

State of Vermont
Agency of Human Services

Global Commitment to Health
11-W-00194/1

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

Quarterly Report for the period
July 1, 2015 – September 30, 2015

Submitted Via Email on November 30, 2015

Table of Contents

- I. Background and Introduction 3
- II. Enrollment Information and Counts 4
- III. Outreach Activities 5
- IV. Operational/Policy Developments/Issues 6
- V. Expenditure Containment Initiatives 11
- VI. Financial/Budget Neutrality Development/Issues 27
- VII. Member Month Reporting 27
- VIII. Consumer Issues 28
- IX. Quality Improvement..... 29
- X. Compliance 32
- XI. Demonstration Evaluation 33
- XII. Reported Purposes for Capitated Revenue Expenditures 34
- XIII. Enclosures/Attachments 34
- XIV. State Contact(s)..... 35

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 third quarterly report for waiver year 10, covering the period from July 1, 2015 through September 30, 2015 (QE0915).*

II. Enrollment Information and Counts

Key updates from QE0915:

- 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.

Table 1 is populated based on reports run the Monday after the last day of the quarter, in this case on October 5, 2015. Results yielding $\leq 5\%$ fluctuation from quarter to quarter are considered as illustrating normal deviations reflecting retroactive eligibility determinations and expected terminations. Results reflecting $> 5\%$ fluctuation between quarters are reviewed by staff from DVHA and AHS to provide further detail and explanation of the changes in enrollment. The explanation of any substantial fluctuations observed in Demonstration Populations during QE0915 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*, QE0915

Demonstration Population	Current Enrollees Last Day of Qtr	Previously Reported Enrollees Last Day of Qtr	Percent Variance 6/30/2015 to 9/30/2015	Variance by Enrollee Count 6/30/2015 to 9/30/2015
	September 30, 2015	June 30, 2015		
Demonstration Population 1:	37,584	36,924	1.79%	660
Demonstration Population 2:	83,453	81,872	1.93%	1,581
Demonstration Population 3:	58,457	57,432	1.78%	1,025
Demonstration Population 4:	2,799	2,809	-0.36%	(10)
Demonstration Population 5:	894	869	2.88%	25
Demonstration Population 6:	905	931	-2.79%	(26)
Demonstration Population 7:	7,399	7,467	-0.91%	(68)
Demonstration Population 8:	4,246	4,257	-0.26%	(11)
	195,737	192,561	1.65%	

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

III. Outreach Activities

i. Member Relations

Key updates from QE0915:

- A banner was published notifying providers that enrollment application would be accepted for Licensed Alcohol and Drug Counselors beginning October 1, 2015
- New Provider Enrollment and Revalidation requirements as of September 1, 2015
- New requirements for Non-Emergency Medicaid Transportation as of July 1, 2015 The Medicaid and Exchange Advisory Board met twice in this quarter.

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

A banner was published notifying providers that The Department of Vermont Health Access (DVHA) will begin accepting applications from Licensed Alcohol and Drug Counselors (LADC) to become enrolled as Vermont Medicaid providers with an effective date of October 1, 2015. This increased the network of providers for our members.

As of September 1, 2015 DVHA implemented new requirements for Provider Enrollment and Revalidation in accordance with the Federal Affordable Care Act 42 CFR 455 Subpart E Provider Screening in order to strengthen safeguard against improper payment and harm to members. Enrollment term will be up to five (5) years after use of new forms and process, Enrollment forms are the same for revalidation and new enrollment, New application for billing providers, Abbreviated application for non-billing providers (e.g. Ordering, Prescribing, Referring and Attending), Enrollment application for Medicare-enrolled providers submitting crossover claims only, Disclosing Entity form for persons with an ownership or controlling interest, managing employees and agents, New general provider agreements and Special provisions by provider type. There is a web page dedicated to the New Enrollment/Revalidation: <http://www.vtmedicaid.com/Enrollment/enrollmentIndex.html#/>

As of July 1, 2015, the mileage limit for Non-Emergency Medicaid transportation for out-of-area/out-of-state referrals increased from 30 miles to 60 miles. If a Vermont Medicaid member has a Medicaid-billable appointment at a participating provider greater than 60 miles from their residence, the referring provider is required to fill out the Physician Referral Form. This form is not required if the appointment is located within the 60 mile limit.

The Medicaid and Exchange Advisory Board (MEAB) held meetings on July 27, 2015 and September 28, 2015 No meetings are held in August. 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 QE0915:

- Operational staff used new functionality to clear the backlog of customer change requests which had grown as high as 10,272 in May.
- The State completed the transition of Vermont Health Connect's system hosting services from CGI to Optum in September and focused on developing and testing two system upgrades which would support the renewal process for QHP and Medicaid customers.

At the end of QE0915, Vermont Health Connect announced that the backlog of change requests had been cleared; that the marketplace was operating at a vastly improved customer service level for change requests; and customers would be able to report many changes online. This accomplishment marked a major milestone and was made possible by new technology that was deployed at the end of May combined with a summer of hard work by operational staff to work through the backlog of change requests which had grown as high as 10,272 in May.

The State completed the transition of Vermont Health Connect's system hosting services from CGI to Optum in September. This transition had been identified as a key hurdle on the path to delivering automated renewal functionality. With the hosting transition complete, the State worked with its systems integrator, Optum, to finish the development and testing of two additional system upgrades. The October system upgrade focused on automated renewal functionality for QHP customers and included self-service plan selection during open enrollment, self-service change reporting, and the ability to make recurring payments. The December system upgrade focuses on functionality to support Medicaid renewals.

Maximus continues to manage the VHC Customer Support Center (call center), currently utilizing 62 customer service representatives (monthly average for the quarter). The call center serves Vermonters enrolled in both public and private health insurance coverage, providing Level 1 call center support, which includes phone applications, payment, basic coverage questions, and change of circumstance requests. Maximus is also the entry point for individuals requiring greater levels of assistance with case resolution. They transfer calls to the State's Health Access Eligibility Unit for resolution and log service requests, which are escalated to the appropriate resolver group. Throughout QE0915, the system's performance continued to be stable and operated as expected. The Customer Support Center managed incoming call volume, receiving more than 82,000 calls over the quarter, with an abandon rate of 6.65% and answering seven out of ten (71%) calls within 30 seconds.

ii. *Choices for Care*

Key updates from QE0915:

- The Choices for Care (CFC) July 2015 Data Report shows a 3% increase in total CFC enrollments since January 2015.
- CFC community-based enrollments continue to increase, while CFC Nursing Facility enrollments continue to decline.
- The Money Follows the Person (MFP) grant celebrated a milestone reaching 200 people who have transitioned from nursing facilities to community-based living.
- AHS continues to educate stakeholders on the GC Comprehensive Quality Strategy (CQS) including the assessment and implementation of federal Home and Community-Based Services (HCBS) regulations in Vermont.
- Vermont works to comply with new Department of Labor “Home Care” Rule.

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.

Data Report

The Department of Disabilities, Aging and Independent Living (DAIL) published the July 2015 Choices for Care Data Report.

Highlights of the data report include:

- The continued shift from nursing facility to more community-based services and supports, with an emphasis on person-centered choice.
- A 13% increase in the number of people receiving Moderate Needs Services since January 2015.
- The Moderate Needs provider wait lists continue to increase and are at approximately 500 people statewide due to limits on funding.
- Though total expenditures for SFY15 (approximately \$182.6 million) were less than the budgeted amount (approximately \$184.3 million), the difference is relatively small. The State will be closely monitoring spending to avoid implementing a High Needs wait list.
- Though a large majority of people (94%) continue to rate their community-based services as excellent or good, only approximately 60% of people are satisfied with their social life.

Chart 1: Choices for Care: Total Number of Enrolled Participants by Setting

Data source: SAMS

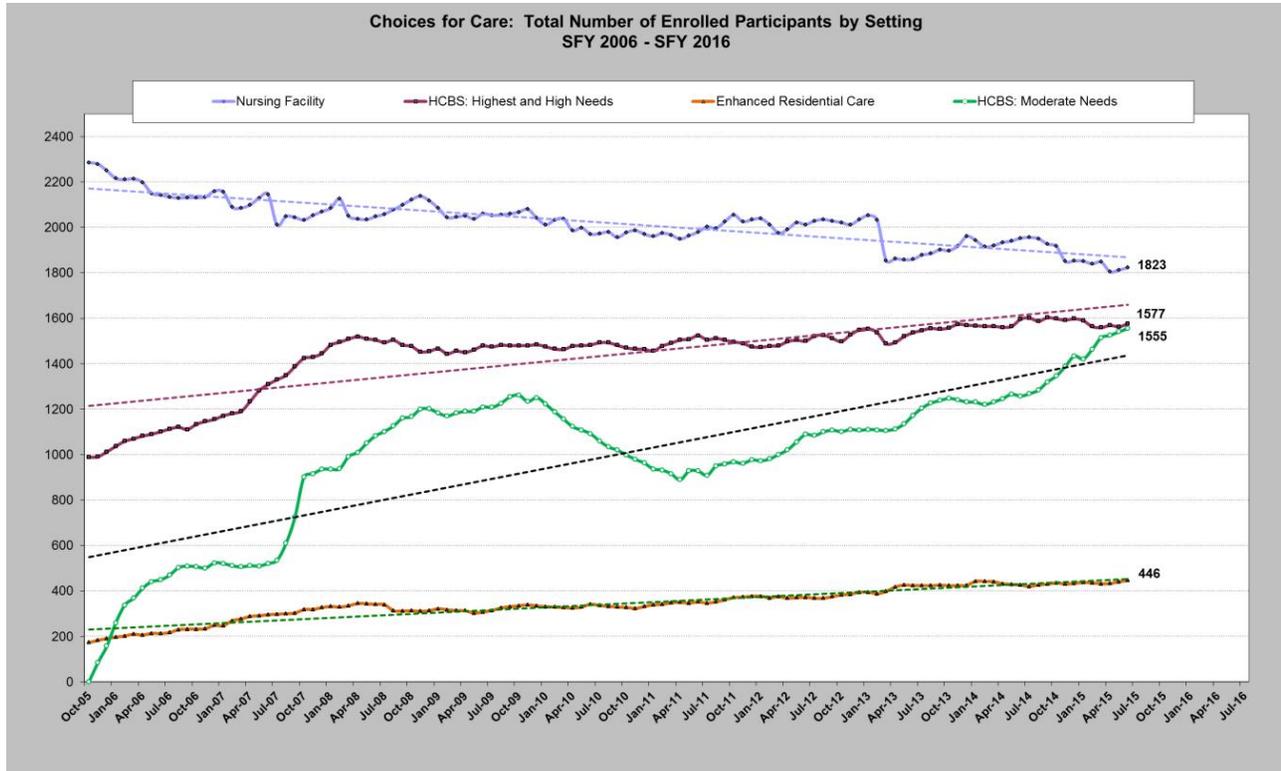


Chart 2: DAIL LTSS HCBS Consumer Survey: CFC, ASP, TBI Potentially “Promising” Results

