local Learning Collaboratives which include all insurance carriers as well as community stakeholders toward an integrated care management process and care plan.

Due to their Medicaid knowledge and case management experience, VCCI nurse case managers have been hired by partners of the VCCI, and at a higher pay scale than provided by the State. DVHA and AHS are currently assessing a market factor adjustment for nursing positions to support both recruitment and retention. This is targeted for completion in August 2015 and likely not implemented until July 1 2016, pending budget approval.

Medicaid Obstetric and Maternal Supports (MOMS) Care Management
The VCCI launched its initial pilot program for pregnancy case management services in October 2013. While strides were made, the clinical team recommended that 2 registered nurses (RNs) were not indicated as a centralized resource, and a better model to support clinical and quality goals could be achieved via one nurse case management expert functioning as a liaison with other state and community partners and as an expert consultant to the VCCI field staff receiving referrals for at risk pregnant women. As a result, there is currently a single centralized resource/expert available to the field staff as well as community and statewide partners. Since this change, 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 focus of the MOMS program is supported by data on Medicaid members with mental health and substance use/abuse and those at risk for premature delivery. Additional data analysis is underway to assess and select additional intervention strategies and related evaluation based on cost drivers (i.e. pregnant women with a substance abuse history).

APS Contract:
APS Healthcare provides several services to support the VCCI, including supplemental professional staffing and data analytics. APS Healthcare delivers enhanced information technology and decision-support tools to assist staff in doing outreach to the most costly and complex beneficiaries. Additionally, APS Healthcare provides supplemental population-based reports on gaps in care to

PCPs, which support ACO providers and case managers working with patients who are considered high utilizers and/or at risk to become so. These reports will sunset in October as APS will not be supporting migration to ICD-10 coding structure due to their transition, and the new vendor onboarding will not be completed until December 2015.

To ensure continuity of the VCCI business operations during the Medicaid Management Information Systems (MMIS)/Care Management (CM) procurement and on-boarding process, DVHA extended its contract with APS Healthcare through December 31, 2015. This will help facilitate the transition to the new enterprise level CM vendor. The VCCI is working proactively with APS Healthcare to facilitate a smooth transition of the historic data to the new vendor in a timely fashion and format that supports data consumption by the new system. Initial test files were provided by APS to DVHA in June and it is anticipated that live data will be provided to the new vendor, eQH, in August.

One Provider Health Registry (PHR) for chronic heart failure was developed and released this quarter and will be the last such PHR developed by APS on behalf of DVHA, due to change in contract terms. These tools will be developed and available in the new eQH Enterprise Care Management system.

Activities supported by APS this quarter include:

- Collaboration on the data transition plan required to support data migration to the new CM vendor and prevent interruption of VCCI services to Medicaid members.
- Continued outreach and program education by the VCCI pharmacist to high volume Medicaid pharmacies serving the VCCI population.
- Average VCCI caseload (DVHA/APS) for QE0615 was: 601, with 1460 unique members.

Enterprise Care Management vendor transition:
The VCCI will be the initial DVHA unit to go live in the new enterprise care management system with the selected vendor, eQHealth (eQH). As a result, the VCCI is heavily engaged in planning and development of system design efforts including data migration, development of eligibility rules, workflow mapping, assessments and related alerts in the new system.

The VCCI is anticipating the loss of 13 clinical and analytical FTE's due to the contract dissolution and will need to restructure operations concurrent with going live 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 supports over the next few quarters.

In support of the transition, the VCCI has identified a full time subject matter expert (SME) using one of two VCCI managers who support field based service operation, quality, hiring, evaluation, etc. The VCCI has also reallocated a field staff nurse to a senior nurse case manager position to support program fidelity, clinical and quality performance; and a SME backup to support a variety of program operational needs and data migration that will enhance user defined dash boards to enhance adoption. The VCCI is working with eQH and AHS Organizational Change Management (OCM) staff to facilitate system adoption by VCCI field staff.

iii. Blueprint for Health

Key updates from QE0615:

- The Blueprint for Health and Vermont's three ACOs are implementing Unified Community Collaboratives in each Hospital Service Region.
- The Blueprint issued a new round of Health Services Area Profiles to guide quality improvement and care coordination initiatives at the community level.
- The Vermont legislature appropriated additional funds to support increased Medicaid contribution to the total cost of the Blueprint Community Health Teams consistent with the market share of Medicaid covered lives in Vermont.
- The legislature also appropriated additional funds to support an increase to the Per Member Per Month Payments made to providers that meet the 2014 NCQA Patient Centered Medical Homes and, for the first time, performance based payments. These payments will go into effect January 1, 2016.
- The Blueprint has approached a saturation point where the program has recruited most of the 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 127.
- The enrollment in the "Hub & Spoke" health home continues to grow.

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

The Blueprint program's payment and service delivery reforms include patient centered medical homes (PCMHs), multi-disciplinary community health teams (CHTs), comparative reporting from statewide data systems, and activities focused on continuous improvement (Learning Health System). The program is intended to ensure that all citizens have access to high quality primary care and preventive health services and to establish a foundation for a high value health system in Vermont. To date, two payments have been adopted by all major insurers to support Blueprint primary care. The first payment is made to primary care practices based on their score on National Committee for Quality Assurance (NCQA) medical home standards and the second is a payment to support community health team staff as a shared cost with other insurers. Both are capitated payments applied to the medical home population.

At the end of the 2015 session, the Vermont Legislature appropriated new funds to increase the capacity of primary care, provide citizens with better access to team based services, and strengthen the basis for a community oriented health system structure across Vermont. The programmatic and payment changes are designed to establish a more systematic approach to coordinating local services and quality initiatives across the state. This will be achieved through integration of accountable care organization and Blueprint program activities in a *unified collaborative* to guide quality and coordination initiatives in each service area and an aligned medical home payment model that promotes coordination and better service area results on core measures of quality and performance.

The *unified community collaboratives* (UCC) are being developed locally in each of Vermont's 14 Health Services Areas to integrate the Blueprint for Health; the three ACO provider networks; and key

[1] 18 VSA Chapter 13.

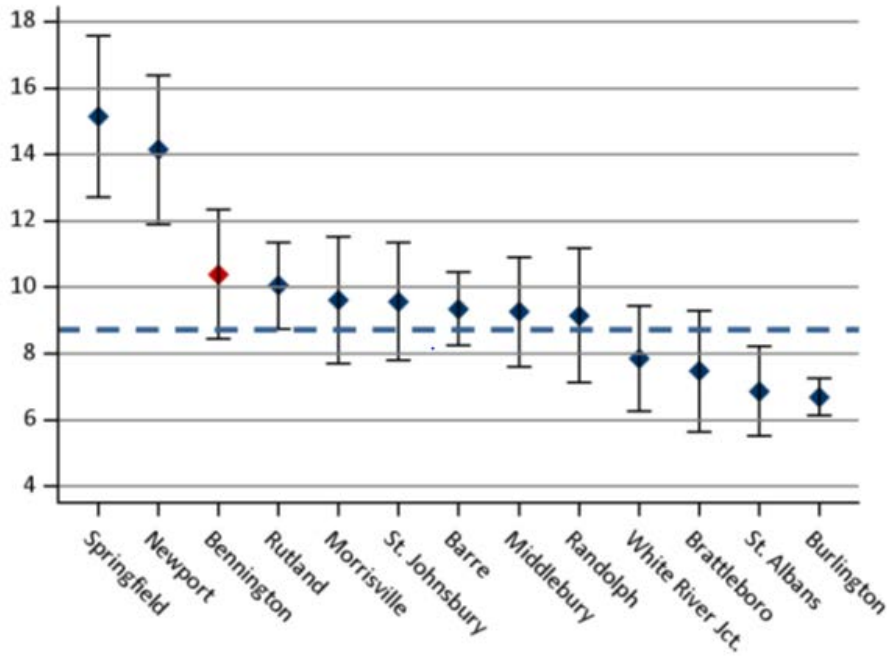
community health, housing, and human services partners. The UCC structure, with administrative support and an aligned medical home payment model will result in more effective health services as measured by:

- Improved results for priority measures of quality
- Improved results for priority measures of health status
- Improved patterns of utilization (preventive services, unnecessary care)
- Improved access and patient experience.

Health Services Area Profiles:
The Blueprint issued a new round of Health Services Area Profiles to guide quality improvement and care coordination initiatives at the community level. These profiles can be found at: http://blueprintforhealth.vermont.gov/reports_and_analytics/hospital_service_area_profiles

Current measurement of regional and practice level outcomes across Vermont highlights opportunities for UCCs to organize more cohesive services and lead improvement. When adjusted for differences in the population, there is significant variation in measures of expenditures, utilization, and quality. The variation across settings offers an opportunity for UCC leadership teams and participants to examine differences and to plan initiatives that can reduce unnecessary variation and improve rates of recommended services. One example is the Prevention Quality Indicator (PQI) measuring the rate of hospitalizations per 1,000 people, ages 18 and older, for a composite of chronic conditions including: diabetes with short-term complications, diabetes with long-term complications, uncontrolled diabetes without complications, diabetes with lower-extremity amputations, COPD, asthma, hypertension, heart failure, and angina without a cardiac procedure. The 2013 service area results for this indicator, which is included in Vermont's core measure set for shared savings programs, highlights the variation that is seen with most core quality and performance measures.

Chart 1. Prevention Quality Indicator—Hospitalizations per 1,000 people, ages 18 and older



Overall improvement in this measure, and reduction in variation across settings, is most likely with well-planned coordination across provider types including primary care, specialty care, and community services that improve self-management capabilities for vulnerable populations such as

seniors without adequate support. Hospitalization rates for these types of conditions are driven by complex life circumstances, often related to social, economic, and behavioral factors that influence the ability to engage in daily preventive care.

New Payments:
The new medical home payment model includes the following elements:

- Base Component: Based on NCQA recognition & UCC Participation.
  - Requires successful recognition of 2014 NCQA standards (any qualifying score).
  - Requires active participation in the local UCC, including orienting practice and CHT staff activities to achieve the goals that are prioritized by the local UCCs. Minimum requirement is active participation with at least one UCC priority initiative each calendar year.
  - All qualifying practices receive $3.00 PPPM (per patient per month).
- Quality Performance Component: Based on HSA results for Quality Index.
  - Up to $ 0.25 PPPM for results that exceed benchmark.
- Utilization Performance Component: Based on HSA results for Utilization Index.
  - Up to $ 0.25 PPPM for results that exceed benchmark.

Market Share Adjustment for Community Health Team:
As the health insurance market has changed in Vermont, the relative contribution of each payer to the shared utility of the Community Health Team requires adjusting. Planning for this and the resulting increased participation from Medicaid and Blue Cross Blue Shield was completed in this reporting quarter. Due to the terms in the current Multi-Payer Demonstration Program with CMS, Medicare's share will remain constant with a 22.22% share of community health team costs, which is in close alignment with their market share. An example of the change to each insurer's share of costs, based on their current proportion of attributed medical home patients, is shown below along with the proposed amounts.

Table 2. Market share basis for community health team costs.

	Current share of CHT Costs	Proposed share of CHT Costs*
Medicare	22.22%	22.22%
Medicaid	24.22%	35.66%
BCBS	24.22%	36.92%
MVP	11.12%	4.71%
Cigna	18.22%	0.49%
Total	100.00%	100.00%

*Each insurer's percentage of community health team cost is based on their attributed proportion of the total medical home population.

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 5,069 Medicaid beneficiaries in Hub and Spoke programs combined as of June 30, 2015. The following tables present the caseloads of regional Hub and Spoke staffing as of June 30, 2015. Spoke staffing is scaled at 1 registered nurse and 1 licensed clinician for every 100 patients receiving MAT.

Table 3. Hub Implementation as of June 30, 2015

Program	Region	Start Date	# Clients	# Buprenorphine	# Methadone
Chittenden Center	Chittenden, Franklin, Grand Isle & Addison	1/13	884	267	617
BAART Central Vermont	Washington, Lamoille, Orange	7/13	370	1961	209
Habit OPCO / Retreat	Windsor, Windham	7/13	545	200	345
West Ridge	Rutland, Bennington	11/13	446	161	285
BAART NEK	Essex, Orleans, Caledonia	1/14	540	133	407
STATEWIDE			**2785**	**922**	**1863**

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 4. Spoke Implementation as of June 30, 2015

Region	Total # MD prescribing pts	# MD prescribing to ≥ 10 pts	Staff FTE Available Funding	Staff FTE Hired	Medicaid Beneficiaries
Bennington	11	8	5.0	4.6	246
St. Albans	12	9	7.5	4.6	363
Rutland	9	5	5.5	3.5	256
Chittenden	30	15	9.0	7.25	420
Brattleboro	18	5	4.0	4.81	170
Springfield	6	1	1.0	1.5	52
Windsor	7	3	2.5	2.5	130
Randolph	4	3	2.0	1.4	100
Barre	14	7	5.5	5.5	251
Lamoille	6	3	3.0	3.6	139
Newport & St Johnsbury	8	4	2.0	1.0	87
Addison	5	2	1.5	1.5	64
Upper Valley	4	0	.5	0	6
Total	131*	65	49	41.76	2,284

*3 providers prescribe in more than one region.
Additional Table Notes: Beneficiary count based on pharmacy claims April - June 2015. An additional 150 Medicaid beneficiaries are served by 21 out-of-state providers. Staff hired is based on a Blueprint portal report that was run July 20, 2015.

iv. Behavioral Health

Key updates from QE0615:

- Behavioral Health Team assumed responsibilities for utilization management of substance abuse residential facilities from the Alcohol and Drug Abuse Program.
- Developed an ABA benefit in accordance with Vermont Act 158 of 2012; the Team performed outreach to providers regarding enrollment.
- Performed outreach to providers and partners in preparation for the alignment of inpatient opiate detoxification authorizations with nationally recognized clinical criteria.