Source: 2014 Vermont Long-Term Services and Supports HCBS Consumer Survey Report

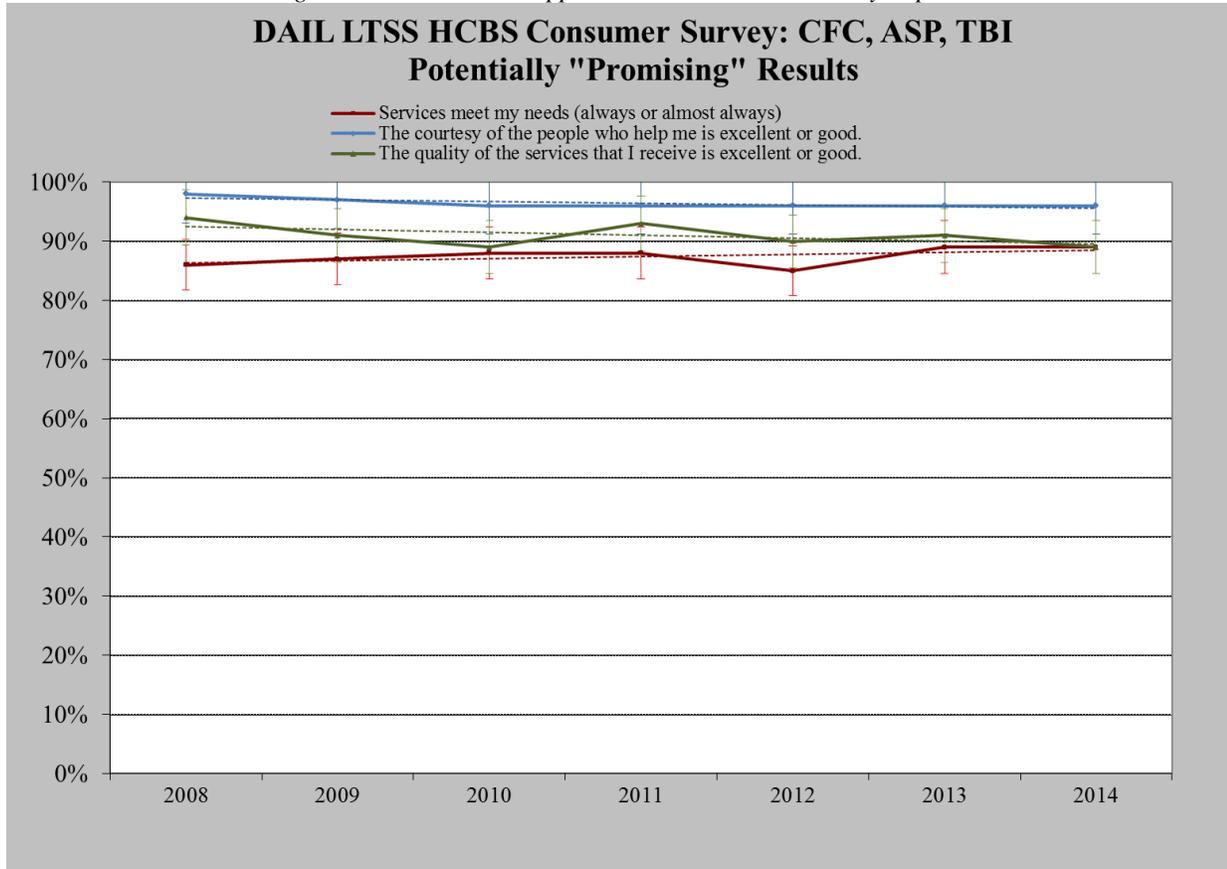
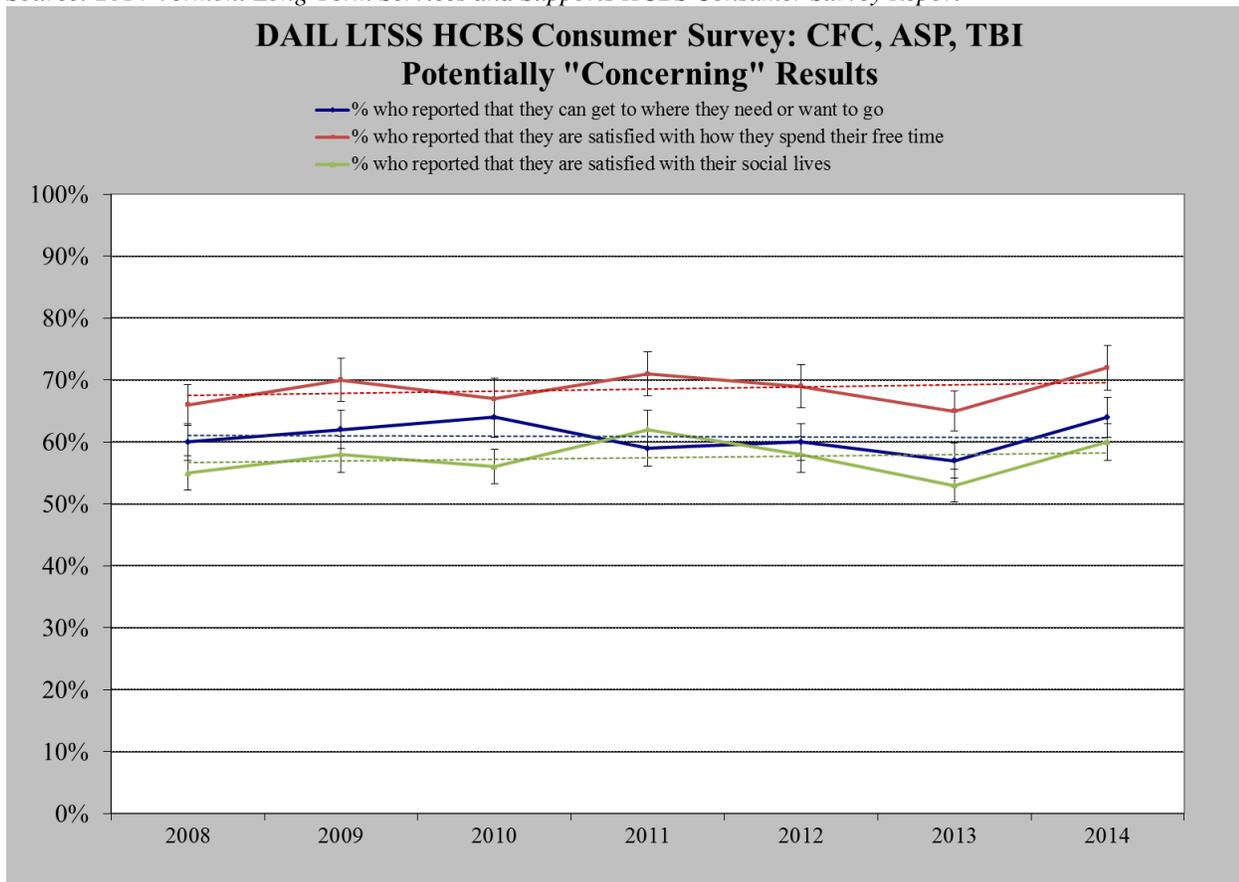


Chart 3: DAIL LTSS HCBS Consumer Survey: CFC, ASP, TBI Potentially “Concerning” Results

Source: 2014 Vermont Long-Term Services and Supports HCBS Consumer Survey Report



For the complete Choices for Care Data Report July 2015, go to: <http://ddas.vt.gov/ddas-publications/publications-cfc/cfc-qtrly-data-rprts/cfc-quarterly-data-reports#documentContent>.

Money Follows the Person

The Money Follows the Person (MFP) program continues to work with Vermont partners to identify ways to ensure people have choice and access to community-based services while identifying important elements that help people remain in the setting they choose. Areas of focus include improving discharge planning efforts to ensure critical supplies and services are in place upon discharge and maximizing community-based services and monitoring to reduce the chances of a person returning to the nursing facility. These efforts have contributed to meeting the milestone of 200 people transitioning since the beginning of the grant. The MFP team will continue to work with CMS on finalizing Vermont’s budget and sustainability plan through 2020.

HCBS Regulations

The Agency of Human Services (AHS) in partnership with the DAIL continues to reach out to Vermont stakeholders to educate partners about the new Comprehensive Quality Strategy (CQS) and federal Home and Community-Based Services (HCBS) regulations. As outlined in the CQS, efforts

initially focus on Choices for Care home-based settings, including Adult Family Care with regards to setting characteristics, person-centered planning and conflict-free case management.

Department of Labor “Home Care” Rule

Vermont continues to work closely with its partners to implement changes to comply with the new federal Department of Labor regulations. The rule went into effect on October 13, 2015 with DOL’s “selective enforcement” period to begin thirty (30) days thereafter.

Vermont has assessed that over 56% of all CFC home-based services receive self-directed services through an Intermediary Services Organization (ISO) and are subject to the new rules. About 15% of those people are on the Flexible Choices budget option in which the rate is set by the consumer/surrogate employer. About 85% of all self-directed people are on the hourly fee-for-service, consumer/surrogate direct option in which the rate is set by the State through the Collective Bargaining Agreement (CBA). CFC services include personal care, respite and companion care. This means that a portion of a person’s weekly services may be exempt under the “companionship services” exemption.

Changes include systems updates to enable the State to properly track employees who work more than 40 hours per work week and ways to pay employees overtime when appropriate. Vermont is also working on creating a budget-based plan for all self-directed employers to allow more flexibility, set their own wages, overtime within an approved budget and minimum and maximum wage limits.

V. Expenditure Containment Initiatives

i. Medicaid Shared Savings Program

Key updates from QE0915:

- As of October, 74,744 Medicaid beneficiaries are attributed to two accountable care organizations (ACOs) through the Vermont Medicaid Shared Savings Program (VMSSP).
- Completed Performance Year 1 Shared Savings Program final calculation. Both CHAC and OCVT demonstrated enough savings to be eligible for shared savings.
- Received State Plan Amendment (SPA) approval from CMS for Year 2 of the VMSSP on September 3, 2015.
- Signed Year 2 VMSSP contract with CHAC and continuing discussion with OCVT.
- Concluded that there will be no change to VMSSP Year 3 TCOC.

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

Beneficiary attribution in the VMSSP continues to increase as new providers are added to participating ACO entities, with 929 providers participating in the program, resulting in 74,774 total beneficiaries attributed—approximately 47,000 lives in OneCare Vermont (OCVT) and 27,000 lives in Community Health Accountable Care (CHAC).

DVHA and CHAC signed the VMSSP Year 2 Contract Amendment Agreement, while DVHA and OCVT continue to discuss the Program Integrity section of the Contract Amendment.

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. Based on the comments received, DVHA has decided *not to expand TCOC in Year 3*.

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 QE0915:

- The Enterprise Medicaid Management Information Systems/Care Management (MMIS/CM) kick off meeting with eQH - new vendor - occurred in June 2015. We are planning for a December 2015 launch, starting with the VCCI.
- The APS Healthcare contract will sunset December 2015 with transition planning underway including data sharing with the new MMIS/CM vendor, eQHealth.
- The VCCI is working with both Medicaid ACO's to establish direct referral and communication systems for the highest risk and cost Medicaid population in order to improve efficiency and support collaborative efforts toward common goals.

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 new vendor, eQH, will be working with Medicaid and the VCCI regarding new predictive modeling and stratification tools to enhance our ability to identify and intervene with members; and to track the clinical and financial improvements within the eQH reporting suite.

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 financial results will not be available until the 6 month claims run-out. Clinical information reveals significant improvement in adherence to ACE/ARB treatment for the VCCI intervened population with 82.4% for intervened vs. 64.8% for eligible without intervention by VCCI staff. Similarly, when looking at both a beta blocker and ACE/ARB adherence, the VCCI intervened population demonstrated 9% greater adherence (53.8%) than the non-VCCI cohort (44.2%). VCCI achieved improvements for depression management with 12% greater medication adherence for VCCI members than non-members. Asthma and diabetes prescription adherence however was essentially the same among both groups.

The VCCI continues its collaboration with ACO partners to enhance the number of hospitals providing secure File Transfer Protocol (FTP) data feeds for its focused efforts on transitions in care and prevention of 30-day hospital readmissions. The VCCI has access to hospital data on inpatient and ED admissions through data sharing from partner hospitals. While the VCCI now receives electronic data from 6 partner hospitals, the goal is to have electronic census data from all hospitals in FFY 2016. The VCCI will continue these efforts after transition to the new eQH system.

The 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. As there are many concurrent local efforts underway, there has been push back in some communities.

This enhanced service coordination was also a goal of the VHCIP Care Management and Care Models (CMCM) workgroup (now merged with the provider practice workgroup), which launched an integrated care management learning collaborative. The collaboratives were extended to additional hospital service areas in the last quarter, with the intention of having all communities participate by 2016. There is a goal of enhanced communication and coordination to prevent redundancies and with a 'single, shared care plan' the long term vision. This effort is an output of the SIM grant funding which includes insurance carriers, providers and community stakeholders.

VCCI continues to struggle with some natural attrition of nurses, as well as loss due to salary inequity. DVHA is aggressively working with other departments and state human resource leadership toward evaluation and implementation of a potential market factor adjustment. The job descriptions for nursing positions have been completed with final review and grading of positions to be complete by December 2015; followed by a legislative and related 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. The program is receiving significant attention as evidenced by increase in our referral rates. We anticipate the ability to better track case management in the new Care Management system.

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 (the top 5%). 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 is facilitating the transition to the new enterprise level CM vendor. The VCCI has been working proactively and successfully with APS Healthcare to date, to facilitate the smooth transition of the historic data to the new vendor in a timely fashion and format that supports data consumption by the new system. Files were provided by APS to DVHA and to eQH in August and another file transfer (delta) is anticipated in November, a week prior to go live and a day before go live.

Activities supported by APS this quarter include:

- Collaboration on the data transition 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 QE0915 was: 581, with 1761 unique members for the FFY 2015.
- Development of a case transition strategy between DVHA and APS VCCI staff to assure DVHA staff have low caseloads to support new system training requirements.
- A overall VCCI case reduction strategy based on loss of 6 APS/VCCI nursing staff at time of contract termination (December 2015).

Enterprise Care Management vendor transition:

The VCCI 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 was heavily engaged in planning and development of system design including data migration, development of eligibility rules, workflow mapping, assessments and related alerts in the new system. These efforts will transition in the last

quarter to focus on UAT and related staff training to support ‘go live’ in December.

The VCCI is anticipating the loss of 13 clinical and analytical FTE’s due to the contract dissolution and is restructuring operations concurrent with going live efforts in the new eQH system. The VCCI was not able to secure additional state FTEs to replace the vendor staff due to State budget constraints. As a result, DVHA anticipates a decline in the number of cases that the VCCI supports over the next few quarters. The VCCI leadership and central office team will also move to a new Waterbury location in January 2016 shortly after system launch.

In support of these transitions, the VCCI has adjusted staffing and roles to support field operations with the loss of an FTE regional manager to the CM efforts as a FTE ‘subject matter expert’. The VCCI SME backup, not a nurse or manager, has been supporting a variety of program operational needs including audits to enhance clinical data migration to the new system; outreach and early efforts with ACO’s to develop a referral process for January 2016, as we will not have outreach staff with the termination of the APS contract.

In preparation for ‘go live’ the VCCI management team is working with eQH and AHS Organizational Change Management (OCM) staff to develop a training plan and to facilitate system adoption by VCCI field staff.

iii. *Blueprint for Health*

Key updates from QE0915:

- The Blueprint for Health and Vermont’s three ACOs continue work to develop a local Unified Community Collaborative (UCC) in each Hospital Service Region. Blueprint project managers staff and organize the committees with support from clinical consultants hired by OneCare Vermont and Community Health Accountable Care (CHAC).
- Each UCC has selected Quality Improvement projects; many include increasing the rates of hospice utilization and decreasing repeat use of Emergency Rooms.
- The Blueprint, in collaboration with the payers, began work to finalize the methodology for the quality composite component of the new payment system to begin Jan 1, 2016.
- Working with the Green Mountain Care Board and the three Vermont ACO’s the Blueprint began implementing a series of learning collaboratives focused on inter-organizational care coordination for people with multiple, complex conditions.
- The number of Blueprint PCMH practices held steady at 127.
- A Blueprint evaluation study was published in Population Health Management. “Vermont’s Community – Oriented All-Payer Medical Home Model Reduces Expenditures and Utilization While Delivering High-Quality Care, September 2015.
- The Alcohol and Drug Abuse Division of the Vermont Department of Health reported that the previous quarter enrollment figures in Hub programs mistakenly included out-of-state residents. The enrollment figures below are correct, and reflect an increase in Vermont residents served in the “Hub & Spoke” health home from the previous quarter.

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 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.

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 PPM (per patient per month).
- Quality Performance Component: Based on HSA results for Quality Index.
 - Up to \$ 0.25 PPM for results that exceed benchmark.
- Utilization Performance Component: Based on HSA results for Utilization Index.

¹ 18 VSA Chapter 13.

- Up to \$ 0.25 PPPM for results that exceed benchmark.

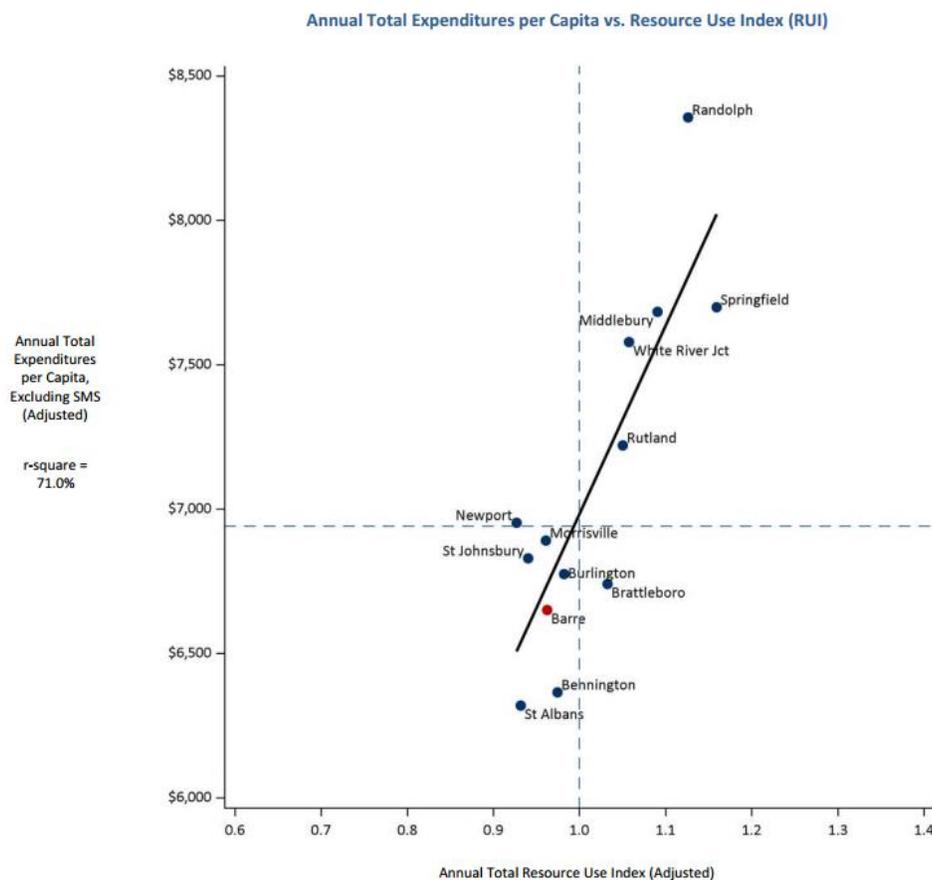
Health Services Area Profiles:

The Blueprint Health Services Area Profiles 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

The latest profiles reflect calendar year 2014 data and these will be used for the quality and utilization payment component described above. The chart below shows the measure on which the utilization component is being calculated. This graphic demonstrates the relationship between risk-adjusted expenditures, excluding Special Medicaid Services (transportation, home and community based services, dental etc.), and risk-adjusted utilization for each of the Hospital Services Areas (HSA) in Vermont. The chart illustrates the specified HSA’s risk adjusted rate (the red dot) compared to those of all other HSA’s statewide (the blue dots). The dashed lines show the average expenditures per capita and average Resource Use Index statewide (i.e., 1.00). HSA’s with higher expenditures and utilization are in the upper right-hand quadrant, while HSA’s with lower expenditures and utilization are in the lower left-hand quadrant. An RUI value greater than 1.00 indicates higher than average utilization; conversely, a value lower than 1.00 indicates lower than average utilization. A trend line has been included in the graphic, which demonstrates that, in general, HSA’s with higher risk adjusted utilization had higher risk adjusted expenditures. The variation between HSA’s despite risk adjustment and in a relatively small health care market indicate there is substantial opportunity to improve and reduce variation in this measure.

Chart 4: Annual Total Expenditures per Capita vs. Resource Use Index



In addition, in this reporting quarter, the ACO's and Blueprint reached agreement on the specific measures that will be used for the quality composite for the new payments. The measures reflect a balance of pediatric and chronic conditions and are:

- Developmental screening in the first three years of life (NQF 1448)
- Adolescent well visits (NCQA HEDIS AWC)
- Diabetes Mellitus: HbA1c Poor Control (NQF: 0059 HEDIS)
- Admissions for DM, COPD, HF, Angina w/o cardiac procedure, Asthma, DM with lower extremity amputation (PQI 92 Chronic Composite).

Integrated Communities Care Management Learning Collaborative

First piloted in three communities last year, the ACOs, GMCB, and Blueprint for Health are expanding the care coordination collaboratives statewide. Each community organizes partners from primary care, home health, designated community mental health and addictions treatment agencies, housing, and area agencies on aging to address hi risk beneficiaries in an inter-organizational and coordinated care approach. Community teams are provided with training, tools, and technical assistance throughout a year and they test mechanisms for shared care planning and coordination on a cohort of 20-25 very complex patients. Consistent with learning collaborative methodology, each community collects the same measures and shares practices with their peers. Process measures include the number of information sharing agreements between organizations and presence of care coordination protocols between primary care providers and community partners. Outcome measures include reduction in avoidable ER visits and reduction in inpatient admissions for ambulatory care sensitive conditions.

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 5,151 Medicaid beneficiaries in Hub and Spoke programs combined as of September 30, 2015. The following tables present the caseloads of regional Hub and Spoke staffing as of September 30, 2015. Spoke staffing is scaled at 1 registered nurse and 1 licensed clinician for every 100 patients receiving MAT.

Table 2. Hub Implementation as of September 30, 2015

Program	Region	Start Date	# Clients	# Buprenorphine	# Methadone
Chittenden Center	Chittenden, Franklin, Grand Isle & Addison	1/13	861	262	599
BAART Central Vermont	Washington, Lamoille, Orange	7/13	415	183	232
Habit OPCO / Retreat	Windsor, Windham	7/13	578	203	375
West Ridge	Rutland, Bennington	11/13	421	144	277
BAART NEK	Essex, Orleans, Caledonia	1/14	559	139	420
STATEWIDE			2834	931	1903

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

Table 3. Spoke Patients, Providers & Staffing: September 2015

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

Table Notes: Beneficiary count based on pharmacy claims July-September, 2015; an additional 181 Medicaid beneficiaries are served by 25 out-of-state providers. Staff hired based on Blueprint portal report 9/21/15. *4 providers prescribe in more than one region.

iv. *Behavioral Health*

Key updates from QE0915:

- McKesson InterQual criteria adopted 7/1/15 for inpatient detoxification service authorizations
- Applied Behavior Analysis benefit became active 7/1/15

The DVHA Behavioral Health Team offers a comprehensive approach for behavioral health care coordination. The Team is responsible for concurrent review and authorization of inpatient psychiatric and detox services for Medicaid primary members as well as the utilization management activities for substance abuse residential services for Medicaid primary and uninsured Vermonters. The Team works closely with staff at the inpatient and residential facilities and, when appropriate, the Team collaborates directly with and supports collaboration between facility staff and staff from VCCI, DCF, DMH and ADAP to ensure timely and appropriate transitions of care. The Team also manages the Team Care Program (lock-in) for Medicaid members.

The Applied Behavior Analysis (ABA) benefit was implemented July 1, 2015. The Autism Specialist provided a great deal of support both in person and via phone to individual providers and groups as they navigated enrollment and prior authorization processes. The Autism Specialist has continued

working with DVHA Quality and AHS staff to develop a method of outcome data collection and a scorecard to track these measures related to the ABA benefit. The DVHA Managed Care Medical Committee (MCMC) is in the process of developing a Clinical Practice Guideline for Applied Behavior Analysis services and will be conducting an external review process with Vermont Medicaid enrolled ABA providers.