The DVHA Behavioral Health Team offers a comprehensive approach for behavioral health care coordination. The Team continues to be responsible for concurrent review and authorization of inpatient psychiatric and detox services for Medicaid primary members. This quarter, in addition to their existing responsibilities, the Team assumed the utilization management activities from the Alcohol and Drug Abuse Program (ADAP) 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 facilitates collaboration between facility staff and staff from VCCI, DMH and ADAP to ensure timely and appropriate discharge plans. The Team also manages the Team Care Program (lock-in) for Medicaid members.

During this quarter, the Autism Specialist, in collaboration with Agency partners, finalized the proposed benefit design for applied behavioral analysis (ABA) services and posted the proposed design for public comment. The benefit design was finalized for July 1, 2015, and both targeted and general outreach to providers was provided to encourage them to enroll with Vermont Medicaid. Work continued on the data collection plan for outcome measures for these services, development of an ABA supplement to the provider manual, and finalizing the ABA authorization data collection tools within an electronic record-keeping system. Staff continued to work with the AHS Medicaid Policy Unit on the upcoming State Plan Amendment submission and have continued working with DVHA Quality and AHS staff to develop a scorecard to track outcome measures related to the ABA benefit. The DVHA Managed Care Medical Committee (MCMC) reviewed and accepted a recommendation that a clinical practice guideline be developed for the Applied Behavior Analysis services covered by Vermont Medicaid. This will be developed beginning next quarter.

The Behavioral Health staff continues to collaborate with DMH in performing concurrent review and authorization for all inpatient psychiatric and detoxification services. Since assuming the responsibilities for the substance abuse residential utilization management, the Team has developed a similar collaboration with ADAP staff.

During this quarter, staff continued to solidify and improve the processes for enhanced collaboration with the VCCI. The Behavioral Health Team and the VCCI worked to develop a method by which inpatient admissions data is provided to the VCCI data analyst to mine for beneficiaries who are appropriate for VCCI services. VCCI staff and utilization review staff work collaboratively throughout the inpatient stay and after discharge to ensure that the VCCI staff is provided with contact information

for the member and facility staff; clinical documentation is also relayed to the VCCI staff as appropriate. The Team, in collaboration with VCCI management, continues to examine these collaborative processes and are working to increase efficiency. To this end, a targeted outreach to the inpatient facilities was conducted this quarter to increase awareness of the VCCI program and benefits and to reduce perceived barriers to VCCI services.

The Behavioral Health Team, in collaboration with the Clinical Operations Unit and the Quality Team completed medical record reviews and for three hybrid HEDIS measures chosen by DVHA. The measures are in the process of being validated which will inform next steps for the upcoming fiscal year.

v. Pharmacy and 340B Drug Discount Program

Key updates from QE0615:

- Vermont has realized $ $99,119.25 net cost savings for this reporting period and year to date net cost savings of $363,347.06 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 $ $99,119.25 net cost savings and year to date net cost savings of $363,347.06 through Medicaid participation of a relatively small number of eligible covered entities.

v. Mental Health System of Care

Key updates from QE0615:

- The Vermont Psychiatric Care Hospital is operating at full capacity of 25 beds.
- Soteria-Vermont has opened and is fully operational.

The Department of Mental Health (DMH) is continuing its Post-Irene work to build capacity within the inpatient and outpatient systems; expand quality and evaluation activities; and improve transitions of care. During this quarter, fourteen Level I beds at the Brattleboro Retreat and seven Level I beds at Rutland Regional Medical Center were fully operational, and, the Vermont Psychiatric Care Hospital (VPCH) operated at full capacity of 25 beds. Soteria-Vermont (see below) received final licensing and began accepting admissions during this quarter. With the completion of this final milestone, all of the psychiatric beds conceptualized and funded[2] through Act 79 of 2012 are operational.

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

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

Chart 2: Psychiatric Beds in the System of Care

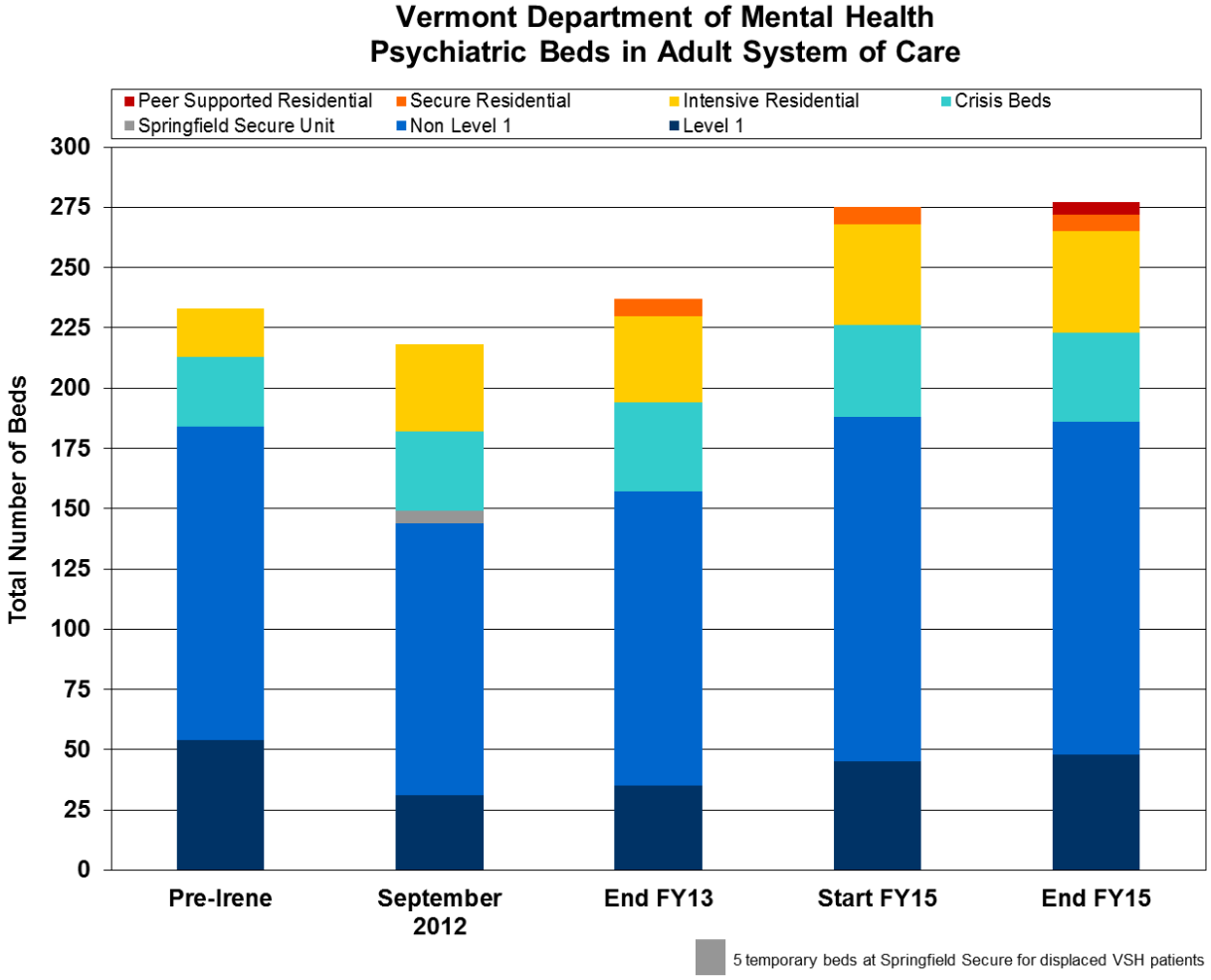


Chart 2 shows the changes in available psychiatric placements since August 2011. The total number of inpatient beds in the system at the start of SFY 2015 was 275. These include inpatient psychiatric treatment beds, residential treatment programs, crisis beds and peer-supported placements for transition.

Soteria-Vermont is the last of the facilities conceptualized in Act 79 (and funded by the legislature) to open. During this quarter, Soteria-Vermont received full licensure from the Division of Licensing and Protection as a five-bed Therapeutic Community Residence and began accepting admissions. Located in Burlington's Old North End, Soteria-Vermont offers a supportive environment for individuals going through an early experience of psychosis. The program practices a cautious and limited use of psychoactive medications and provides a safe, flexible, empowering, home-like environment.

At this time, demand for inpatient care still exceeds current capacity with some frequency. This is disruptive to the emergency care setting and not a standard that the Department regards as adequate for individuals requiring inpatient care. To address this ongoing issue, DMH is continuing to monitor the functioning of the clinical resource management system to "coordinate the movement of individuals to appropriate services throughout the continuum of care and to perform ongoing evaluations and improvements of the mental health system," as written in Act 79. This system encompasses the following functions:

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

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

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

Integrating Family Services (IFS) Initiative:
IFS was previously called Integrated Family Services; recently the name of this initiative was changed from 'Integrated' to 'Integrating.' This was to acknowledge and more clearly identify the fact that IFS is not a program, but an approach. This name shift has assisted in clarifying how the State talks about and moves IFS forward in regions.

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 all AHS children, youth and family services together in an integrated and consistent continuum for families. The premise being that giving families early support, education and intervention will produce more favorable health outcomes at a lower cost than the current practice of 'waiting until circumstances are bad enough' to access funding which often results in treatment programs that are out of home or out of state. Several efforts are underway and include: performance based reimbursement projects, capitated annual budgets, and flexible choices for self-managed services. This integration is an ongoing process that is evolving into a very positive direction for children and families.

Annual Aggregate Budgets and 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.

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

- Increased service hours overall, increased number of people served, and simultaneous reduction in requests for children's mental health crisis services.
- Stable trend line for children entering the State's custody, at the same time as the balance of the State has experienced a near doubling of that number.
- Increased ability to provide the right services to children and their families more immediately.
- Increased ability to provide services in a child's natural setting.
- Increased ability to work with a variety of providers and bring resources together to support families.
- Reduction in separate and conflicting paperwork, having a positive impact on the number of hours clinicians can spend on direct services.

- A more immediate response to families who ask for help who, prior to this pilot, were 'not sick enough' to meet funding criteria.
- Unified local efforts to offer a single onsite response to families combining multiple state and federal programs that would otherwise be offered at differing times and places.
- Initial numbers indicate an ability to serve more children and families with the same amount of resources.

The financial model supporting this agreement includes a monthly 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. Per member per month and case rates are not based on any one group of services being 'loaded' into a claim; they are global aggregate budget/minimum caseload. Annually, providers and the State will reconcile actual financial experience to the grant.

The interest in moving IFS statewide continues; there continues to be strong leadership support at the Agency level and the IFS Management Team has collaboratively created and disseminated a number of readiness documents for communities looking to move forward with implementing the IFS approach. At this time, it appears at least two regions will be ready to move forward with IFS in SFY2017. In addition to the readiness guidance, IFS has also launched five work groups related to the strategic and work plan goals set forth through June 2016. There are over 90 members across these work groups who represent state, local and community partners. Additionally, IFS continues to work on statewide health care reform and aligning approaches to achieve an integrated behavioral and physical health system.

VI. Financial/Budget Neutrality Development/Issues

AHS kicked off the FFY16 actuarially certified rate setting process during QE0615. The State has contracted work with Milliman, who will be setting the rates, and PHPG, who will be assisting in data validation of medical and pharmacy claims.

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.

In prior quarters, the State's eligibility system faced some difficulty with accurate beneficiary coding post-ACA implementation. In QE0615, there were improvements made to the functionality of proper Medicaid Eligibility Groups (MEGs) within Vermont Health Connect. This functionality was implemented for all new cases going forward, renewals or those cases that have a change of circumstance.

One issue that was identified and rectified in QE0615 related to the Aid Category Code (ACC) C9 being assigned incorrectly in Vermont Health Connect at the time of enrollment. C9 was being assigned incorrectly to enrollees as Underinsured (a GC Optional covered population) when they

should have been assigned as a CHIP enrollee. These enrollees and their relevant claims were identified and corrected in QE0615, including claims that were paid in QE0914-QE0315.

VII. Member Month Reporting

Demonstration Populations are not synonymous with MEG reporting. The numbers presented in the following table avoid duplication of population counts. To achieve this, Demonstration Populations 1, 2, and 3 may be reduced compared to their corresponding MEGs in order to draw counts for Demonstration Populations 4, 5, and 6. For example, individuals qualifying for inclusion in Demonstration Population 6 (via the appropriate placement level) may elsewhere be reported as MEG 1, 2 or 3.

Data reported in Table 4 are not used in Budget Neutrality Calculations or Capitation Payments, as information will change at the end of the quarter. The information in this table cannot be summed across quarters. All payments are adjusted at the end of the year to reconcile expected population movement between eligibility groups.