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 improve the process 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. VCCI and the Quality Unit staff have also collaborated with DMH and DVHA clinical leadership to improve communication between the designated hospitals and VCCI staff, providing education around VCCI staffs' role as a part of the Medicaid program and the permitted communications allowed by HIPPA to ensure coordinated care and appropriate care transitions. The Team, in collaboration with VCCI management, continues to examine these collaborative processes and are working to increase efficiency and to ensure a seamless transition when the new Care Management platform comes online in December 2015.

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 were validated and the DVHA is in the process of contracting with our current vendor to continue the hybrid chart review process this fiscal year.

v. *Pharmacy and 340B Drug Discount Program*

Key updates from QE0915:

- Vermont has realized \$328,746.20 net cost savings for this reporting period and year to date net cost savings of \$592,974.01 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 \$328,746.20 net cost savings and year to date net cost savings of \$592,974.01 through Medicaid participation of a relatively small number of eligible covered entities.

v. *Mental Health System of Care*

Key updates from QE0915:

- Planning process leading to development of a permanent secure (locked) residential recovery facility was initiated
- Modifications were made to improve the Clinical Care Management System

The Department of Mental Health completed the build-out of the Mental Health System of Care as required by Act 79 of 2012. Completion of this new framework of public mental health services was accomplished in the aftermath of Tropical Storm Irene over the course of three years. The system is recovering from this disruption, and showing its resiliency. It is useful to reflect on what the system has been able to accomplish with the support of the Administration, legislators, prior leadership of

DMH, designated agency providers, hospitals, sheriffs, local and state law enforcement officers, peer providers and the advocacy community, family members, support systems, and countless others who have helped in meeting the needs of Vermonters in ways that went beyond the usual and customary supports for this prolonged period of time.

- ✓ DMH developed replacement inpatient bed capacity for individuals requiring the most acute inpatient psychiatric care at Brattleboro Retreat and RRMC
- ✓ DMH opened and closed an 8-bed temporary hospital in Morrisville that was both JC accredited and CMS certified
- ✓ DMH opened a new 25-bed hospital, the Vermont Psychiatric Care Hospital in Berlin, that has also achieved the same accreditation and certification
- ✓ DMH opened a secure residential recovery program in its temporary location in Middlesex
- ✓ DMH opened a peer-supported residential recovery program in Chittenden County, Soteria House
- ✓ In participating hospitals, there are now a total of 188 adult inpatient beds across the system of care
- ✓ In the community, DMH has a total of 37 crisis beds and 42 residential recovery beds across the state

Operationalizing the newly configured system of care continues to present challenges as well as opportunities for change. Health care reform hopes to improve how and where services are delivered, how those services are paid for, and how to promote better outcomes data on how the services are changing people's lives. Whole person care supports integrated treatment. These reforms need our attention so that mental health and physical health care services are equally considered and provided for in our service delivery system.

Secure Residential Recovery Services

Availability of a secure (locked) residential recovery facility in the system of care is an essential program element. This need was satisfied by the development of a 7-bed facility in a temporary location. Planning for its replacement is underway. The Department of Mental Health issued a Request for Information (RFI) in the third quarter to gather ideas and perspectives from different resources potentially interested in contributing to its development. The characteristics of a new facility, including its capacity, population to be served, location, operating responsibility, and more will be taken into consideration, discussed with the Administration, legislature, and other parties. It is expected that review and analysis of this information will result in a development plan in 2016.

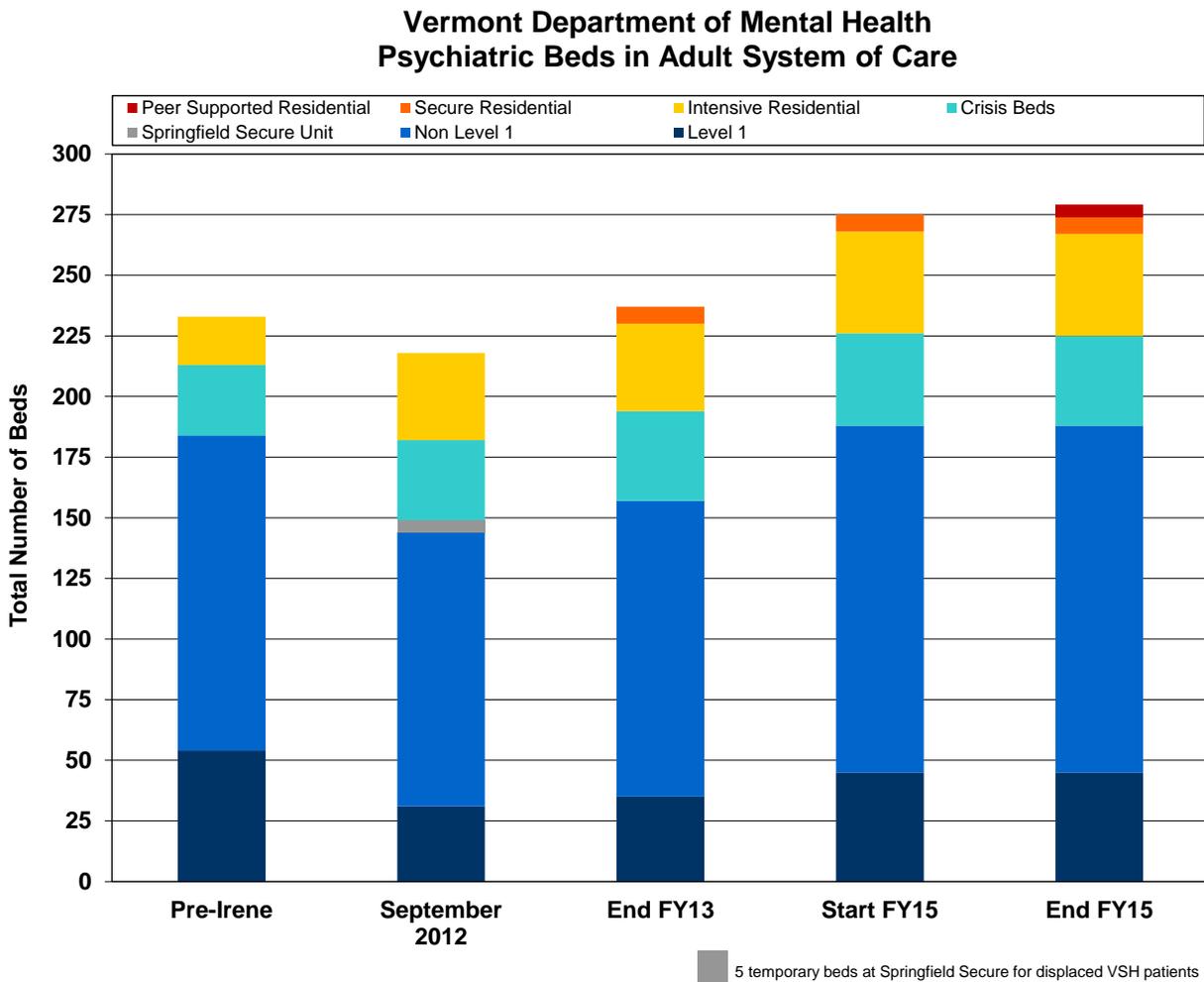
Care Management System

The Department of Mental Health relies on Clinical Care Managers to 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. The Clinical Care Managers provide support to Designated Agencies and monitor care to individuals on Orders of

Non-Hospitalization (ONH).

This Adult Care Management Team has undergone a structural change to better meet the needs of our changing mental health system and to evolve as the new, dispersed system matures. Following Tropical Storm Irene, the Care Management Team members all focused on both admissions and discharges across the state with each care manager covering their “catchment” area. With emergency room wait times diminishing with the opening of all Level I beds, one care manager now oversees all admissions into hospitals, two are primarily focused on discharges from inpatient units as well as admissions to the Intensive Recovery Residences, and the fourth works with Designated Agencies on the oversight of ONH’s (Orders of Non-hospitalization) as well as collaborating with the Department of Corrections on more complex re-entry planning for inmates with mental health needs returning to their communities. These are among the evolving changes made in an effort to continually improve the system of care, the quality of services delivered, the ability to care for people in the most appropriate settings, and the outcomes of the patients, residents, families and communities affected by mental illness.

Chart 5: Psychiatric Beds in the System of Care



Integrating Family Services (IFS) Initiative:

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

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

The IFS Initiative seeks to bring 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.

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

Continued outreach is occurring across the state to education regions about the IFS approach and support them in their efforts to move forward. At this time, it appears at least two regions will be ready to move forward with IFS in SFY2017. Several others are in different phases of exploration- from learning about IFS to scheduling meetings to move forward using the regional readiness documents.

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

- IFS is engaged in a statewide effort to look more effectively at how Vermont uses residential treatment for children and youth.
- IFS is creating a teaming pilot in four regions in Vermont to look at how agency departments can team to support families who have complex needs and therefore are accessing services through a number of the agencies departments (child welfare, economic services, corrections, substance abuse, early childhood).

- Due to positions in the Agency of Education and the Agency of Human Services being eliminated, IFS is partnering with the Disabilities Division to bring together state and community leaders to strategize about how to ensure focus and services occur for children with autism diagnoses in Vermont.

VI. Financial/Budget Neutrality Development/Issues

AHS continued the FFY16 actuarially certified rate setting process during QE0915. 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. During the reconciliation process, we noticed that the financial payouts query used to forecast future costs was missing certain categories of service. Our MMIS contractor, HP, is in the process of fixing this query so we can provide Milliman with the most accurate data.

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 QE0915, 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.

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, Change from Previous Quarter

Demonstration Population	Q3 FFY2015			Q4 FFY 2015		
	April 30, 2015	May 31, 2015	June 30, 2015	July 31, 2015	August 31, 2015	September 30, 2015
Demonstration Population 1	36,929	37,015	36,924	37,451	37,570	37,584
Demonstration Population 2	81,594	81,846	81,872	82,915	83,348	83,453
Demonstration Population 3	56,835	57,246	57,432	58,063	58,390	58,457
Demonstration Population 4	2,959	2,879	2,809	2,906	2,862	2,799
Demonstration Population 5	889	885	869	917	906	894
Demonstration Population 6	913	918	931	920	906	905
Demonstration Population 7	7,550	7,526	7,467	7,397	7,414	7,399
Demonstration Population 8	4,276	4,273	4,257	4,227	4,232	4,246
	191,945	192,588	192,561	194,796	195,628	195,737

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 QE0915:

- DVHA hosted the on-site review for all three EQRO required activities: Performance Improvement Project (PIP) Validation; Review of Compliance with Standards; and Validation of Performance Measures.
- DVHA leadership decided to continue devoting resources to the hybrid data collection methodology and identified two HEDIS measures that we'll work on in 2016.
- DVHA Quality Unit staff began developing a "Quality Reporting" section of the Vermont Medicaid website that will include information on performance measurement, customer satisfaction and quality improvement.

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 once during the quarter. The Committee focused on prioritizing its work plan activities and opted to put resources into reviewing and making recommendations towards the MCE Core Set of *Global Commitment to Health* performance measures. In coming months, the Committee will establish a set of criteria for this core measure list that will be used as a filter as it reviews current measures, as well as gaps and potential new measures to be added to the core list. These performance measures are reported to AHS and then CMS annually.

The AHS Performance Accountability Committee (PAC) also met monthly during the quarter. The group used the Global Commitment to Health (GC) Comprehensive Quality Strategy (CQS) outline to develop a draft version of the full strategy. This document expands the framework identified in the CQS outline and incorporates feedback obtained to date. This version was shared with external stakeholders. At the beginning of the quarter, the AHS Quality Improvement Manager (QIM) presented the document to the DAIL Advisory Board. In addition, the document was presented to the Medicaid and Exchange Advisory Board during the last month of this quarter. The document will be modified to include feedback obtained from stakeholders. Also during this quarter, Public Notice was given for the full version of the Comprehensive Quality Strategy. In addition, a public comment period was open for 30 days – with a formal public hearing being held on August 20, 2015. All written and in-person comments were summarized and posted – along with State responses. The CQS was edited to reflect feedback and submitted to CMS (i.e., STP and 1115 representatives) for review and approval. Next steps include reviewing the results of the systemic assessment, involving stakeholders, determining systemic assessment action items, and deciding on provider self-assessment.