Table 4. Number of Recipients, by Month

	QE0315			QE0615		
Demonstration Population	**January 31, 2015**	**February 28, 2015**	**March 31, 2015**	**April 30, 2015**	**May 31, 2015**	**June 30, 2015**
Demonstration Population 1	36,638	36,744	36,732	36,929	37,015	36,924
Demonstration Population 2	79,924	80,564	81,010	81,594	81,846	81,872
Demonstration Population 3	53,723	55,375	56,047	56,835	57,246	57,432
Demonstration Population 4	3,015	2,971	2,905	2,959	2,879	2,809
Demonstration Population 5	893	876	877	889	885	869
Demonstration Population 6	879	913	918	913	918	931
Demonstration Population 7	7,578	7,570	7,608	7,550	7,526	7,467
Demonstration Population 8	4,332	4,306	4,344	4,276	4,273	4,257
	186,982	189,319	190,441	191,945	192,588	192,561

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 QE0615:

- DVHA Clinical and Quality Unit staff completed medical record abstraction in order to report on three HEDIS measures using the hybrid methodology.
- Work continued on three Performance Improvement Projects, all following the CMS protocols (Breast Cancer Screening, Initiation and Engagement of Alcohol and Other Drug Treatment and Follow-Up After Hospitalization for Mental Illness). An annual summary of the latter was prepared for external review and validation.
- DVHA Quality Unit staff has been trained on the use of a Results Based Accountability (RBA) scorecard tool and with DVHA leadership are discussing a scorecard development plan for performance measure data analysis and reporting.

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 in QE0615. During this period, the Committee reviewed DVHA's work plan and performance measures using a Results Based Accountability (RBA) Scorecard tool. The Committee continued to discuss standard frameworks that will allow for easier data presentation and analysis by all members of this cross-departmental work group.

The AHS Performance Accountability Committee (PAC) also met monthly during the quarter. The group finalized the Global Commitment to Health (GC) driver diagram and the Comprehensive Quality Strategy (CQS) outline. Both documents were shared with external stakeholders. Rather than developing a transition plan – Vermont has opted to have the CQS demonstrate the state's compliance with the HCBS requirements and should suffice as the Statewide Transition Plan. At the beginning of the quarter, the AHS Quality Improvement Manager (QIM) presented both documents to the Medicaid and Exchange Advisory Board. In addition, both documents were presented to the DAIL Advisory Board during the last month of this quarter. Both documents will be modified to include feedback obtained from stakeholders. Also during this quarter, the AHS PAC began to develop a full draft of the CQS. This document expands the framework identified in the CQS outline and incorporates feedback obtained to date. During the next quarter, the full version of the draft CQS will be shared with internal and external stakeholders (including a public notice process) before being sent to CMS for review.

MCE Investment Review:
During this quarter, the MCE investment work group continued to review current MCE investments. Much of this work centers on enhancing investment objectives, developing performance measures, and prioritizing data collection. In addition, separate, yet related work continues on assessing current MCE

investments for conversion to Medicaid billable administration or services when feasible. All MCE investment related work is expected to be completed by October 2015.

Results Based Accountability (RBA) Scorecard Development:
Prior to and during QE0615, the Quality Unit staff participated in an Agency initiative that has moved all departments to the point of using a common data analysis and presentation tool, or the RBA Scorecard. Staff has participated in trainings in order to learn how to build scorecards and DVHA is now embarking on a departmental scorecard development plan. The MCE Quality Committee used the scorecard during this reporting period to report out on DMH population and program level performance measures. DVHA plans in coming quarters to not only develop the scorecards for internal monitoring, but also use them for external quality reporting, both at the legislative level and on DVHA's website.

External Quality Review (EQR) Preparation:
During this quarter, review documents were sent by the EQRO to DVHA for all three EQRO required activities: Performance Improvement Project (PIP) Validation; Review of Compliance with Standards; and Validation of Performance Measures. The AHS Quality QIM participated in a technical assistance call with the EQRO and face-to-face meetings with DVHA to clarify elements contained in the PIP data collection tool. The PIP validation tool was completed by DVHA and submitted to the EQRO at the end of this quarter. Feedback and scoring is expected to take place during next quarter. Also during this quarter, the AHS QIM participated in technical assistance calls with the EQRO and DVHA to prepare for the Performance Measure Validation on-site review. During these calls, it was decided that both administrative and hybrid measures would be validated by the EQRO this year. The scope of the review was finalized and initial rates were sent to the EQRO along with requested documentation. The on-site review is scheduled for early next quarter. Finally, the AHS QIM participated in a number of calls/meetings to clarify the requirements for this year's compliance on-site review. During the quarter, all review documents were posted by the EQRO and completed/reposted by DVHA. The on-site review is scheduled for early next quarter.

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). A core committee worked closely with vendors Verisk and HSAG to develop internal policies and procedures for the MRR. DVHA contracted with Verisk to complete the record retrieval and DVHA staff completed the record abstraction using Verisk software. Abstractors were trained in early March 2015 and the MRR ran from mid-March through June 26, 2015. The hybrid HEDIS measures will be validated by HSAG in July 2015.

Formal (Validated) Performance Improvement Project:
DVHA continues to lead an AHS-wide Performance Improvement Project (PIP) on Follow-up After Hospitalization (FUH) for Mental Illness, the study indicator for which is the HEDIS measure of the same name (FUH HEDIS). During this quarter, follow-up appointment scheduling reports were again prepared and distributed to the designated hospitals and will continue to be distributed on a quarterly basis. Members of the FUH implementation team also attended the designated hospital in-person meeting in May 2015. The hospital staff in attendance recommended that the State also connect more directly with the hospital social workers over the course of this project. Preliminary (not yet validated until July 2015) calendar year 2014 FUH measure results were also shared with the implementation team by the DVHA Data Unit. 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 implementation team performed outreach to and met with staff who work with local Medicaid ACOs and FQHCs to discuss the potential for collaborative work towards better aftercare planning for Medicaid beneficiaries who are attributed to their practices. This idea will be developed further during the next quarter.

Adult Medicaid Quality (AMQ) Grant Performance Improvement Projects:

- Breast Cancer Screening (BCS) PIP:

The goal of this project is to increase the overall HEDIS rate of female Medicaid beneficiaries ages 50-74 receiving a mammogram. The BCS interventions involve a two-pronged approach aimed at both providers (gap in care lists) and beneficiaries (educational materials and grocery store gift card incentive). The DVHA Quality Unit requested and received a no-cost extension for the AMQ Grant. Therefore, the BCS PIP team extended the project for a second year. Year 2 interventions were implemented January 2, 2015 and ran through June 30, 2015. The BCS PIP team is allowing three months for claims run-out (July 1, 2015-September 30, 2015), and will run the final project results in October 2015.

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

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

The IET project's interventions also involve a two-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. Over the last quarter, the IET PIP team developed additional project activities to sustain the extension of the interventions, including additional outreach to PCPs and a full day of training for the licensed clinicians enrolled in the project. The preliminary project results will be run in May 2016.

Consumer Assessment of Healthcare Providers and Systems Survey:

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

X. Compliance

Key updates from QE0615:

- DVHA plans for the 2015 EQRO Audit.
- IGA monitoring processes are now in place.

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:
During this quarter, DVHA planned for its 2015 EQRO compliance audit, which includes an onsite review on July 15, 2015. This year's review covers the following standards:

I. Practice Guidelines, including the processes through which clinical practice guidelines are selected, created, shared and reviewed. DVHA currently has two clinical practice guidelines which cover Medication Assisted Treatment for opioid addiction and diabetes clinical practice guidelines. Additional guidelines are under consideration, which might include Applied Behavior Analysis.
II. Quality Assessment and Performance Improvement (QAPI) Program. DVHA is required to have a comprehensive quality plan/program which includes collaboration across the AHS departments responsible for delivering managed care programs. One of the primary components of this program is performance improvement. DVHA has participated in several formal performance improvement projects this year, all of which were led by the Quality Unit.
III. Health Information Systems. DVHA must maintain data systems that accurately collect and report data about utilization, member demographics, network adequacy, covered services and other data. This system must also include protections to ensure that claims are paid accurately. DVHA contracts with HP Enterprise Services to administer the Medicaid Management Information System.

IGA Monitoring Plans Compliance Committee:
AHS, DVHA and its IGA partners continue to collaborate on IGA compliance and compliance with federal managed care laws. During this quarter, the Compliance Director met with each IGA department to review their delegated activities in order to ensure compliance with federal law and to build new communication channels for compliance issues. The Compliance Director will meet formally with each IGA department at least twice per year, with informal conversations/meetings scheduled as needed. During this quarter, the Compliance Director also convened the Compliance Committee and discussed the following topics: purpose and responsibilities. During their discussions, the group agreed that it should address Agency-wide and MCE-specific adherence to Program Integrity and Global Commitment to Health Medicaid waiver regulatory guidelines. In addition, the group agreed that its recommendations should directly inform the MCE Compliance Plan. Finally, the group reviewed their following responsibilities: identifying best practices and tools for conducting Program Integrity & Regulatory Compliance audits as well as establishing, maintaining, and further developing the GC Compliance Plan.

XI. Demonstration Evaluation

The QIM continued to work with staff at the Pacific Health Policy Group (PHPG) to develop a new waiver evaluation plan. The new plan will take key evaluation elements from the previous Global Commitment to Health waiver as well as the previous Choices for Care waiver. A draft waiver evaluation plan will be submitted to CMS during the next quarter. In addition, the AHS QIM convened an evaluation work group to begin to plan for the interim evaluation report that is due upon renewal of the waiver. This document will be informed by the draft evaluation plan that is currently being developed. 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 2014.

XIII. Enclosures/Attachments

Attachment 1: Budget Neutrality Workbook

Attachment 2: Enrollment and Expenditures Report

Attachment 3: Complaints Received by Health Access Member Services

Attachment 4: Medicaid Managed Care Entity Grievance and Appeal Reports

Attachment 5: Office of the Health Care Advocate Report

Attachment 6: State Fiscal Year 2014 Managed Care Entity Investments

XIV. State Contact(s)

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

Date Submitted to CMS: August 26, 2015

ATTACHMENTS

Global Commitment Expenditure Tracking

Attachment 1 - Budget Neutrality Workbook

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 columns J:K for Budget Neutrality calculation - **Includes** New Adult	Cumulative Waiver Cap - **Excluding** New Adult per 10/2/13 STCs	Variance to Cap under/(over)
1205	$ 178,493,793														$ 178,493,793					
0306	$ 189,414,365	$ 14,472,838												$ 14,472,838	$ 203,887,203					
0606	$ 209,647,618	$ (14,172,165)												$ (14,172,165)	$ 195,475,453					
0906	$ 194,437,742	$ 133,350												$ 133,350	$ 194,571,092					
WY1 SUM	$ 771,993,518	$ 434,023												$ 434,023	**$ 782,159,845**		**$ 4,620,302**	**$ 786,780,147**	**$ 841,266,663**	**$ 54,486,516**
1206	$ 203,444,640	$ 8,903												$ 8,903	$ 203,453,543					
0307	$ 203,804,330	$ 8,894,097												$ 8,894,097	$ 212,698,427					
0607	$ 186,458,403	$ 814,587	$ (68,408)											$ 746,179	$ 187,204,582					
0907	$ 225,219,267	$ -	$ -											$ -	$ 225,219,267					
WY2 SUM	$ 818,926,640	$ 9,717,587	$ (68,408)											$ 9,649,179	**$ 802,884,359**		**$ 6,464,439**	$ 809,348,797		
Cumulative																		**$ 1,596,128,945**	**$ 1,684,861,317**	**$ 88,732,372**
1207	$ 213,871,059	$ -	$ 1,010,348											$ 1,010,348	$ 214,881,406					
0308	$ 162,921,830	$ -	$ -											$ -	$ 162,921,830					
0608	$ 196,466,768	$ 14,717	$ -	$ 40,276,433										$ 40,291,150	$ 236,757,918					
0908	$ 228,593,470	$ -	$ -	$ -										$ -	$ 228,593,470					
WY3 SUM	$ 801,853,126	$ 14,717	$ 1,010,348	$ 40,276,433										$ 41,301,498	**$ 881,729,256**		**$ 6,457,896**	$ 888,187,152		
Cumulative																		**$ 2,484,316,097**	**$ 2,604,109,308**	**$ 119,793,211**
1208	$ 228,768,784		$ -	$ -										$ -	$ 228,768,784					
0309	$ 225,691,930		$ (16,984,221)	$ 38,998,635	$ (4,144,041)									$ 17,870,373	$ 243,562,303					
0609	$ 204,169,638		$ -	$ 686,851	$ 5,522,763									$ 6,209,614	$ 210,379,252					
0909	$ 235,585,153		$ -	$ 30,199	$ 34,064,109									$ 34,094,308	$ 269,679,461					
WY4 SUM	$ 894,215,505	$ -	$ (16,984,221)	$ 39,715,685	$ 35,442,831									$ 58,174,295	**$ 935,368,819**		**$ 5,495,618**	$ 940,864,437		
Cumulative																		**$ 3,425,180,534**	**$ 3,606,430,571**	**$ 181,250,037**
1209	$ 241,939,196				$ 5,192,468									$ 5,192,468	$ 247,131,664					
0310	$ 246,257,198				$ 531,141	$ 4,400,166								$ 4,931,306	$ 251,188,504					
0610	$ 253,045,787				$ 248,301	$ 5,260,537								$ 5,508,838	$ 258,554,625					
0910	$ 252,294,668			$ (115,989)	$ (261,426)	$ 3,348,303								$ 2,970,888	$ 255,265,556					
WY5 SUM	$ 993,536,849	$ -	$ -	$ (115,989)	$ 5,710,484	$ 13,009,006								$ 18,603,501	**$ 1,012,990,839**		**$ 5,939,459**	$ 1,018,930,298		
Cumulative																		**$ 4,444,110,832**	**$ 4,700,022,174**	**$ 255,911,342**
1210	$ 262,106,988				$ -	$ 6,444,984								$ 6,444,984	$ 268,551,972					
0311	$ 257,140,611													$ -	$ 257,140,611					
0611	$ 277,708,043						$ (121,416)							$ (121,416)	$ 277,586,627					
0911	$ 243,508,248						$5,528,143							$ 5,528,143	$ 249,036,391					
WY6 SUM	$ 1,040,463,890	$ -	$ -	$ -	$ -	$ 6,444,984	$5,406,727							$ 11,851,711	**$ 1,045,342,616**		**$ 6,071,553**	$ 1,051,414,168		
Cumulative																		**$ 5,495,525,000**	**$ 5,865,213,737**	**$ 369,688,737**
1211	$ 253,147,037						$ (531,744)							$ (531,744)	$ 252,615,293					
0312	$ 267,978,672						$ 3,742	$ 49,079						$ 52,821	$ 268,031,493					
0612	$ 302,958,610							$ 6,393,928						$ 6,393,928	$ 309,352,538					
0912	$ 262,406,131							$ 7,750,994						$ 7,750,994	$ 270,157,125					
WY7 SUM	$ 1,086,490,450	$ -	$ -	$ -	$ -	$ -	$ (528,002)	$ 14,194,000						$ 13,665,998	**$ 1,134,526,550**		**$ 5,751,066**	$ 1,140,277,616		
Cumulative																		**$ 6,635,802,617**	**$ 7,113,290,903**	**$ 477,488,286**
1212	$ 282,701,072							$ 3,036,447						$ 3,036,447	$ 285,737,519					
0313	$ 285,985,057							$ 991,340						$ 991,340	$ 286,976,397					
0613	$ 336,946,361							29,814,314	$ (125,679)					$ 29,688,635	$ 366,634,996					
0913	$ 286,067,548								$ 2,162,772					$ 2,162,772	$ 288,230,320					
WY8 SUM	$ 1,191,700,038	$ -	$ -	$ -	$ -	$ -	$ -	$ 33,842,100	$ 2,037,093					$ 35,879,193	**$ 1,199,887,555**		**$ 6,260,794**	$ 1,206,148,349		
Cumulative																		**$ 7,841,950,966**	**$ 8,450,684,486**	**$ 608,733,520**
1213	$ 319,939,651								$ 3,652,767					$ 3,652,767	$ 323,592,418					
WY**9a** SUM	$ 319,939,651	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 3,652,767					$ 3,652,767	$ 319,921,780		**$ 1,214,631**	$ 321,136,411		
Cumulative																		**$ 8,163,087,376**	**$ 8,955,886,798**	**$ 792,799,422**
0314	$ 288,542,475								$ 2,159,834					$ 2,159,834	$ 290,702,309					
0614	$ 288,845,927													$ -	$ 288,845,927					
0914	$ 242,449,803								$ 337,823	$ (17,871)	$ 1,743,008			$ 2,062,960	$ 244,512,763					
1214	$ 286,853,166										$ 867,215			$ 867,215	$ 287,720,381					
WY**9b** SUM	$ 1,106,691,370	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 2,497,657	$ (17,871)	$ 2,610,223			$ 5,090,009	$ 1,108,774,682		**$ 5,086,126**	$ 1,113,860,808		
Cumulative																		**$ 9,276,948,185**	**$ 10,290,338,883**	**$ 1,013,390,698**
0315	$ 321,140,737													$ -	$ 321,140,737					
0615	$ 357,677,001										$ (526,911)			$ (526,911)	$ 357,150,090					
0915														$ -	$ -					
1215														$ -	$ -					
WY10 SUM	$ 678,817,739	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ (526,911)	$ -		$ (526,911)	$ 678,817,739		**$ -**	$ 678,817,739		
Cumulative																		**$ 9,955,765,923**	**$ 11,969,357,946**	**$ 2,013,592,023**
0316														$ -	$ -					
0616														$ -	$ -					
0916														$ -	$ -					
1216														$ -	$ -					
WY11 SUM	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -		**$ -**	$ -		
Cumulative																		**$ 9,955,765,923**	**$ 13,752,420,439**	**$ 3,796,654,516**
	$ 9,704,628,776	$ 10,166,327	$ (16,042,281)	$ 79,876,130	$ 41,153,315	$ 19,453,990	$4,878,725	$ 48,036,100	$ 8,187,517	$ (17,871)	$ 2,083,312	$ -	$ -		**$ 9,902,404,040**	$ -	$ 53,361,884			

Attachment 2 - Enrollment and 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

The Department of Vermont Health Access

Caseload and Expenditure Report ~ DVHA Only Medicaid Spend

DVHA YTD '15

Thursday July 30, 2015

	SFY '15 BAA			SFY '15 Actuals thru June 16, 2015			
	Caseload	Expenses	PMPM	Caseload	Expenses	PMPM	% of Approp. Spent to Date
ABD Adult	15,378	$ 111,329,467	$ 603.29	15,808	$ 102,508,327	$ 540.39	92.08%
ABD Dual	17,682	$ 49,095,602	$ 231.38	18,163	$ 53,518,538	$ 245.55	109.01%
General Adult	15,504	$ 87,534,771	$ 470.48	17,412	$ 88,383,933	$ 423.00	100.97%
New Adult	48,500	$ 191,135,130	$ 328.41	53,124	$ 224,311,542	$ 351.87	117.36%
Exchange Premium Assistance #	18,007	$ 7,974,888	$ 36.91	16,906	$ 5,611,465	$ 27.66	70.36%
Exchange Cost Sharing #	5,859	$ 1,372,578	$ 19.52	5,322	$ 1,138,775	$ 17.83	82.97%
ABD Child	3,713	$ 39,229,677	$ 880.37	3,612	$ 30,889,676	$ 712.66	78.74%
General Child	58,301	$ 133,584,397	$ 190.94	60,756	$ 144,338,098	$ 197.98	108.05%
Underinsured Child	1,082	$ 1,274,160	$ 98.10	927	$ 1,253,421	$ 112.68	98.37%
SCHIP	4,273	$ 7,165,946	$ 139.74	4,463	$ 7,471,592	$ 139.53	104.27%
Pharmacy Only	12,684	$ 6,571,233	$ 43.17	12,005	$ 4,914,695	$ 34.12	74.79%
Choices for Care	4,177	$ 208,784,793	$ 4,165.02	4,034	$ 208,149,276	$ 4,299.72	99.70%
Total Medicaid Claims Paid	205,162	$ 845,052,643	$ 343.25	212,530	$ 872,163,455	$ 341.98	103.21%

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

The Department of Vermont Health Access

Caseload and Expenditure Report ~ All AHS Medicaid Spend

All AHS YTD '15

Thursday July 30, 2015

	SFY '15 BAA			SFY '15 Actuals thru June 16, 2015			
	Caseload	Expenses	PMPM	Caseload	Expenses	PMPM	% of Approp. Spent to Date
ABD Adult	15,378	$ 193,276,892	$ 1,047.35	15,808	$ 185,718,082	$ 979.05	96.09%
ABD Dual	17,682	$ 201,843,736	$ 951.26	18,163	$ 216,083,619	$ 991.42	107.05%
General Adult	15,504	$ 97,628,847	$ 524.74	17,412	$ 98,968,224	$ 473.66	101.37%
New Adult	48,500	$ 209,264,433	$ 359.56	53,124	$ 246,954,265	$ 387.39	118.01%
Exchange Premium Assistance #	18,007	$ 7,974,888	$ 36.91	16,906	$ 5,611,465	$ 27.66	70.36%
Exchange Cost Sharing #	5,859	$ 1,372,578	$ 19.52	5,322	$ 1,138,775	$ 17.83	82.97%
ABD Child	3,713	$ 94,079,724	$ 2,111.29	3,612	$ 87,051,488	$ 2,008.39	92.53%
General Child	58,301	$ 240,111,188	$ 343.21	60,756	$ 267,623,445	$ 367.08	111.46%
Underinsured Child	1,082	$ 2,731,816	$ 210.34	927	$ 2,962,429	$ 266.31	108.44%
SCHIP	4,273	$ 9,918,936	$ 193.43	4,463	$ 8,775,083	$ 163.87	88.47%
Pharmacy Only	12,684	$ 6,571,233	$ 43.17	12,005	$ 4,914,695	$ 34.12	74.79%
Choices for Care	4,177	$ 208,784,793	$ 4,165.02	4,034	$ 208,149,276	$ 4,299.72	99.70%
Total Medicaid Claims Paid	205,162	$ 1,273,559,065	$ 517.30	212,530	$ 1,334,170,171	$ 523.13	104.76%

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

Attachment 3

State of Vermont
Department of Vermont Health Access
312 Hurricane Lane, Suite 201
Williston VT 05495-2807
dvha.vermont.gov

[Phone] 802-879-5900
[Fax] 802-879-5651

Agency of Human Services

Questions, Complaints and Concerns Received by Health Access Member Services
March 30, 2015 – July 4, 2015

March 30 – April 4

- Legacy Medicaid clients transitioning to VHC: CSR's assisted with the application, mailed a paper application, or advised how to complete an application online.
- PDP bills still received after transitioning to VPharm: CSR's followed the KB reference and advised accordingly.

April 6 – April 11

- Legacy Medicaid clients transitioning to VHC: CSR's assisted with the application, mailed a paper application, or advised how to complete an application online.
- Urgent System Discrepancies with DSS: CSR's sent issues to the Goold Helpdesk.

April 13 – April 18

- Legacy Medicaid clients transitioning to VHC: CSR's assisted with the application, mailed a paper application, or advised how to complete an application online.
- Urgent System Discrepancies with DSS: CSR's sent issues to the Goold Helpdesk.

April 20 – April 25

- Legacy Medicaid clients transitioning to VHC: CSR's assisted with the application, mailed a paper application, or advised how to complete an application online.
- Urgent System Discrepancies with DSS: CSR's sent issues to the Goold Helpdesk.

April 27 – May 2

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

May 4 – May 9

- Legacy Medicaid clients transitioning to VHC: CSR's assisted with the application, mailed a paper application, or advised how to complete an application online.
- VPharm bill not received, though ACCESS shows as sent: CSR's advised the amount, due date, and mailing address to send in a payment.

May 11 - May 16

- Applications: CSR's assisted in completing the application process or advised of other application channels.

May 18 – May 23

- Nothing to report.

May 25 – May 30

- Medicaid Renewals: CSR's assisted in completing the application process or advised of other application channels.

June 1 – June 6

- Pharmacy Program Review concerns: CSR's advised that the deadline has been extended as per the Recent Information Updated reference.
- Medicaid Renewals: CSR's escalated an SR for the loss of MEC or advised of other application channels.

June 8 – June 13

- Pharmacy Program Review concerns: CSR's advised that the deadline has been extended as per the Recent Information Updated reference.
- Medicaid Renewals: CSR's escalated an SR for the loss of MEC or advised of other application channels.

June 15 – June 20

- Medicaid Renewals: CSR's escalated an SR for the loss of MEC or advised of other application channels.

June 22 – June 27

- VPharm Review Extensions: CSR's reviewed the account and confirmed no other household member were active on other programs then advised of extension.
- Medicaid Renewals: CSR's escalated an SR for the loss of MEC or advised of other application channels.

June 29 – July 4

- VPharm Review Extensions: CSR's reviewed the account and confirmed no other household member were active on other programs then advised of extension.
- Medicaid Renewals: CSR's escalated an SR for the loss of MEC or advised of other application channels.

VERMONT

Agency of Human Services

Grievance and Appeal Quarterly Report
Medicaid MCE All Departments Combined Data
April 1, 2015 – June 30, 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 2, 2013, from the centralized database for grievances and appeals that were filed from April 1, 2015 through June 30, 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 16 grievances filed with the MCE; eight were addressed during the quarter and none were 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 16 grievances filed, DMH had 79%, DAIL had 14% and DVHA had 7%. There were no grievances filed for the DCF, or VDH during this quarter.

There were no Grievance Reviews filed this quarter.