MCE Investment Review:

During this quarter, the AHS Quality Improvement Manager (QIM) presented the results of the MCE investment work group to the AHS Inter-Agency Operations Team (IOPT). The AHS PAC has proposed the development of a MCE Investment Scorecard to enhance the transparency of investment performance. The group will review similar scorecards in use across the Agency – and develop a sample scorecard for the IPOT to consider. In addition, separate, yet related work continues on

assessing current MCE investments for conversion to Medicaid billable administration or services when feasible.

External Quality Review (EQR):

During this quarter, DVHA hosted the on-site review for two of the three EQRO required activities: Review of Compliance with Standards and the Validation of Performance Measures. In addition, the EQRO completed a desk review in order to validate DVHA's Performance Improvement Project (PIP). A brief overview of findings is highlighted here:

- PIP Validation - 90% of the PIP evaluation elements were *Met*. However, DVHA did not achieve improvement in study rates, therefore the critical elements related to real improvement were *Not Met* and resulted in an ultimate validation status of *Not Met*. The EQRO's recommendations for next steps were taken into consideration during QE0915. More information about DVHA's ongoing FUH PIP work can be found later in this report.
- Review of Compliance with Standards – the standards under review were Practice Guidelines, QAPI Program, and Health Information Systems. Overall, DVHA had a compliance score of 96.8%. One (1) element within the Practice Guidelines standard was *Not Met*, but was corrected prior to the end of QE0915.
- Validation of Performance Measures – Fifteen (15) performance measures were validated by the EQRO, including three (3) hybrid measures for which DVHA staff had performed the medical record abstraction. DVHA's final results on the hybrid measures were all approved, which was a great accomplishment for the DVHA Quality and Clinical teams that collaborated during this effort. The EQRO reviewers acknowledged that substantial undertaking and encouraged DVHA to continue the efforts. DVHA scored "Acceptable" on Data Integration, Data Control and Performance Measure Documentation.

Overall, the DVHA staff found the external review to be helpful and very much appreciate the collaborative nature of our EQRO relationship.

During this time, the AHS Quality QIM attended both on-site EQRO reviews – and participated in numerous PIP validation calls. Once the reviews were completed – time was spent clarifying any follow up items. In addition, draft reports for each activity were reviewed by both DVHA and AHS – with final reports being delivered by the end of the quarter. During the next quarter, the AHS QIM will work with the EQRO to develop the annual technical report.

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). Our results were validated by HSAG in July 2015, as mentioned above. In QE0915, DVHA Quality Unit staff reviewed the results of the audit, as well as the feedback received in order to pro-actively plan for MRR activities going into 2016. DVHA leadership decided to continue devoting resources to the hybrid data collection methodology and identified two (2) measures that we'll work on in 2016 – controlling high blood pressure and adult BMI assessment. The 2015 MRR project manager began cross-training other staff within the Quality Improvement and Clinical Integrity Unit as preparation for 2016.

Formal (Validated) Performance Improvement Project:

DVHA continues to lead an AHS-wide Performance Improvement Project (PIP) on Follow-up After Hospitalization (FUH) for Mental Illness, the study indicator for which is the HEDIS measure of the same name (FUH HEDIS). During this quarter, follow-up appointment scheduling reports were again prepared and distributed to the designated hospitals and will continue to be distributed on a quarterly

basis. Due to lack of movement in the overall FUH measure rates and feedback from designated hospital partners, the FUH PIP implementation team continued to discuss an additional intervention for Year 2 of the project that would enhance the work already done in Year 1. During this reporting period, members of the FUH 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 was to increase the overall HEDIS rate of female Medicaid beneficiaries ages 50-74 receiving a mammogram every two years. There were two interventions; one aimed at providers (sending quarterly gap in care lists) and one aimed at beneficiaries (educational materials and grocery store gift card incentive). There were two annual intervention cycles in 2014 and 2015. Intervention results for both cycles were modest, ranging from 6.5 percent to 15.7 percent. Since the AMQ Grant ends in December 2015, a third intervention cycle will not be implemented. However, the initiatives will continue in slightly different ways.

The Vermonters Taking Action Against Cancer (VTAAC) All-Payer Joint Project is picking up where the PIP provider intervention ended. MVP, BCBSVT & Medicaid are coordinating efforts to continue sending quarterly GIC lists to the 32 practices Medicaid has been sending to for the last two years. The insurers are using MVP's format so the practices can merge and sort the three lists. A cover letter describing the joint effort is being drafted; the first round of joint GIC lists is scheduled to go out the week of October 12th. DVHA was pleased to be able to continue to collaborate with the private insurers as well as continue to partner with the practices in quality improvement projects. As chance would have it, the Vermont Department of Health (VDH) recently reached out to the DVHA to see if there is interest in partnering with VDH in getting a cancer screening brochure out to targeted Medicaid beneficiaries. The BCS PIP team saw this as a perfect opportunity to extend the PIP beneficiary intervention. DVHA and VDH are now working on getting a cover letter and cancer screening brochure (including screening recommendations for breast, cervical, colorectal, lung, skin and prostate cancers) printed and sent to male Medicaid beneficiaries ages 50-75 and female Medicaid beneficiaries ages 40-75 in January 2016.

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

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

The IET project's interventions 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. 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:

DVHA worked with WBA Research, Inc., a NCQA-certified vendor, in 2015 and focused 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 delivered by WBA Research to DVHA at the end of 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 (NORC). Results of the 2015 adults CAHPS survey will be available by NORC in the spring of 2016. The DVHA Quality Unit will continue to work on survey result analysis and reporting out to appropriate groups within the Department and Agency. As we head into the next quarter, the DVHA is connecting with the Blueprint for Health to discuss the potential for CAHPS survey coordination.

Addition of Quality Reporting section of Vermont Medicaid Website:

The DVHA Quality Improvement Administrator began developing a “Quality Reporting” section of the Vermont Medicaid website that will include information on performance measurement, customer satisfaction and quality improvement. The QI Administrator will be using some of the Results Based Accountability (RBA) scorecards mentioned in previous quarterly reports as the data presentation tool.

X. Compliance

Key updates from QE0915:

- 2015 EQRO audit completed
- Enhancement to IGA monitoring process (new review checklist)
- Improved coordination between Compliance Committee, Quality Committee and Medical Committee

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:

On July 15, DVHA and its managed care partners completed the annual EQRO audit. This year’s review covered 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 (MMIS).

During this review, only one potential weakness was revealed. DVHA's clinical practice guidelines need more frequent review. The Managed Care Medical Committee is aware of this weakness and they are modifying their work plans accordingly.

For each of the other standards, the auditors did not indicate the need for required corrective actions. The final report will be detailed in the next quarterly update.

Enhancement to IGA monitoring process

DVHA developed a new internal auditing checklist that will enhance the ability to monitor program compliance with partnering departments/agencies. This checklist includes all managed care compliance standards, matches the EQRO review cycles and will be adapted for each department/agency with whom DVHA works. The checklist will also serve as a way to collect information for quality and clinical initiatives so that one review will cover all three needs (quality, compliance and clinical needs). Starting next quarter, DVHA's compliance team will schedule quarterly reviews to begin testing and using this new tool.

Improved coordination between Compliance Committee, Quality Committee and Medical Committee
Coordination of these three committees (Compliance, Quality and Clinical committees) has always been a priority for DVHA. In order to improve this coordination, the chairs from each committee now meet every two weeks to discuss activities, find areas for collaboration and ensure that committees are not duplicating efforts.

Another goal of this group is to improve continuity between each committee. For example, the Compliance Committee might become aware of an issue of non-compliance related to a clinical process. In the course of developing a corrective action for this process, the Compliance Committee might pull in the Quality committee to consider a quality improvement initiative around the process. If the process needs to be changed, the Clinical Committee would take the lead in order to ensure that the clinical process is still consistent with current research and best medical practices. These new coordination efforts will ensure true continuity across these different focuses rather than a simple project handoff between each group.

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: November 30, 2015

ATTACHMENTS

Global Commitment Expenditure Tracking

Attachment 1 - Budget Neutrality Workbook

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	\$ 178,493,793						
0306	\$ 189,414,365	\$ 14,472,838											\$ 203,887,203	\$ 203,887,203						
0606	\$ 209,647,618	\$ (14,172,165)											\$ 195,475,453	\$ 195,475,453						
0906	\$ 194,437,742	\$ 133,350											\$ 194,571,092	\$ 194,571,092						
WY1 SUM	\$ 771,993,518	\$ 434,023											\$ 434,023	\$ 782,159,845		\$ 4,620,302	\$ 786,780,147	\$ 841,266,663	\$ 54,486,516	
1206	\$ 203,444,640	\$ 8,903											\$ 8,903	\$ 203,453,543						
0307	\$ 203,804,330	\$ 8,894,097											\$ 8,894,097	\$ 212,698,427						
0607	\$ 186,458,403	\$ 814,587	\$ (68,408)										\$ 746,179	\$ 187,204,582						
0907	\$ 225,219,267	\$ -	\$ -										\$ -	\$ 225,219,267						
WY2 SUM	\$ 818,926,640	\$ 9,717,587	\$ (68,408)										\$ 9,649,179	\$ 802,884,359		\$ 6,464,439	\$ 809,348,797	\$ 1,684,861,317	\$ 88,732,372	
Cumulative																				
1207	\$ 213,871,059	\$ -	\$ 1,010,348										\$ 1,010,348	\$ 214,881,406						
0308	\$ 162,921,830	\$ -	\$ -										\$ -	\$ 162,921,830						
0608	\$ 196,466,768	\$ 14,717	\$ -	\$ 40,276,433									\$ 40,291,150	\$ 236,757,918						
0908	\$ 228,593,470	\$ -	\$ -	\$ -									\$ -	\$ 228,593,470						
WY3 SUM	\$ 801,853,126	\$ 14,717	\$ 1,010,348	\$ 40,276,433									\$ 41,301,498	\$ 881,729,256		\$ 6,457,896	\$ 888,187,152	\$ 2,604,109,308	\$ 119,793,211	
Cumulative																				
1208	\$ 228,768,784	\$ -	\$ -										\$ -	\$ 228,768,784						
0309	\$ 225,691,930	\$ (16,984,221)	\$ 38,998,635	\$ (4,144,041)									\$ 17,870,373	\$ 243,562,303						
0609	\$ 204,169,638	\$ -	\$ 686,851	\$ 5,522,763									\$ 6,209,614	\$ 210,379,252						
0909	\$ 235,585,153	\$ -	\$ 30,199	\$ 34,064,109									\$ 34,094,308	\$ 269,679,461						
WY4 SUM	\$ 894,215,505	\$ -	\$ (16,984,221)	\$ 39,715,685	\$ 35,442,831								\$ 58,174,295	\$ 935,368,819		\$ 5,495,618	\$ 940,864,437	\$ 3,606,430,571	\$ 181,250,037	
Cumulative																				
1209	\$ 241,939,196	\$ -	\$ -	\$ 5,192,468									\$ 5,192,468	\$ 247,131,664						
0310	\$ 246,257,198	\$ -	\$ -	\$ 531,141	\$ 4,400,166								\$ 4,931,306	\$ 251,188,504						
0610	\$ 253,045,787	\$ -	\$ -	\$ 248,301	\$ 5,260,537								\$ 5,508,838	\$ 258,554,625						
0910	\$ 252,294,668	\$ -	\$ (115,989)	\$ (261,426)	\$ 3,348,303								\$ 2,970,888	\$ 255,265,556						
WY5 SUM	\$ 993,536,849	\$ -	\$ (115,989)	\$ 5,710,484	\$ 13,009,006								\$ 18,603,501	\$ 1,012,990,839		\$ 5,939,459	\$ 1,018,930,298	\$ 4,700,022,174	\$ 255,911,342	
Cumulative																				
1210	\$ 262,106,988	\$ -	\$ -	\$ 6,444,984									\$ 6,444,984	\$ 268,551,972						
0311	\$ 257,140,611	\$ -	\$ -	\$ -									\$ -	\$ 257,140,611						
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	\$ 5,865,213,737	\$ 369,688,737	
Cumulative																				
1211	\$ 253,147,037	\$ -	\$ -	\$ (531,744)									\$ (531,744)	\$ 252,615,293						
0312	\$ 267,978,672	\$ -	\$ -	\$ 3,742	\$ 49,079								\$ 52,821	\$ 268,031,493						
0612	\$ 302,958,610	\$ -	\$ -	\$ 6,393,928									\$ 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	\$ 7,113,290,903	\$ 477,488,286	
Cumulative																				
1212	\$ 282,701,072	\$ -	\$ -	\$ 3,036,447									\$ 3,036,447	\$ 285,737,519						
0313	\$ 285,985,057	\$ -	\$ -	\$ 991,340									\$ 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	\$ 8,450,684,486	\$ 608,733,520	
Cumulative																				
1213	\$ 319,939,651	\$ -	\$ -	\$ 3,652,767									\$ 3,652,767	\$ 323,592,418						
WY9a SUM	\$ 319,939,651	\$ -	\$ -	\$ 3,652,767									\$ 3,652,767	\$ 319,921,780		\$ 1,214,631	\$ 321,136,411	\$ 8,955,886,798	\$ 792,799,422	
Cumulative																				
0314	\$ 288,542,475	\$ -	\$ -	\$ 2,159,834									\$ 2,159,834	\$ 290,702,309						
0614	\$ 288,845,927	\$ -	\$ -	\$ -									\$ -	\$ 288,845,927						
0914	\$ 242,449,803	\$ -	\$ -	\$ 337,823	\$ (17,871)	\$ 1,515,302							\$ 1,835,254	\$ 244,285,056						
1214	\$ 286,853,166	\$ -	\$ -	\$ 867,215									\$ 867,215	\$ 287,720,381						
WY9b SUM	\$ 1,106,691,370	\$ -	\$ -	\$ 2,497,657	\$ (17,871)	\$ 2,382,517							\$ 4,862,303	\$ 1,108,546,976		\$ 5,086,126	\$ 1,113,633,102	\$ 10,290,338,883	\$ 1,013,618,405	
Cumulative																				
0315	\$ 321,140,737	\$ -	\$ -	\$ (526,911)									\$ -	\$ 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	\$ 11,969,357,946	\$ 2,013,819,729	
Cumulative																				
0316	\$ -	\$ -	\$ -	\$ -									\$ -	\$ -						
0616	\$ -	\$ -	\$ -	\$ -									\$ -	\$ -						
0916	\$ -	\$ -	\$ -	\$ -									\$ -	\$ -						
1216	\$ -	\$ -	\$ -	\$ -									\$ -	\$ -						
WY11 SUM	\$ -	\$ -	\$ -	\$ -	\$ -								\$ -	\$ -		\$ -	\$ -	\$ 9,955,538,217	\$ 13,752,420,439	\$ 3,796,882,222
Cumulative																				
WY12 SUM	\$ 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)	\$ 1,855,606	\$ -	\$ -	\$ 9,902,176,333	\$ -	\$ 53,361,884	\$ -	\$ -	\$ -	