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

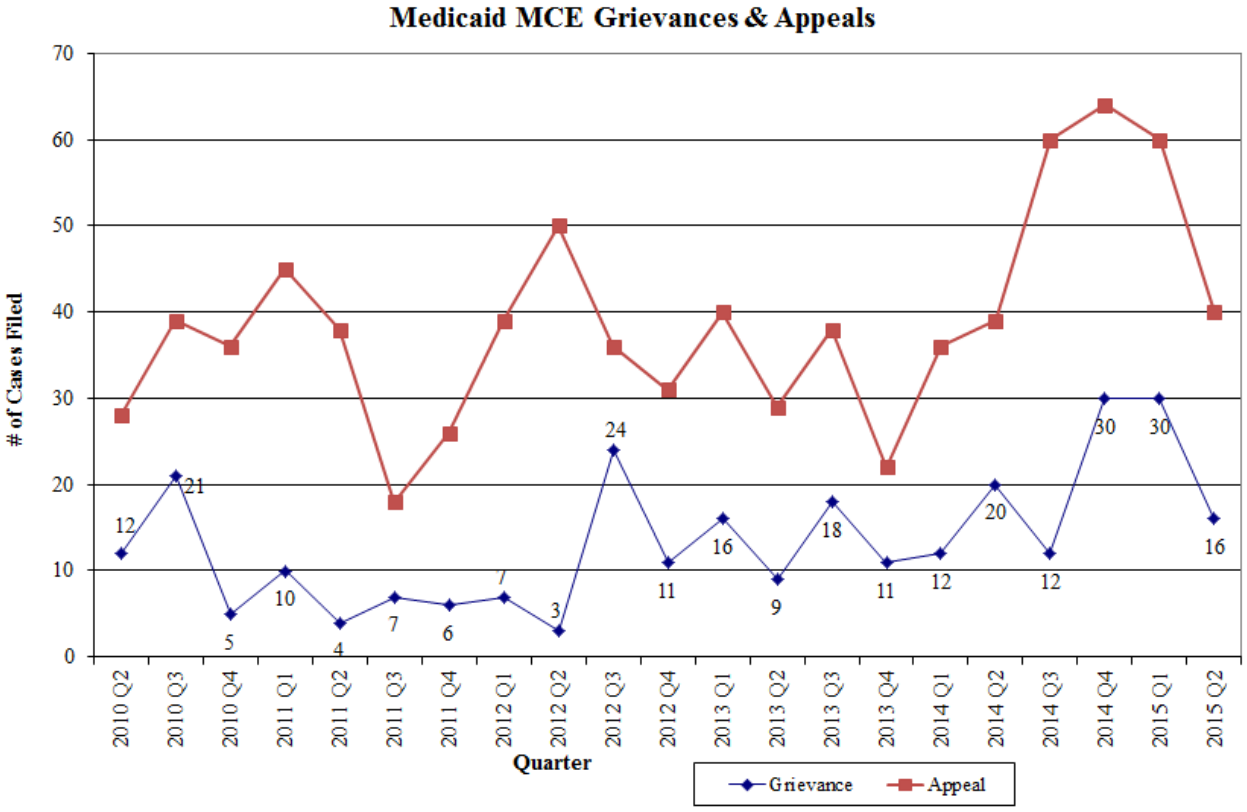
1. denial or limitation of authorization of a requested covered service or eligibility for service, including the type, scope or level of service;
2. reduction, suspension or termination of a previously authorized covered service or a service plan;
3. denial, in whole or in part, of payment for a covered 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 40 appeals filed with the MCE; 13 requested an expedited decision with eight of them meeting criteria. Of these 40 appeals, 26 were resolved (65% of filed appeals), 12 were still pending (30%), and 1 was filed too late (5%). In nine cases (35% of those resolved), the original decision was upheld by the person hearing the appeal, ten cases (38% of those resolved) were reversed, one had a modified approval (4%), and six were approved by the applicable department/DA/SSA before the appeal meeting (23% of those resolved).

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

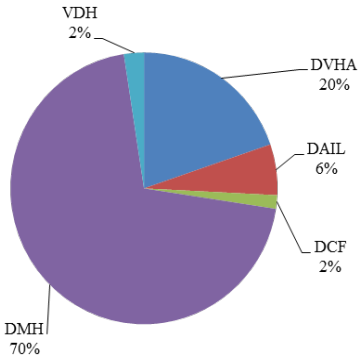
Of the 40 appeals filed, 22 were filed by beneficiaries (55%), 14 were filed by a representative of the beneficiary (35%) and 4 were filed by the provider (10%). Of the 40 appeals filed, DVHA had 73%, DAIL had 22%, and VDH had 5%.

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

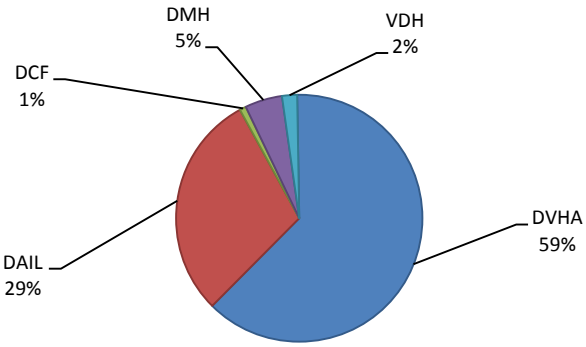


MCE Grievance & Appeals by Department
From January 1, 2008 through June 30, 2015

Grievances



Appeals



Attachment 5

VERMONT LEGAL AID, INC.

OFFICE OF THE HEALTH CARE ADVOCATE

264 NORTH WINOOSKI AVE. - P.O. BOX 1367
BURLINGTON, VERMONT 05402
(800) 917-7787 (VOICE AND TTY)
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BURLINGTON
RUTLAND
ST. JOHNSBURY

OFFICES:
MONTPELIER
SPRINGFIELD

QUARTERLY REPORT
April 1, 2015 – June 30, 2015
to the
Agency of Administration
submitted by
Trinka Kerr, Chief Health Care Advocate
July 21, 2015

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 April 1, 2015 - June 30, 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**: 1,008 calls
  - **Department of Vermont Health Access (DVHA) beneficiaries**: 298 calls or **30%** of total calls
  - **Commercial plan beneficiaries**: 350 calls or **35%**
  - **Uninsured Vermonters**: 85 calls or **8%**
  - **Vermont Health Connect (VHC)**: 508 calls or **50%** (this data report draws from the All Calls data set)
  - **Two Reportable Activities (Summary & Detail):** 168 activities, 33 documents

Overall call volume decreased 26% from last quarter, mainly due to a drop in calls in June. This halted a steady increase in calls since the launch of Vermont Health Connect.

Vermont Health Connect calls decreased 28%, but many problems continued. The technology fix at the end of May made a small dent in June's call volume. Change of circumstance cases fell 30%, and billing and invoice cases fell 22% for the quarter. Problems with invoicing and billing are the number one complaint about VHC.

We saved individual consumers $54,412 this quarter, and $600,233 in SFY 2015.

Four new rate review cases were filed, including the exchange filings, which are set for hearing on July 28th and 29th. The HCA and its independent actuary are currently analyzing those filings and preparing for the hearings.

One major Certificate of Need case went to hearing this quarter, the University of Vermont Medical Center's Replacement of Inpatient Beds. The HCA participated fully in the proceedings as an interested party.

The HCA worked hard to help Vermonters sort through many health insurance-related tax problems this quarter as the tax consequences of the Affordable Care Act went into effect. In addition to working with individual consumers, the HCA's tax attorney worked with VHC and with the Vermont Tax Professionals Association. We also created two form letters for consumers to request IRS penalty relief under two different ACA provisions. These letter templates are posted on our website.

Our website is getting more and more hits. Pageviews increased 78% over the same quarter last year. Two commonly viewed pages related to access to dental services and Medicaid income limits.

See our **recommendations** to the state at the end of the Individual Consumer Assistance section, on pages 13-15.

II. Individual Consumer Assistance

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

The HCA received 1,008 calls[1] this quarter. We divided these calls into five issue categories. The figures below are based on the All Calls data. The percentage and number of calls in each issue category based on the caller's primary issue were as follows:

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

- **18.95%** (191) about **Access to Care**;
- **14.68%** (148) about **Billing/Coverage**;
- **1.09%** (11) about **Buying Insurance;**
- **13.19%** (133) about **Consumer Education**;
- **30.46%** (307) about **Eligibility** for state and federal programs; and
- **18.87%** (218) 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 307 of our cases had eligibility for state health care programs as the primary issue, there were actually a total of 884 cases that had some eligibility issue. This is because it is possible to have multiple types of issues in a single case.

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

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

A. The HCA's overall call volume decreased 26% due to a drop in calls in June, halting the steady increase in calls since the launch of Vermont Health Connect in October 2013.

This quarter we received 1,008 calls, compared to last quarter's record high of 1,367, a 26% drop. Previous totals for this quarter were: 1,022 in 2014, 721 in 2013, and 717 in 2012. This quarter's decrease was mainly due to a 12% drop in calls in June (303), compared to June 2014 (344). April and May calls were still record highs for those months. June 2015 was the first time since November 2013 that we didn't break a monthly call volume record.

Also note that our call volume for the first six months of this calendar year is more than the total call volume we had for a full year ten years ago!

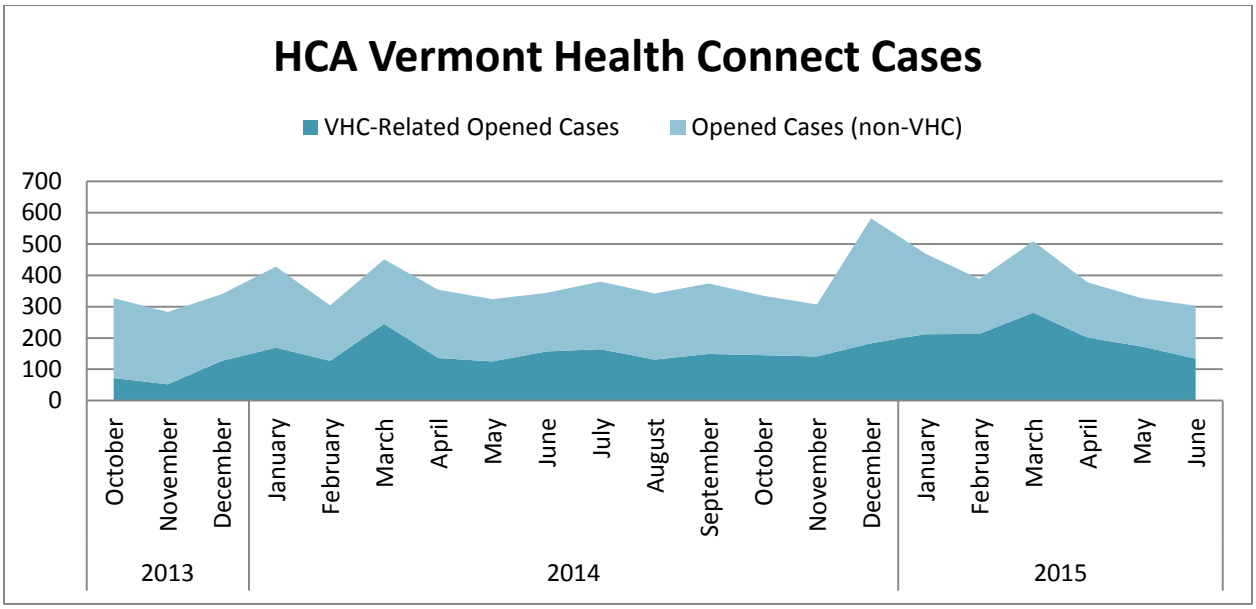
All Cases (2005-2015)											
	2005	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**
January	178	313	280	309	240	218	329	282	289	428	470
February	160	209	172	232	255	228	246	233	283	304	388
March	188	192	219	229	256	250	281	262	263	451	509
April	173	192	190	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	n/a
August	214	216	250	152	173	234	276	263	224	342	n/a
September	172	181	167	147	218	310	323	251	256	374	n/a
October	191	225	229	237	216	300	254	341	327	335	n/a
November	168	216	195	192	170	300	251	274	283	306	n/a
December	175	185	198	214	161	289	222	227	340	583	n/a
Total	**2200**	**2583**	**2560**	**2604**	**2616**	**3077**	**3209**	**3105**	**3257**	**4526**	**2375**

B. Vermont Health Connect calls decreased 28%, but many problems continued.

Problems with VHC continued, but since the technology upgrades of the Release 1 deployment at the end of May, which included the change of circumstance functionality, there has been some improvement. Our call volume did drop in June. We will have to wait and see whether the decrease in calls was the beginning of a trend or just a temporary blip.

We received 508 VHC calls this quarter compared to 706 for the previous quarter, a 28% decline. However, the VHC-related call volume was still higher than in three out of the four quarters in 2014 (541, 418, 444, and 469), and was 22% higher than the same quarter last year (508 versus 418). A real spike in VHC calls occurred in the previous quarter, specifically in March (281). VHC calls have steadily decreased since then: 201 in April, 173 in May, and 134 in June.

Half of all our calls were VHC-related, which was about the same percentage as last quarter. They involved the same types of problems described in earlier HCA reports. These mainly related to issues carrying out requested changes and billing hassles, both mostly due to VHC's inadequate technology. Some cases involved problems carried over from 2014 that had not yet been resolved; others were new. Many were complex. About 26% of the cases closed during this period were complex, i.e. took more than two hours of an advocate's time. This is the same percentage of complex cases as last quarter.



C. Change of circumstance cases fell 30% due to a drop off in June.

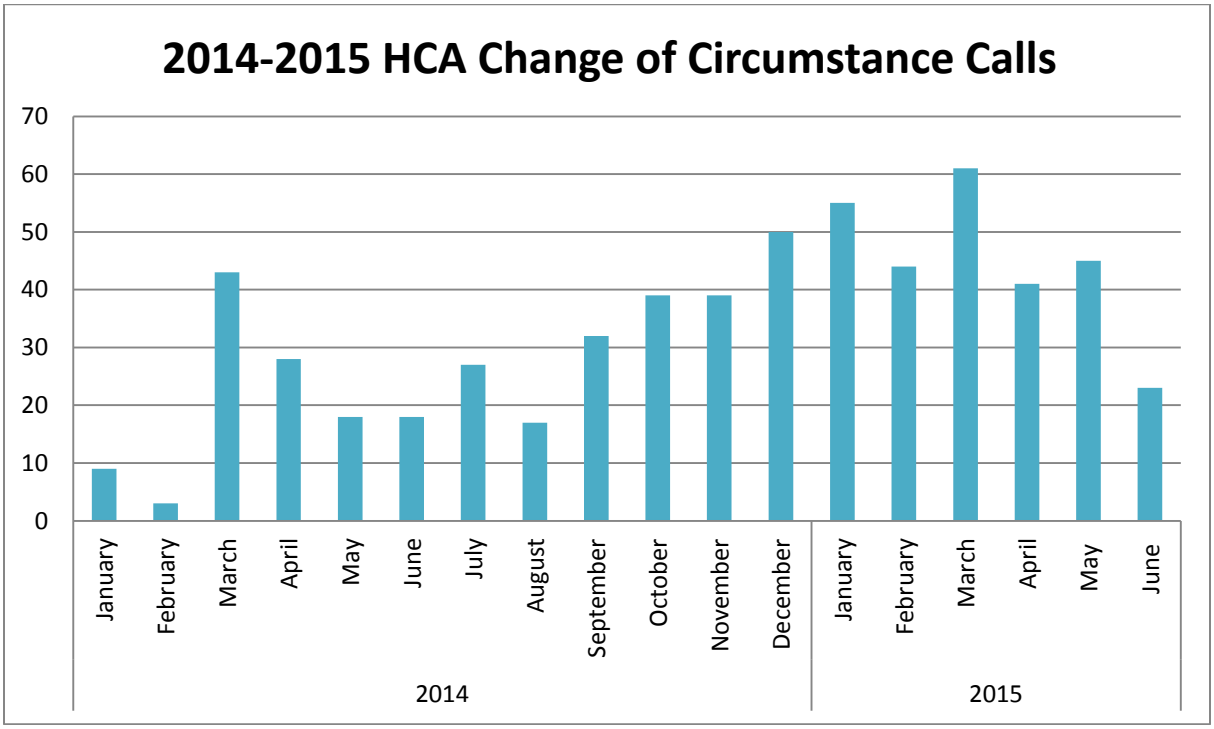
The total number of COC cases fell this quarter from 155 to 109: 41 in April, 45 in May, and June saw a 49% decrease to 23 COC calls! Last quarter the breakdown was: 55 in January, 44 in February, and 61 in March. For the sake of comparison: in all of the April to June quarter last year we only received a total of 64 COC calls, and just 18 in June 2014. The number of COC problems steadily rose after August 2014, to its apparent peak in March 2015. Since March the number of COC calls has been dropping.

VHC deployed the long awaited COC functionality as promised by May 31st. Up until that time all COCs had to be done manually, which was a difficult, time consuming and error prone process. VHC accumulated a large (about 10,000 cases) backlog of COCs which it is now steadily reducing.

Although the new COC functionality was activated starting June 1st, VHC and Member Services staff had to be trained on how to use it. Testing and training continued all through June, and VHC gradually had staff start to use the automated system. By the end of the month the new functionality seemed to be decreasing the number of newly created problems and contributing to our drop in call volume. However, there are still situations where workarounds need to be developed.

Our experience throughout June was that getting many types of COCs completed continued to be very difficult. VHC worked closely with us to expedite access to care and resolve our pending COC cases. We began to have weekly meetings with VHC staff to work through the more complex cases. By the end of June, we slowly started to see the impact of VHC's technology improvements. Some cases that had been "stuck" were finally able to be resolved.

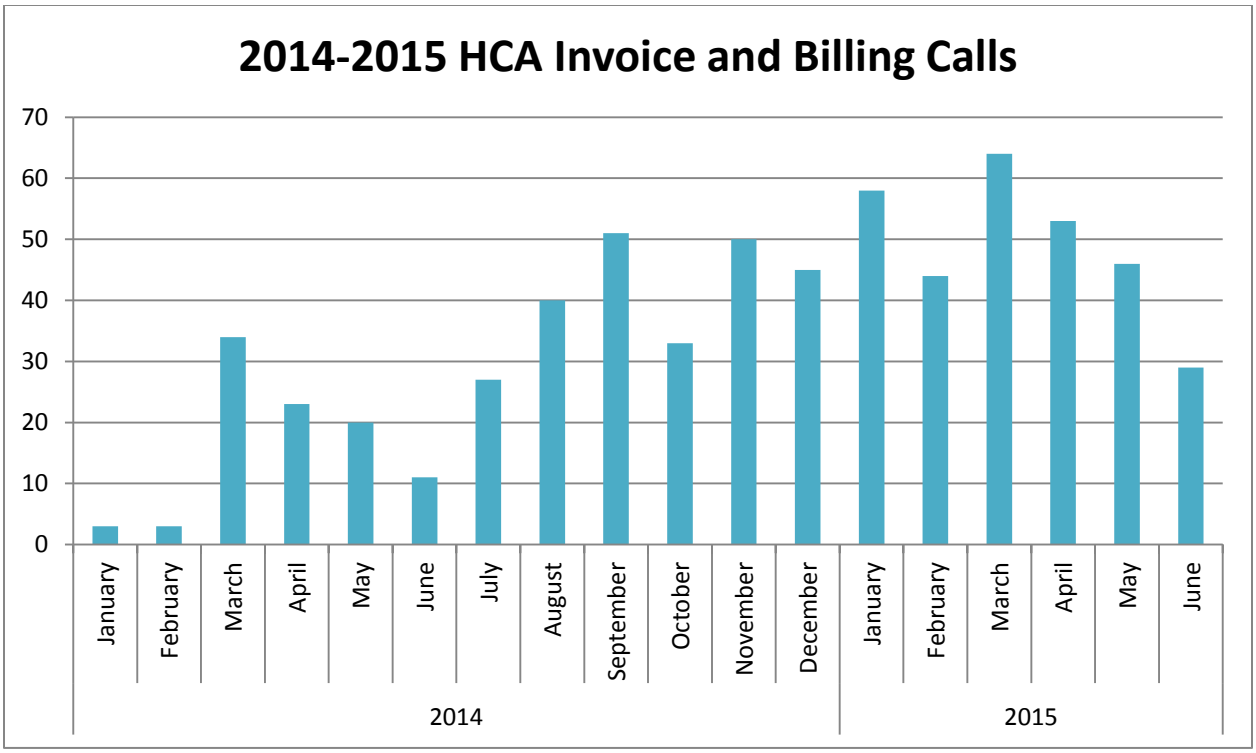
We are cautiously optimistic that in the next quarter we will see continued improvement, and Vermont consumers will, too.



D. Vermont Health Connect invoice, billing and payment problems decreased 22%.

Many consumers who purchased Qualified Health Plans (QHP) from VHC continued to have invoicing and billing problems. This was the number one complaint about VHC. The problems included non-receipt of invoices, multiple invoices in one month, 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 of these cases involved problems from 2014 that were not completely resolved, and many were related to COC difficulties.

This quarter we received 128 calls involving invoices, billing and premium processing, compared to 164 last quarter, and 125 the quarter before, when primary and secondary issues are counted. In June 2015 we received 29 billing problem calls, compared to 11 in June 2014.



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 1,008 (compared to 1,367 last quarter)

1. VHC complaints 151 calls (compared to 204 last quarter)
2. VHC Invoice/billing Problem 128 (164)
3. VHC Change of Circumstance 109 (155)
4. Complaints about providers 99 (96)
5. Information about VHC 96 (197)
6. MAGI Medicaid eligibility 79 (101)
7. VHC Premium Tax Credit eligibility 78 (137)
   Information about DVHA programs 78 (122)
8. DVHA/VHC Premium billing 65 (103)
9. Access to Prescription Drugs 58 (87)
10. VHC Renewals 56 (160)
11. Affordability issue that created an access problem 56 (117)
12. Premium Billing 54 (38)
13. IRS Reconciliation consumer education 46 (82)
14. Special Enrollment Periods 43 (43)
15. Grace Periods-VHC 42 (17)

Vermont Health Connect Calls 508 (compared to 706 last quarter)

1. VHC complaints 150 (202)
2. VHC Invoice/Payment/Billing problem 126 (164)
3. Change of Circumstance 109 (155)
4. Information about VHC 91 (196)
5. Premium Tax Credit Eligibility 78 (136)
6. MAGI Medicaid eligibility 65 (94)
7. DVHA/VHC Premium billing 62 (101)
8. VHC Renewals 55 (160)
9. Premiums billing 48 (38)
10. IRS Reconciliation consumer education 46 (82)
11. Grace Periods –VHC 42 (17)

DVHA Beneficiary Calls 298 (compared to 414) last quarter)

1. Information about DVHA programs 46 (58)
2. Complaints about Providers 43 (57)
3. MAGI Medicaid eligibility 37 (39)
4. Medicaid Billing 30 (41)
5. Access to Prescription Drugs 28 (52)
6. Medicaid eligibility 22 (23)
7. Change of Circumstance 21 (19)
8. Affordability 18 (44)
   Information about VHC 18 (21)
9. Balance billing-Medicaid 16 (13)
10. Problem with Medicaid PBM 14 (42) [Note this sharp decline in the complaints about DVHA's new pharmacy benefit manager, although there are still some problems.]

Commercial Plan Beneficiary Calls 350 (compared to 492 last quarter)

1. VHC complaints 105 (129)
2. VHC invoice/payment problem 96 (119)
3. Change of Circumstance 68 (102)
4. Information about VHC 57 (108)
5. DVHA/VHC premiums billing 54 (78)
6. Premium Tax Credit eligibility 47 (81))
7. QHP Renewals 40 (123)
8. Premium billing 38 (38)
   Grace Periods-VHC 38 (17)
9. IRS Reconciliation consumer education 37 (66)
10. Notices-confusing 31 (39)

F. Hotline call volume by type of insurance:

The HCA received 1,008 total calls this quarter. Callers had the following insurance status:

- **DVHA program beneficiaries** (Medicaid, VPharm, or both Medicaid and Medicare aka "dual eligibles") insured **30%** (298 calls), compared to 30% (414) last quarter;
- **Medicare**[2] **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 **18%** (184), compared to 19% (264) last quarter;
- **Commercial plan beneficiaries** (employer sponsored insurance, small group plans, or individual plans) insured **35%** (350), compared to 36% (492) last quarter; and
- **Uninsured** callers made up **8%** (85) of the calls, compared to 11% (150) last quarter.
- In the remainder of calls insurance status was either unknown or not relevant.

G. Dispositions of closed cases

All Calls

We closed 1,065 cases this quarter, compared to 1,340 last quarter.

- 28% (299 cases) were resolved by brief analysis and advice;
- 24% (254) were resolved by brief analysis and referral;
- 26% (278) of the cases were complex interventions involving complex analysis, usually direct intervention, and more than two hours of an advocate's time;
- 16% (168) were resolved by direct intervention, including calling an insurance company, calling providers, writing letters, gathering supporting medical documentation, etc.;
- Just 2 cases were resolved in the initial call.
- In the remaining cases, clients withdrew, resolved the issue on their own, or had some other outcome.

- Appeals: The HCA assisted 27 individuals with appeals: 2 commercial plan appeals, 17 Fair Hearings, 2 VHC expedited internal hearings, 5 DVHA internal MCO appeals and 1 Medicare appeal. Most of our cases involving VHC and DVHA problems are resolved without using the formal appeals process.

DVHA Beneficiary Calls

We closed 329 DVHA cases this quarter, compared to 395 last quarter.

- 30% (99 cases) were resolved by brief analysis and advice;
- 26% (84) were resolved by brief analysis and referral;
- 21% (70) were considered complex intervention, which involves complex analysis, usually direct intervention, and more than two hours of an advocate's time;

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

- 22% (72) were resolved by direct intervention on the caller's behalf, including advocacy with DVHA and providers, writing letters, and gathering medical information;
- No DVHA cases were resolved in the initial call.
- In the remaining cases, clients withdrew, resolved the issue on their own, or had some other outcome.

- Appeals: 24 cases involved appeals: 17 Fair Hearings, 2 VHC expedited internal hearings, and 5 internal MCO appeals.

Commercial Plan Beneficiary Calls
We closed 381 cases involving individuals on commercial plans, compared to 488 last quarter.

- 27% (104 cases) were resolved by brief analysis and advice;
- 15% (56) were resolved by brief analysis and referral;
- 35% (132) were considered complex intervention, which involves complex analysis, usually direct intervention, and more than two hours of an advocate's time;
- 19% (74) were resolved by direct intervention on the caller's behalf, including advocacy with the carrier and providers, writing letters, and gathering medical information;
- Just one call from a commercial plan beneficiary was resolved in the initial call.
- In the remaining cases clients withdrew, resolved the issue on their own, or had some other outcome.

- Appeals: 2 cases involved commercial plan appeals: one Level 1 appeal, and one Level 2. No external reviews.

H. Case outcomes

All Calls
The HCA helped 102 people get enrolled in insurance plans and prevented 16 insurance terminations or reductions. We obtained coverage for services for 30 people. We got 31 claims paid, written off or reimbursed. We helped 2 people complete applications and estimated VHC insurance program eligibility for 26 more. We provided other billing assistance to 62 individuals. We obtained hospital patient assistance for 1 person. We provided 534 individuals with advice and education. We obtained other access or eligibility outcomes for 103 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 $54,412.07** in cases opened this quarter**.** In SFY 2015, we saved Vermonters **$600,223.56.**

I. Case examples

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

1. When Ms. A filed her tax return, she learned she owed the IRS $9,000. The IRS said this was because she had received too much Premium Tax Credit (PTC) in 2014 based on her income. The IRS gave her twenty days to respond. In a panic because she did not have the $9,000, Ms. A called the HCA for help. She told the HCA advocate that she had started 2014 on a Qualified Health Plan (QHP) purchased through Vermont Health Connect, and received PTC to help pay the monthly premiums. In the spring of 2014, her husband started a new job that offered insurance, and he added her to his plan. She reported the change to VHC and stopped paying her VHC premiums, but her QHP was never terminated. At the end of the year VHC generated a 1095-A, a tax form which showed which months she had marketplace coverage and the premium tax credit received for each month. Ms. A's 1095-A incorrectly showed that she had QHP coverage and received tax credits for the entire year. She had sent this form in with her tax return, as required. After hearing her story, the HCA advocate contacted VHC and requested retroactive termination of Ms. A's QHP back to when she went on her husband's insurance. The advocate also requested a corrected 1095-A. VHC made the changes and sent Ms. A the corrected Form 1095-A. Ms. A sent the new information to the IRS and did not have to pay the $9,000.