Attachment 2 - Enrollment & Expenditures Report

Glossary of Terms

PMPM – Per Member Per Month

MEG – Medicaid Eligibility Group

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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



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

Agency of Human Services

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

**Questions, Complaints and Concerns Received by Health Access Member Services
July 6, 2015 – October 2, 2015**

July 6 – July 10

- 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.

July 13 – July 17

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

July 20- July 24

- Medicaid Renewals: CSR's escalated an SR for the loss of MEC or advised of other application channels.
- VPharm Payments: CSR's explained payment protocol and advised to send in payments before the end of the month.

July 27 – July 31

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

August 3 – August 7

- Medicaid Renewals: CSR's escalated an SR for the loss of MEC or advised of other application channels.
- Payment Confirmation: CSR's researched and advised whether payment had been received.

August 10 – August 14

- Medicaid Renewals: CSR's escalated an SR for the loss of MEC or advised of other application channels.
- Payment Confirmation: CSR's researched and advised whether payment had been received.

August 17 – August 21

- Legacy Medicaid Renewals: CSR's assisted in completing the application process or advised of other application channels
- Payment Confirmation: CSR's researched and advised whether payment had been



received.

August 24 – August 28

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

August 31 – September 4

- PCP Enrollment: CSR's assisted in finding a PCP or entering current PCP.

September 7 – September 11

- PCP Enrollment: CSR's assisted in finding a PCP or entering current PCP.

September 14 – September 18

- PCP Enrollment: CSR's assisted in finding a PCP or entering current PCP.

September 21 – September 25

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

September 28 – October 2

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



**Grievance and Appeal Quarterly Report
Medicaid MCE All Departments Combined Data
July 1, 2015 – September 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 November 23, 2015, from the centralized database for grievances and appeals that were filed from July 1, 2015 through September 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 26 grievances filed with the MCE; eleven were addressed during the quarter and one was withdrawn. Grievances must be addressed within 90 days of filing, so having pending cases at the end of the quarter is to be expected. Acknowledgement letters of the receipt of a grievance must be sent within five days; the average was two days. Of the grievances filed, 72% were filed by beneficiaries, 21% were filed by a representative of the beneficiary and 7% were filed by other. Of the 26 grievances filed, DMH had 69%, DVHA had 23% and DAIL had 8%. 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:

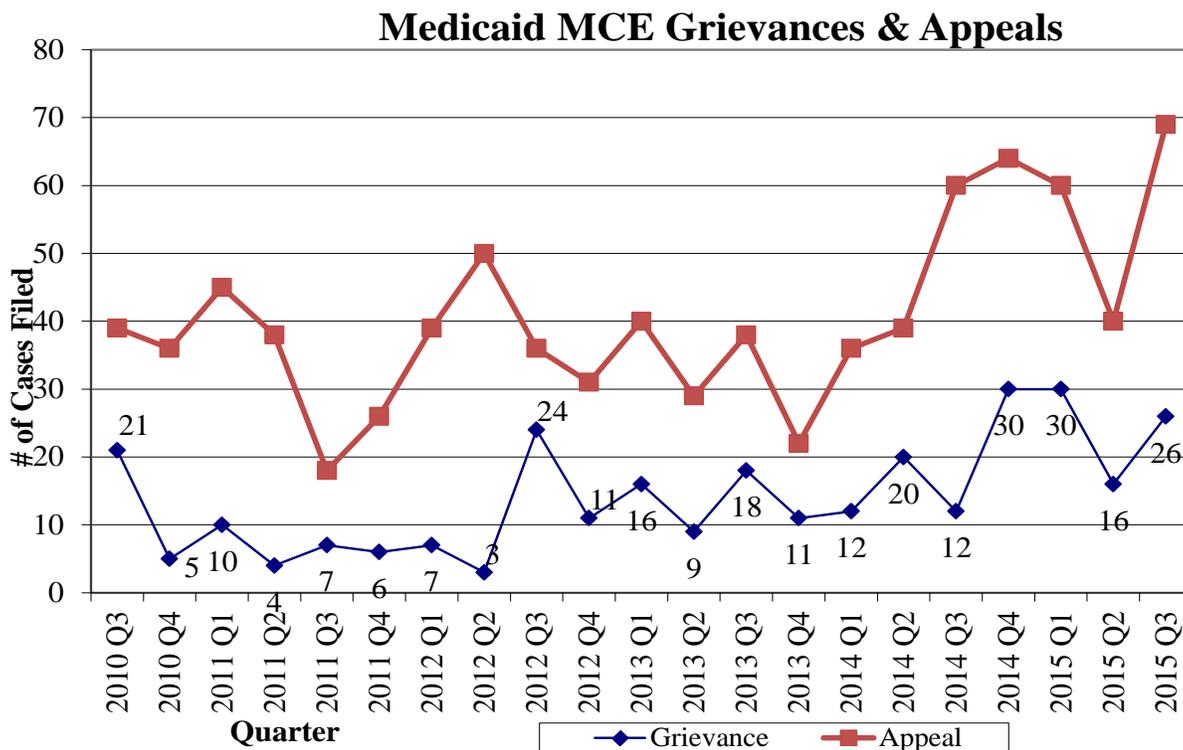
1. denial or limitation of authorization of a requested covered service or eligibility for service, including the type, scope or level of service;
2. reduction, suspension or termination of a previously authorized covered service or a service plan;
3. denial, in whole or in part, of payment for a covered 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 69 appeals filed with the MCE; 32 requested an expedited decision with eighteen of them meeting criteria. Of these 69 appeals, 57 were resolved (83% of filed appeals), 11 were still pending (16%), and 1 was withdrawn (1%). In twenty three cases (40% of those resolved), the original decision was upheld by the person hearing the appeal, thirty cases (53% of those resolved) were reversed, and four had a modified approval (7%).

Of the 57 appeals that were resolved this quarter, 96% were resolved within the statutory time frame of 45 days, with one (4%) being extended by the beneficiary; 92% were resolved within 30 days. The average number of days it took to resolve these cases was 18 days. Acknowledgement letters of the receipt of an appeal must be sent within five days; the average was three days.

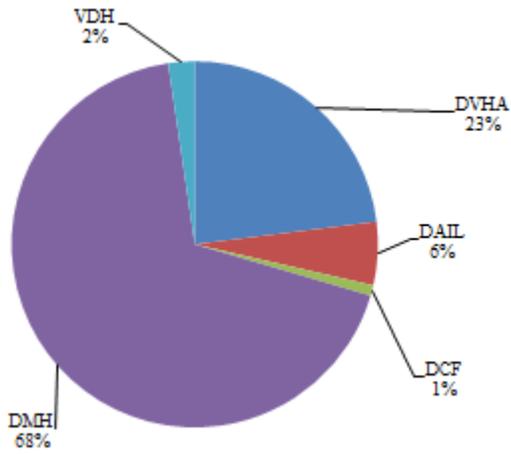
Of the 69 appeals filed, 38 were filed by beneficiaries (55%), 24 were filed by a representative of the beneficiary (35%) and 7 were filed by the provider (10%). Of the 69 appeals filed, DVHA had 75%, and DAIL had 25%.

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 five fair hearings filed this quarter.

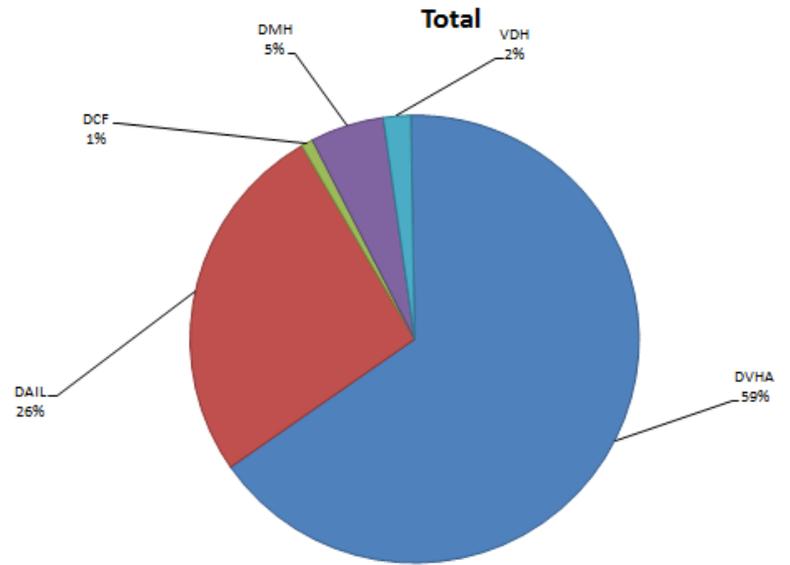


MCE Grievance & Appeals by Department From January 1, 2008 through September 30, 2015

Grievances



Appeals



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)
FAX (802) 863-7152
(802) 863-2316

OFFICES:

BURLINGTON
RUTLAND
ST. JOHNSBURY

OFFICES:

MONTPELIER
SPRINGFIELD

QUARTERLY REPORT

July 1, 2015 – September 30, 2015

to the

Agency of Administration

submitted by

Trinka Kerr, Chief Health Care Advocate

October 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 July 1, 2015 - September 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:** 1,015 calls (compared to 1,008 last quarter)
 - **Department of Vermont Health Access (DVHA) beneficiaries:** 287 calls or **28%** of total calls (compared to 298 and 30% last quarter)
 - **Commercial plan beneficiaries:** 278 calls or **27%** (348 and 35%)
 - **Uninsured Vermonters:** 152 calls or **15%** (89 and 8%)
 - **Vermont Health Connect (VHC):** 470 calls or **46%** (509 and 50%; the VHC data report draws from the All Calls data set)
 - **Two Reportable Activities (Summary & Detail):** 119 activities, 36 documents (168 and 33)

Highlights

- Total call volume was about the same as last quarter (1,015 versus 1,008), and slightly lower (7%) than the same quarter last year (1,096).