2. A problem with the application of a grace period caused an incorrect coverage termination. Mr. B called the HCA because he did not understand why his QHP had been closed. He had paid late a few times, but knew that he had caught up on all of his monthly premium payments. The HCA advocate reviewed his payment record and found that when he had paid late, he was put into a grace period and never taken out. Individuals who receive premium tax credits get a three month grace period if they make a late payment. The only way to get out of a grace period is to get completely caught up on payments. If at the end of the three months payments are not completely up to date, then coverage can be terminated. When several late payments are made, the status of the grace period can get confusing. The advocate determined that Mr. B had indeed caught up on his payments within the three month grace period, but VHC had not taken him out of the grace period and had incorrectly closed his plan. The HCA advocate contacted VHC and pointed out the error and VHC had Mr. B's coverage reinstated the next day.

3. Ms. C called the HCA because she did not have any health care coverage for the second year in a row. In 2014 Ms. C had paid for insurance for seven months through VHC, but was never able to get the coverage activated. After a lot of back and forth, ultimately

VHC refunded her 2014 premium payments. When she filed her tax return she learned that she had to pay a tax penalty for the months that she did not have insurance. To avoid having this problem again, she tried to sign up for 2015 coverage during the open enrollment period. Because she had some issues with the VHC website, she began to worry that her application might not have actually gone through. She called VHC in March to double check the status of her application and was told that, indeed, she did not have any coverage, and that it was now too late to enroll. She called the HCA. When the HCA advocate investigated, she realized that Ms. C was eligible for a Special Enrollment Period (SEP). Because this was the first year that health insurance was tied to tax liability under the Affordable Care Act , the IRS created a new SEP for individuals who had to pay a tax penalty for not having coverage in 2014. Because Ms. C had had to pay such a penalty, she was eligible for this new SEP. The HCA advocate contacted VHC and argued that Ms. C should have been told about her eligibility for the SEP when she had called to double check her coverage. She requested that Ms. C be given the SEP with an April 1 start date, which is when she would have been able to enroll if she had been properly advised. VHC agreed. Ms. C was relieved that she finally had active coverage after more than a year of trying.

4. Mr. D was in pain and needed surgery, but he had no health care coverage. He called the HCA because he did not know what to do. He had very little income. Although he was over 65, he had not worked enough quarters to qualify for free Medicare Part A. He had not signed up for Medicare Part B either because he could not afford the monthly premiums. He had applied for Medicaid for the Aged Blind and Disabled (MABD), but was denied because he had savings in the bank over the $2,000 resource limit. He was also not eligible for MAGI Medicaid because of his age. When the HCA advocate reviewed his situation, she realized that Mr. D would be eligible for a Medicare Savings Program as a Qualified Medicare Beneficiary (QMB). The MSPs do not have resource limits, which meant that Mr. D's savings would not prevent him from getting on one of the programs. The advocate helped Mr. D fill out another application, and this time he was approved for QMB. QMB covers the costs of Medicare Part A and Part B premiums, Medicare cost-sharing and late-enrollment penalties. With QMB, Mr. D was able to get onto both Medicare Part A and Part B. The MSP also qualified him for a Special Enrollment Period for Part D, so he could get prescription drug coverage. Mr. D will now be able to have his surgery to alleviate his pain.

5. Mr. E called the HCA because he was in debt, and unable to afford care for his many medical conditions. Although he had Medicare, he was struggling to afford the premiums and the cost-sharing. He was over income for MABD, but could not afford a

supplemental plan. Medicare generally covers 80% of medical expenses, but he had to pay the remaining 20%. He was also having trouble paying his Medicare Part B premiums of $104.90 per month. His income was too high to qualify for any of the state programs that would help pay for his Part B premium, the Medicare Savings Programs. In fact, he had been on an MSP but had been terminated from the program because his earned income increased slightly. The HCA advocate realized that Mr. E should have been screened for another program that would cover his cost-sharing and also give him more complete coverage. Because he had a part-time job, Mr. E was eligible for Medicaid for the Working Disabled, which has a higher income limit than MABD. The advocate helped him with the application and requested a rush on it. Mr. E was found eligible for MWD within days. Medicare will continue to cover 80% of his medical expenses, and Medicaid will cover the remaining 20%. Having Medicaid coverage also means that Mr. E can now have some dental coverage which will allow him to start seeing a dentist again, and the cost-sharing savings will make it easier for Mr. E to afford his Part B premiums.

6. Mother has difficulty getting continuous glucose monitor for child with diabetes. Ms. F's school age child had diabetes, and his doctor wanted him to switch from an insulin pump to a continuous glucose monitor. The doctor believed that the new monitor would be better for managing his diabetes. Ms F had been working for almost six months to get the glucose monitor approved by Medicaid. The provider said they submitted the prior authorization request numerous times, but still had not gotten a decision. DVHA was telling Ms. F that it had not received any prior authorization requests. Ms. F felt she was going around in circles so she called the HCA. The HCA advocate contacted DVHA on the family's behalf and asked it to review its prior authorization requests to see if any had been submitted by this provider. DVHA found and approved the prior authorization request that day. Ms. F was finally able to get the new monitor for her child.

J. Recommendations to the State of Vermont

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

We are still seeing many problems with invoicing and billing. This was the second quarter that the number of invoice and billing complaints exceeded the number of COC complaints. It is not clear whether these problems are due to issues with VHC or Benaissance (VHC's premium processer), or both. In any case, for many people the system is not working well. The problems included non-receipt of invoices, multiple invoices in one month, 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. Sometimes there is a time lag and lack of accuracy in the transmittal of payment information from VHC to the carriers, which affects whether the carriers are willing to provide coverage. This has become more critical now that all three carriers (BlueCross Blue Shield of Vermont, MVP, and Northeast Delta Dental) are making greater attempts to enforce premium payment grace periods and are terminating coverage more frequently based on payment information from VHC.

VHC should consider eliminating the middleman premium processor, and allowing payment directly to the carriers

2. *Review the carriers' grace period notices and require clarifications and improvements as necessary.*

Consumers have reported confusion about the meaning of the grace period notices they have received when they fail (or VHC or the carriers think they've failed) to make timely premium payments. Grace period notices are sent by the carriers and not VHC, even though VHC is responsible for processing and tracking premium payments. VHC should review these notices and work with the carriers and stakeholders to make sure they are in plain language, clear, and consistent with the Health Benefit Eligibility and Enrollment (HBEE) regulations.

3. *Follow through on the implementation of the proper Federal Poverty Levels for MAGI Medicaid and Dr. Dynasaur.*

This year the State of Vermont did not begin determining eligibility for MAGI Medicaid and Dr. Dynasaur using 2015 FPLs until June 17, 2015.[3] The federal Department of Health and Human Services issued the 2015 FPLs in February. The HCA and the Medicaid and Exchange Advisory Board pressed VHC to implement the new FPLs for several months.

VHC's failure to use the 2015 FPLs until four months after they were issued means that some individuals who may have been eligible for Medicaid and Dr. Dynasaur could have been found ineligible, and may not be getting the benefits to which they are entitled. They could be unnecessarily paying premiums and cost sharing for QHPs, when they could be on Medicaid.

We know VHC is working on how to identify these applicants and make them whole, but we want to make sure it happens as quickly as possible. And, we want to make sure that in the

[3] This delay did not affect the determination of Premium Tax Credits because PTC for 2015 coverage is based on 2014 FPLs. Medicaid for Children and Adults (MCA, aka MAGI Medicaid) uses the current year's FPLs.

future the FPLs are implemented in a timely manner. VHC has said that it will implement the new FPLs by April 1 each year starting in 2016, and we want to make sure that happens as well.

4. *Work with stakeholders to improve and clarify the processes and regulations for eligibility for long term care services and supports.*

As the SOV knows, Vermont Legal Aid had some concerns about the most recent round of Health Benefit Eligibility and Enrollment (HBEE) regulations. At the Legislative Committee on Administrative Rules (LCAR) meeting in June, the SOV agreed to work with us to clarify how eligibility and coverage is supposed to work for all the waiver programs in light of the new HBEE rules. We are mentioning this ongoing effort here as a "recommendation" in order to emphasize the importance of the SOV's commitment to work with us to clarify these eligibility processes and improve the HBEE or other regulations.

III. Consumer protection activities

A. Rate review work

The HCA monitors insurance carrier requests for premium rates, which are usually rate increases. Carriers filed four new rate review cases with the Green Mountain Care Board in this quarter. The HCA entered Notices of Appearance in three of these cases. None of the cases was ready for hearing during the quarter.

We submitted memoranda and the Board issued decisions in four pending rate filings. In all four cases, the Board reduced the requested rates. All of the Board's decisions were consistent with arguments we made for reducing the rates.

The most important pending rate review cases are the two filings for 2016 plans that will be offered on Vermont's exchange, Vermont Health Connect, by Blue Cross Blue Shield of Vermont and MVP. The carriers filed their requests for rate increases on May 15, 2015, and the Board will issue its decisions by August 13, 2015. Hearings are scheduled for July 28 and July 29, 2015 at the Green Mountain Care Board. The HCA has filed Notices of Appearance in both cases.

The HCA has been working closely with its independent actuary, Donna Novak of NovaRest, Inc., to analyze the Exchange filings, suggest questions for the Board's actuaries to pose to the carriers, and to prepare for the hearings.

B. Certificate of Need Applications

The HCA also monitors all the Green Mountain Care Board's Certificate of Need review proceedings. Between April and June of 2015, we primarily participated in two pending CONs as

an interested party: the University of Vermont Medical Center's Replacement of Inpatient Beds and the Northwestern Medical Center's Office Building.

UVMC's Replacement of Inpatient Beds CON went to hearing in May. We prepared for and participated in the two days of hearings. We reviewed and analyzed all the case materials, including the independent architectural report and financial report prepared for the Board. We met with representatives from the Vermont Federation of Nurses and Health Professionals regarding their concerns with the proposed project, and held discussions with representatives from the mental health advocacy community and consumer protection organizations to learn their perspectives on the project. These discussions included Disability Rights Vermont, which the Board gave Amicus Curiae status for the proceedings.

At the UVMC Inpatient Bed CON hearing, the HCA participated as an interested party, including cross examining the witnesses. After the hearing we submitted a post-hearing memo which presented the HCA's analysis of the project. We supported the plan to increase single patient rooms, but stated our concerns that the proposed project would increase costs for patients. We also expressed concern that UVMC did not adequately address the shortage of inpatient psychiatric beds and other shortcomings with the psychiatric unit when it developed this proposal. In addition, we urged the hospital to incorporate staff of all levels and community members in the planning process going forward, and to focus on the community issues stated in its latest Community Health Needs Assessment.

In June, we submitted questions to the Board for Northwestern Medical Center regarding their Office Building CON project. Our questions focused largely on energy efficiency measures, opportunities for staff and community involvement in the planning process, budgetary impacts of the project, the impact of the project on community issues identified in the hospital's latest Community Health Needs Assessment, what services will be provided in the new space, how all space created by the project will be utilized, and how patients can determine their insurance coverage for services out of the emergency room compared to the urgent care center.

C. Other Green Mountain Care Board activities

The HCA continues to participate in the Board's regulatory responsibilities beyond our rate review and CON work. For example:

- The HCA continued to monitor proposed legislative changes to the Board's duties as the legislative session came to a close;
- We submitted formal public comments to the Board on the Vermont Health Care Innovation Project (SIM grant) self-evaluation process. We suggested a number of ways in which the self-evaluation plan could improve its consumer component and include a broader range of consumer voices. The Board incorporated our suggestions into the plan that it passed, contingent upon renegotiation of the scope of work with the evaluation contractor.
- We also submitted formal comments suggesting changes to the Board's website. Our comments focused on ways the Board can make it easier for consumers to access

information about the Certificate of Need and Rate Review processes through the website. The Board says it is in the process of working on its website to incorporate our suggestions.

- We attended seven weekly Green Mountain Care Board meetings, reviewed the video recording from two Board meetings that we could not attend, met with the Board's staff to discuss current health care legislation proposals and other consumer protection priorities, and attended three Data Governance Committee meetings.

D. Vermont Health Care Innovation Project

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

- Participated in 3 meetings as a member of the VHCIP Steering Committee
- Participated, along with representatives from other projects of Vermont Legal Aid, as "active members" in 6 of the 7 VHCIP work groups:
    - Payment Models Work Group
    - Quality and Performance Measures Work Group
    - Population Health Work Group
    - Care Models and Care Management Work Group
    - Disability and Long Term Services and Supports Work Group
    - Health Information Exchange/Health Information Technology Work Group
- Attended 12 VHCIP work group meetings
- Attended 4 meetings of the VHCIP Core Team as an interested party
- Attended 1 meeting of the SIM Self-Evaluation Committee and 2 informal meetings with SIM staff about the self-evaluation plan
- Attended the VHCIP Symposium (sub-grantee reports)
- Attended the VHCIP Convening about the grant's year 2 milestones and plans for their achievement
- Completed an evaluation interview with RTI, the contractor completing the federal evaluation of Vermont's SIM grant

E. Affordable Care Act Tax-related Activities

The federal Affordable Care Act made tax law newly important to effective health advocacy. It imported tax concepts into Medicaid, created a new federal tax credit to subsidize private health insurance purchased through health benefit exchanges, and created a tax penalty for failure to have insurance coverage. In October 2014, the HCA partnered with the Low Income Taxpayer Project at Vermont Legal Aid to engage in education, outreach, and advocacy relating to the Affordable Care Act. This partnership continued during the reporting period.

During this quarter, the HCA continued to employ a half-time tax attorney, who also staffs the Low Income Taxpayer Project at VLA. This allowed the HCA to stay up to date on legal

developments and educate our staff to effectively field calls related to the ACA and Vermont Health Connect. In addition, the tax attorney consulted with HCA advocates when particularly difficult tax issues arose in HCA cases.

In 2015 we saw the first tax season where consumers had to report to the IRS on their health insurance coverage and reconcile any advance payments of the Premium Tax Credit (APTC). Vermont Health Connect (VHC) and other health insurance marketplaces sent tax form 1095-A to consumers and to the IRS. Form 1095-A reports the details of a person's health insurance coverage and the details of any advance payments of the Premium Tax Credit (APTC).

It was a rocky start for the new tax form, as detailed in HCA's previous quarterly report. Many 1095-A forms arrived late or were incorrect. Some consumers discovered when they got their 1095-A that VHC had not processed a coverage change or a plan cancellation that they'd requested in 2014. VHC staff worked hard to correct mistakes as quickly as possible, but the problems were numerous and in some cases difficult to fix. The HCA helped many consumers get account changes made and get amended tax forms from VHC. Still, some people had to file extensions, and some had their tax return processing held up.

A second problem also emerged. Since a person's APTC was based on projected 2014 income, which may have been estimated as early as October 2013, many discovered that they received too much or did not qualify for APTC at all. One Vermont consumer who called the HCA had to repay over $10,000 in subsidies. Many people could not afford to pay their bill by April 15.

The IRS issued FAQ and two different forms of penalty relief to address these problems. First, IRS announced late payment forgiveness for some people who got too much APTC. Later, IRS posted FAQ and announced late payment forgiveness for people whose taxes were affected by a late or incorrect 1095-A. The HCA and Vermont Legal Aid's Vermont Low Income Taxpayer Project (LITP) developed two simple handouts to help people see if they qualify and request penalty relief if they do. When printed double-sided, the handout has instructions on one side and a form letter that clients can use on the other. These handouts are posted on the Health Insurance, Taxes and You page of Vermont Law Help (click on Late Payment Penalties).

During this quarter, the HCA frequently answered tax-related questions from VHC, tax preparers, health assisters, advocates in other states, Congressional caseworkers, and from Vermont consumers. The volume of questions addressed to the tax attorney was lower than last quarter, but still significant (64 compared to over 100 last quarter). This quarter, many of the questions involved Form 1095-A, IRS tax return processing and audit procedures, the advance Premium Tax Credit allocation rules, or the Individual Shared Responsibility Payment. Several consumers received IRS notification that their tax return could not be processed due to issues related to advance payments of the Premium Tax Credit (APTC). Some of these cases involved consumer error, e.g. a child who was named on a 1095-A unbeknownst to the parent claiming that child, and some cases involved late or incorrect forms 1095-A. Other cases were flagged by the IRS for APTC allocation issues, even where the tax return and 1095-A were correct.

The HCA tax attorney also consulted frequently with the HCA advocates as they assisted individuals with ACA tax questions and problems.

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.

HCA continued to communicate with VHC regarding substantive issues as they arose. This quarter, one major issue was the effect of retroactive 2014 account changes on Forms 1095-A (and thus consumers' tax returns). VHC had not finished its 2014 change of circumstances backlog at the time the initial Forms 1095-A were generated, and this issue continued through the current quarter as VHC initiated retroactive coverage terminations in April and May. HCA participated in weekly 1095-A stakeholder calls through April. We also continued our advocacy on proposed revisions to DCF's Health Benefits Eligibility and Enrollment Rule, which implements the Affordable Care Act in Vermont.

F. Other Activities

Blog Post on Penalty Relief and Premium Tax Credit Reconciliation
The HCA's tax attorney authored a blog post, edited by Villanova Tax Professor T. Keith Fogg, on the IRS's penalty relief policy for individuals who received excess advance payments of the Premium Tax Credit (APTC). The post appeared on the tax procedure blog *Procedurally Taxing.* In it, the HCA criticizes the IRS's policy for its complexity and describes the barriers that may prevent deserving consumers from getting relief. The blog post also suggests improvements that could be made to the policy.

Rule 09-03 Work Group
The HCA is one of the stakeholders participating in this work group which was set up in Act 54 of the 2015 legislative session. The work group will 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 in other regulations governing quality and consumer protection. The group will also assess which state entity is the appropriate one to be responsible for functions set forth in the regulations. The group held its first meeting during the quarter.

2017 Qualified Health Plan Work Group
The HCA is participating in this stakeholder group which was convened by the Department of Vermont Health Access to help DVHA develop any recommended changes to benefit design for Qualified Health Plans offered on Vermont Health Connect in 2017. The group met three times during the quarter.

Other Boards, Task Forces, and Work Groups
This quarter the HCA participated in:

- 2 meetings of the Gateways national consumer advocacy group for state-based marketplaces
- 3 Qualified Health Plan Stakeholder Work Group meetings
- 3 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)
- 3 MEAB Individuals and Families Work Group meetings
- 1 informal meeting with Donna Sutton Fay and Jackie Majoros about the MEAB
- 1 VHC Consumer Experience Work Group meeting
- 1 VHC Customer Support meeting with Maximus, VHC, DVHA and HAEU
- 1 meeting about VHC tax issues
- 1 Health Insurance Consumer Protection 09-03 Review Work Group meeting

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

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

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

This quarter, HCA staff:

- Testified before legislative committees 9 times
- Submitted 1 set of written comments/testimony
- Met informally with legislators about legislative initiatives
- Regularly met and collaborated with other advocates on legislative initiatives, including participation in the Surrogate Decision Making working group and the Oral Health Care for All legislative team
- Met with the Speaker of the House regarding access to oral health care
- Attended:
    - 5 meetings of the Senate
    - 4 meetings of the House of Representatives
    - 1 meeting of the House Democratic Caucus
    - 4 meeting of the House Committee on Appropriations
    - 12 meetings of the House Committee on Health Care
    - 1 meeting of the House Committee on Human Services
    - 7 meetings of the House Committee on Ways and Means
    - 4 meetings of the Senate Committee on Appropriations

- 6 meetings of the Senate Committee on Finance
- 1 meeting of the Senate Committee on Government Operations
- 6 meetings of the Senate Committee on Health and Welfare

Administrative Advocacy

This quarter, the HCA:

- Submitted 1 formal comment on VHC's Special Enrollment Period rules
- Raised 3 substantive legal issues with AHS regarding proposed final VHC regulations in Bulletin B15-02FP
- Participated in weekly 1095-A check-in phone calls

This quarter, the HCA:

- Submitted formal comments on VHC regulations
- Met with VHC about implementation of 2015 federal poverty levels
- Met with VHC about the escalation path for cases
- Participated in 2 Health Insurance Marketplace Statement (1095-A) calls
- Corresponded with AHS policy analysts about the proposed HBEE rule and successfully advocated for changes to the rule
- Advocated for policy changes on VHC tax issues
- Discussed VHC policies and practices regarding plan reinstatement and IRS reporting (1095-As) for certain 2014 QHPs

Collaboration with other organizations

The HCA worked with the following organizations this quarter:

- American Bar Association Section of Taxation, Individual and Family Tax Committee
- American Civil Liberties Union (ACLU)
- Campaign for Health Care Security
- Community Catalyst
- Community of Vermont Elders
- Disability Rights Vermont
- Families USA
- IRS Affordable Care Act Office
- IRS Office of Chief Counsel
- IRS Taxpayer Advocate Service
- Peoples Health and Wellness Clinic
- Planned Parenthood of Northern New England
- Vermont Association of Hospitals and Health Systems
- Vermont Oral Health Care for All Coalition
- Vermont Campaign for Health Care Security
- Vermont Dental Hygienists' Association
- Vermont Health Connect
- Vermont Information Technology Leaders
- Vermont Low Income Advocacy Council (VLIAC)

- Vermont Public Interest Research Group
- Vermont Technical College
- Villanova Law School
- Voices for Vermont's Children

Trainings

- 5/1: Consumer's Union Provider Payment Reform Webinar
- 5/12: Consumer's Union Rate Review Conference Call
- 6/5: Legislative Advocacy Training at Vermont Legal Aid Staff College
- 6/22: Legislative Council Vermont Legislative Review
- 6/22: Community Catalyst Hospital Billing Rules Webinar

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 78% in the reporting quarter ending March 31, 2015 (5,252 pageviews), compared with the same quarter in 2014 (2,952 pageviews).
- Like last quarter, the number of people seeking information about dental services increased significantly (306%) over last year. (191 pageviews this quarter, compared with 47 in the same period last year)
- This quarter, again like last quarter, showed a huge increase over last year in the number of people seeking information about Medicaid income limits (1,366 pageviews this quarter, compared with 86 in the same quarter in 2014, an increase of 1,488%). We believe that search engines are delivering this page as a high-ranking source of information about Medicaid income limits.
- Nine of the 15 pages that had the largest number of pageviews focus on Medicaid or long-term care Medicaid (Choices for Care) topics.
- Other topics presented in the top 15 pageviews include:
    - Health home page (+52%)
    - Health Insurance, Taxes and You (New this year/no comparative data)
    - Medical Decisions, Advance Directives and Living Wills (+53%)

- Buying Prescription Drugs (+132%)
- Complaints (things to consider before making a complaint against a provider) (+113%)

PDF Downloads
Thirty-eight out of 76 PDFs downloaded from the Vermont Law Help website were on health care topics. Of those 38 PDFs:

- 21 were created for consumers. The top consumer-focused downloads were:
  - Advance directive, short and long forms
  - Vermont dental clinics chart
  - Advance Premium Tax Credit (APTC) IRS penalty waiver request letter template with instructions
- 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, Nov 2014
  - Tax Issues for Health Assisters Form 8965 Example
- 6 covered topics related to health policy. The top advocate-focused downloads were:
  - Accountable Care Organizations - What is the Evidence?
  - Health Literacy and Plain Language

Our Vermont Dental Clinics Chart was the seventh most downloaded of all PDFs, not limited to health, and our policy paper, Accountable Care Organizations – What is the Evidence?, was ninth.

B. Education

During this quarter, the HCA provided education materials, presentations, and public service announcements both directly to consumers and to individuals and organizations who serve populations that may benefit from the information and education provided. The materials we developed have been shared with health and tax advocates in Vermont and nationwide, and posted to our website.

Flyers, Letter Templates, Other Printed Material
In April, we developed a simple, easy-to-understand template letter that consumers can use to request IRS late-payment-penalty relief resulting from the inability to repay excess Advance Premium Tax Credit (APTC) payments by the April 15 deadline.

We wrote an article that was published in the April issue of Vermont Legal Aid's newsletter, *Justice Quarterly*, which explained the requirement to pay back excess APTC. The article included a link to the template letter consumers can use to request abatement of late payment penalties.

Also in April, the HCA wrote a guest post, *Penalty Relief and Premium Tax Credit Reconciliation*, on a widely read tax procedure blog, Procedurally Taxing.

In June, we produced another simple, easy-to-use template letter that consumers can use to request IRS late-payment-penalty relief. In this case, the letter assists those who were unable to pay their taxes by the April 15 deadline because they did not receive the required 1095-A form on time or because the form they received was wrong.

Presentations

During this quarter, the HCA provided education to more than 100 individuals who serve populations that may benefit from the information and education provided.

Fletcher Free Library (May 4)
The HCA presented at an outreach event for nonprofit and social service agencies offered by navigators from Planned Parenthood of Northern New England and the Vermont Campaign for Health Care Security Education Fund. One staff person from an addiction recovery center attended the program, which provided current information about who can enroll in VHC, how to apply, and how the HCA can help.

American Bar Association Tax Section Meeting (May 8)
The HCA's tax attorney collaborated with the IRS Taxpayer Advocate Service, IRS Office of Chief Counsel, and IRS Wage & Investment's Office of Program Coordination & Integration to present ACA: Implementation Issues Affecting Individuals and Families. The presentation, sponsored by the Individual and Family Taxation Committee, was given to 40 tax attorneys and tax professionals at the May meeting of the ABA Tax Section. Topics included tax assessment and collection issues related to the Premium Tax Credit and the Individual Shared Responsibility penalty, controversy issues for practitioners, IRS communications and partner resources, and the Taxpayer Advocate's leading concerns. The presentation PowerPoint was posted on the VT Law Help public website.

Vermont Tax Professionals Association (May 19)
The HCA announced resources available on HCA's "ACA for Assisters" site and encouraged referrals to the HCA at the May meeting of VTPA, attended by 59 CPAs, enrolled agents, unenrolled tax preparers, and attorneys.

Attachment 6 - MCE Investments SFY14

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

SFY14 Final MCO Investments

8/27/14

MCO Investment Expenditures

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