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

- Vermont Health Connect (VHC) calls decreased slightly (8%) since last quarter (470 compared to 509 last quarter), but were more than the same quarter in 2014 (440).
- VHC change of circumstance (COC) cases continued to decrease and fell an additional 14% after the 30% decrease in the previous quarter.
- Problems with the VHC billing process continued to be the top reason for calling the HCA and calls increased by 10%.
- An increased number of people called about premium payment grace periods and coverage terminations: grace period inquiries more than doubled over last quarter.
- More people are appealing VHC decisions to the Human Services Board, which has been unable to keep up with the increased volume.
- The HCA handled about the same number of Affordable Care Act tax-related questions this quarter as last quarter.
- We saved individual consumers \$110,207.49 in cases opened this quarter. So far in calendar year 2015 we have saved Vermonters \$449,152.36.
- We represented the public before the Green Mountain Care Board in two major rate review proceedings (for the 2016 VHC plans), a major certificate of need proceeding (for a new inpatient bed facility brought by the University of Vermont Medical Center), and the fourteen annual hospital budget reviews.
- The number of people who used our website to find information and guidance on health care issues continued a pattern of strong growth with 72% more pageviews this quarter, compared with the same period in 2014.
- The number of people seeking information about [dental services](#) continued to increase significantly (600%) over last year, as it has the past two quarters, and our Vermont Dental Clinics Chart was the 6th most downloaded PDF from the entire Vermont Law Help website.
- We had five articles published and gave five presentations to audiences ranging from consumers to community partners who serve the public to lawyers and tax professionals. Additionally, we worked to improve three State communications to consumers regarding VHC issues.

II. Individual Consumer Assistance

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

The HCA received 1,015 calls¹ this quarter. We divided these calls into five issue categories. The figures below are based on the All Calls data. The percentage and number of calls in each issue category based on the caller's primary issue were as follows:

- **21.38%** (217) about **Access to Care**;
- **14.98%** (152) about **Billing/Coverage**;
- **1.58%** (16) about **Buying Insurance**;
- **9.56%** (97) about **Consumer Education**;
- **27.98%** (284) about **Eligibility** for state and federal programs; and
- **24.53%** (249) 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 284 of our cases had eligibility for state health care programs as the primary issue, there were actually a total of 737 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.

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

A. The HCA’s overall call volume was about the same as last quarter and 7% lower than the same quarter last year.

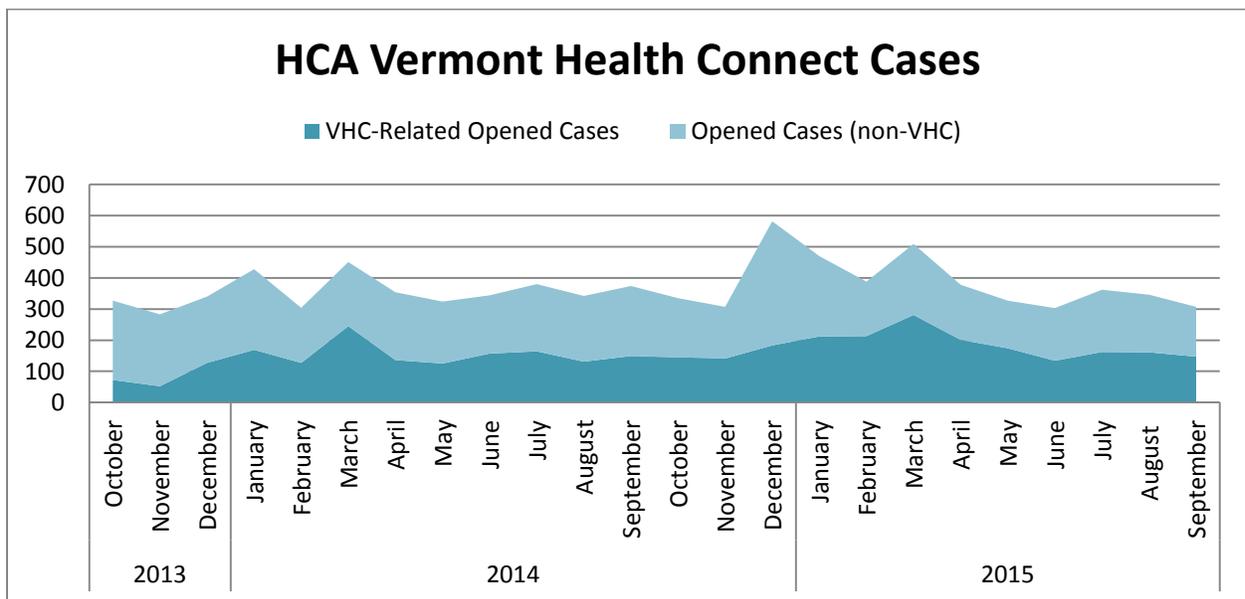
Last quarter we had a 26% decrease in calls from the previous quarter, and that lower call volume has continued. In the first quarter of calendar year 2015 we had a record call volume of 1,367. In the second quarter we received 1,008 calls, and in this quarter we received 1,015. This compares to 1,096 for the same quarter in 2014, a 7% decrease. August volume set the record for that month, but July and September were lower than last year’s record volume. Notably we have already exceeded the total call year volume for every year prior to the launch of VHC, and we have three more months to go to complete the year!

All Cases (2005-2015)											
	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
January	178	313	280	309	240	218	329	282	289	428	470
February	160	209	172	232	255	228	246	233	283	304	388
March	188	192	219	229	256	250	281	262	263	451	509
April	173	192	190	235	213	222	249	252	253	354	378
May	200	235	195	207	213	205	253	242	228	324	327
June	191	236	254	245	276	250	286	223	240	344	303
July	190	183	211	205	225	271	239	255	271	381	362
August	214	216	250	152	173	234	276	263	224	342	346
September	172	181	167	147	218	310	323	251	256	374	307
October	191	225	229	237	216	300	254	341	327	335	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	3390

B. Vermont Health Connect calls decreased 8%, but many problems continued.

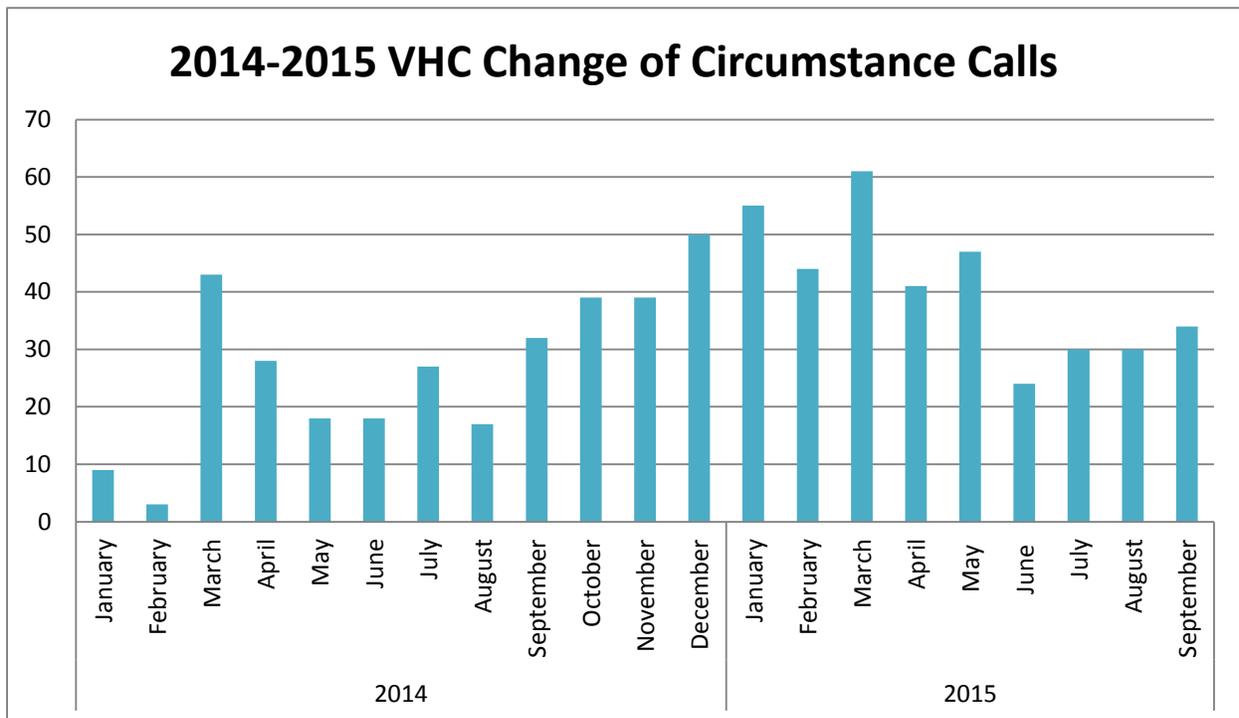
Problems with VHC continued, but since the technology upgrades of the Release 1 (R1) deployment at the end of May there has been some improvement. VHC call volume decreased slightly (8%) this quarter after a big drop last quarter (28%). This quarter we received 470 calls related to VHC, compared to 509 the previous quarter, and 706 in the first quarter of the calendar year. VHC calls were running at 400-500 per quarter until the first quarter of this year, which was when renewals went into effect and we had a very big increase. The VHC call volume has dropped back to the previous level.

The HCA has worked with VHC staff to resolve problems and escalate cases in which Vermonters need immediate access to care. We now have weekly meetings with VHC staff to resolve our more complex cases. When we first started these meetings, our list of cases to be resolved was usually 40 to 50 each week. We are now down to around 30.



C. Vermont Health Connect change of circumstance cases continued to decrease, and fell 14% this quarter.

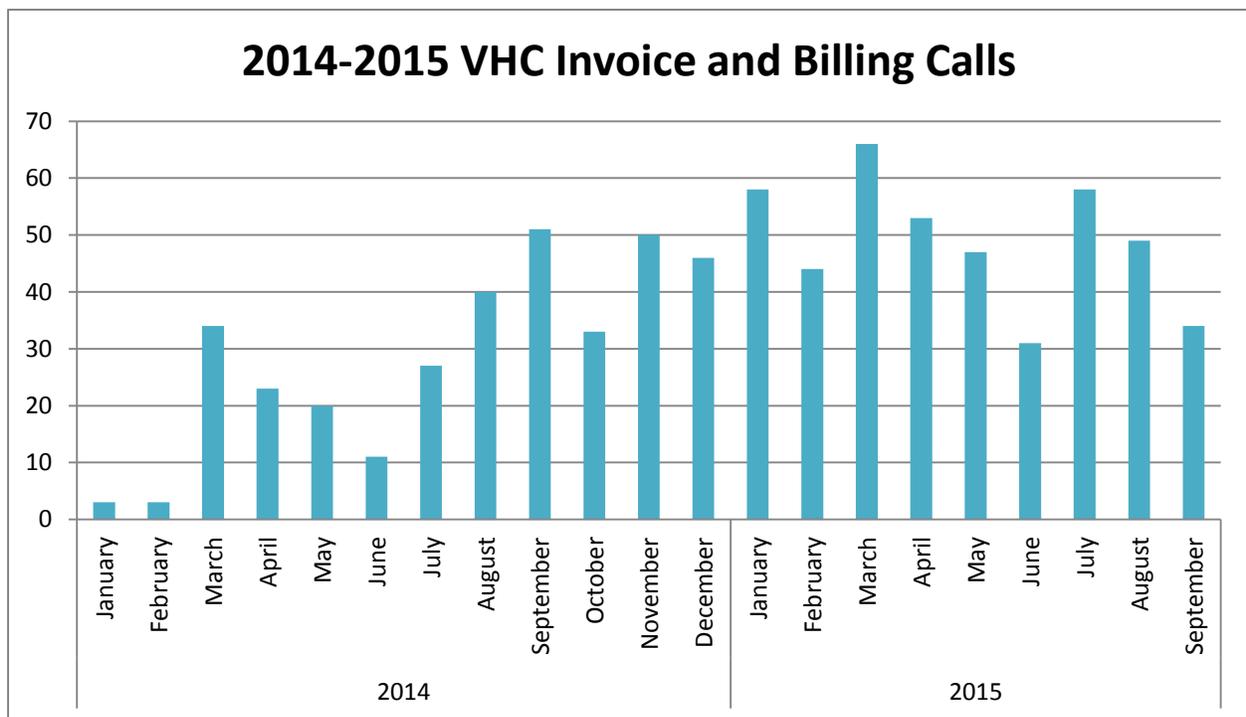
VHC had been plagued by problems resulting from the lack of technological capacity to process changes in customers’ circumstances. Since the deployment of R1 at the end of May, however, this situation has been improving. The number of COC cases has continued to decline, from 155 in the first quarter of CY 2015, to 109 last quarter, and now down to 94 this quarter, when primary and secondary issues are counted. There was a 30% drop from the first to second quarter, and an additional 14% decrease this past quarter.



D. The number one complaint from HCA callers is about Vermont Health Connect billing and payment problems, which increased 10 %.

Many consumers who purchased Qualified Health Plans (QHP) from VHC continued to have invoicing and billing problems. This is the number one complaint about VHC, and is the issue generating the most calls overall. The problems include non-receipt of invoices, delays in processing, delays in applying premiums to the correct account, delays in actually getting coverage, and lost payments. In some cases, the premium problems caused a consumer’s coverage to incorrectly be closed because they were not credited for payments they had actually made. Many were related to COC difficulties.

This quarter we received 141 calls involving invoices, billing and premium processing, compared to 128 last quarter, a 10% increase. We received 164 the previous quarter, and 125 the quarter before that, when primary and secondary issues are counted. We received 29 billing complaint calls in June, 58 in July, 49 in August and 34 in September.



E. More people are calling about premium payment grace periods and terminations.

VHC has specific and limited grace periods for catching up on premium payments. Individuals who do not get Advance Premium Tax Credits get a one month grace period, and those with APTC get three months. Because the carriers are now terminating coverage for non-payment more frequently, we are getting more inquiries about grace periods and terminations. This quarter we got 86 calls related to grace periods, compared to 43 last quarter, and 57 termination cases compared to 41.

The HCA is working with VHC and the carriers to revise the grace period notices to make them more understandable.

F. Human Services Board appeals about VHC decisions are increasing.

Calls requesting help with Fair Hearings before the Human Services Board (HSB) about VHC decisions almost doubled this quarter, 43 compared to 23. The HSB has told the HCA that the number of hearings requested has more than doubled since 2007. In 2007 they had 585 appeals; this year they predict 730 VHC appeals alone, part of a total of around 1,400 appeals. Last year the HSB handled 480 VHC appeals. Many of the cases are the result of VHC technology problems which are waiting to be resolved and about which there are no factual disputes. VHC's struggle to make changes to accounts has caused problems lasting many months for some consumers, who have turned to the HSB to get resolution of their problems.

VHC and DVHA are working with the carriers and the HCA to come up with ways to improve the appeals process and to get resolution of cases earlier to avoid such extensive use of the appeals system.

G. Affordable Care Act tax problems continued.

The HCA answered tax-related questions from VHC, tax preparers, health assisters, and consumer advocates in Vermont and in other states. The volume of questions addressed to the HCA's tax attorney was approximately the same as last quarter (62 compared to 64 last quarter). This quarter, many of the questions involved IRS tax return processing and audit procedures, or the Advance Premium Tax Credit reconciliation rules. One consumer was referred to the Vermont Low Income Tax Project² for representation in an IRS audit of the Premium Tax Credit, which was complicated by multiple VHC errors.

See a full discussion of our tax-related work below on pages 16-18.

² The VLITP is another project within Vermont Legal Aid funded by the IRS. The HCA's tax attorney splits her time between the HCA and the VLITP.

H. 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 1,015 (compared to 1,008 last quarter)

1. VHC Invoice/billing Problem 141 (128)
2. VHC complaints 119 calls (compared to 151 last quarter)
3. Complaints about providers 100 (99)
4. VHC Change of Circumstance 94 (109)
5. Grace Periods-VHC 86 (42)
6. Access to Prescription Drugs 82 (58)
7. MAGI Medicaid eligibility 60 (79)
8. Information about DVHA programs 59 (79)
9. Affordability issue that created an access problem 59 (56)
10. Information about VHC 58 (96)
11. Termination 57 (41)
12. VHC Premium Tax Credit eligibility 46 (78)
13. Consumer Education about Fair Hearings 43 (23)
14. Consumer Education about Medicare 40 (38)
15. DVHA/VHC Premium billing 39 (65)
16. Medicaid eligibility (non-MAGI) 36 (54)
17. Special Enrollment Periods (eligibility) 35 (43)
18. DCF/HAEU Mistake 29 (31)
19. Hospital billing 26 (24)
20. Medicaid billing 24 (35)

Vermont Health Connect Calls 470 (compared to 509 last quarter)

1. VHC Invoice/Payment/Billing problem 141 (126)
2. VHC complaints 118 (118)
3. Change of Circumstance 92 (109)
4. Grace Periods –VHC 86 (42)
5. MAGI Medicaid eligibility 56 (65)
6. Information about VHC 55 (91)
7. Termination 50 (35)
8. Premium Tax Credit Eligibility 46 (78)
9. DVHA/VHC Premium billing 38 (62)
10. Access to Prescription Drugs 38 (12)
11. Consumer Education about Fair Hearings 36 (12)
12. DCF/HAEU Mistake 29 (29)

DVHA Beneficiary Calls 287 (compared to 298 last quarter)

1. Complaints about Providers 43 (43)

2. Access to Prescription Drugs 43 (28)
3. Information about DVHA programs 26 (46)
4. Choosing/Changing Providers 20 (13)
5. MAGI Medicaid eligibility 19 (37)
6. Transportation 18 (12)
7. Affordability 17 (18)
8. Medicaid Billing 17 (30)
9. Change of Circumstance 13 (21)
10. Balance billing-Medicaid 13 (16)
11. Primary Care Doctor (access to) 13 (7)

Commercial Plan Beneficiary Calls 278 (compared to 348 last quarter)

1. VHC invoice/payment problem 84 (96)
2. VHC complaints 66 (105)
3. Change of Circumstance 47 (68)
4. Grace Periods-VHC 44 (38)
5. Information about VHC 33 (57)
6. DVHA/VHC premiums billing 25 (54)
7. Premium Tax Credit eligibility 23 (47)
8. Termination 18 (3)
9. DCF/HAEU Mistake 16 (25)
10. Disenrollment 15 (11)

I. Hotline call volume by type of insurance:

The HCA received 1,015 total calls this quarter. Callers had the following insurance status:

- **DVHA program beneficiaries** (Medicaid, VPharm, or both Medicaid and Medicare aka “dual eligibles”) insured **28%** (287 calls), compared to 30% (298) last quarter;
- **Medicare³ 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 **16%** (165), compared to 18% (184) last quarter;
- **Commercial plan beneficiaries** (employer sponsored insurance, small group plans, or individual plans) insured **27%** (278), compared to 35% (348) last quarter; and
- **Uninsured** callers made up **15%** (152) of the calls, compared to 8% (89) last quarter.
- In the remainder of calls insurance status was either unknown or not relevant.

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

J. Dispositions of closed cases

All Calls

We closed 1,083 cases this quarter, compared to 1,065 last quarter.

- 30% (321 cases) were resolved by brief analysis and advice;
- 24% (259) were resolved by brief analysis and referral;
- 28% (304) of the cases were complex interventions involving complex analysis, usually direct intervention, and more than two hours of an advocate's time;
- 12% (128) were resolved by direct intervention, including calling an insurance company, calling providers, writing letters, gathering supporting medical documentation, etc.;
- 1 consumer was represented in a commercial plan internal appeal, and 1 in a DVHA internal appeal;
- 5 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 37 individuals with appeals: 2 commercial plan appeals, 27 Fair Hearings, 4 VHC expedited internal hearings, 2 DVHA internal MCO appeals and 2 Medicare appeals. Most of our cases involving VHC and DVHA problems are resolved without using the formal appeals process.

DVHA Beneficiary Calls

We closed 309 DVHA cases this quarter, compared to 329 last quarter.

- 33% (102 cases) were resolved by brief analysis and advice;
- 29% (90) were resolved by brief analysis and referral;
- 18% (55) were considered complex intervention, which involves complex analysis, usually direct intervention, and more than two hours of an advocate's time;
- 15% (46) were resolved by direct intervention on the caller's behalf, including advocacy with DVHA and providers, writing letters, and gathering medical information;
- 4 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: 7 cases involved appeals on behalf of DVHA program beneficiaries: 4 Fair Hearings, 2 internal MCO appeals, and 1 Medicare Part D appeal.

Commercial Plan Beneficiary Calls

We closed 293 cases involving individuals on commercial plans, compared to 381 last quarter.

- 28% (83 cases) were resolved by brief analysis and advice;
- 12% (34) were resolved by brief analysis and referral;

- 37% (115) were considered complex intervention, which involves complex analysis, usually direct intervention, and more than two hours of an advocate's time;
- 15% (45) 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: 30 cases involved appeals for individuals on commercial plan: 2 Level 1 internal appeals, 23 Fair Hearings, 4 Expedited Fair Hearings, and 1 Medicare Part A appeal.

K. Case outcomes

All Calls

The HCA helped 105 people get enrolled in insurance plans and prevented 17 insurance terminations or reductions. We obtained coverage for services for 39 people. We got 23 claims paid, written off or reimbursed. We helped 2 people complete applications and estimated VHC insurance program eligibility for 14 more. We provided other billing assistance to 54 individuals. We obtained hospital patient assistance for 1 person. We provided 539 individuals with advice and education. We obtained other access or eligibility outcomes for 91 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 \$110,207.49** in cases opened this quarter. So far in calendar year 2015 we have saved Vermonters **\$449,152.36**.

L. Case examples

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

1. Worker went without health insurance due to incorrect information from VHC. Mr. A called the HCA because he did not have health care coverage and had been told by VHC that he was not eligible. An outdoor worker, he was worried about an accident or injury. Earlier in the year he had coverage through his employer, but lost that coverage when the job ended. Before his employer coverage had ended, he had called VHC to find out how and when to apply for coverage due to losing employer sponsored insurance. He was told incorrectly that he could not apply for VHC coverage until he had actually lost the coverage. So Mr. A did not apply. He then left the state to work at

a short-term temporary job. When he returned to Vermont he called VHC again. This time he was told that he could not enroll because he had missed his 60 day Special Enrollment Period (SEP) from the loss of employer sponsored insurance. The HCA advocate contacted VHC on his behalf and asked that he be given another SEP because of the incorrect information he had been given earlier. Under VHC rules Mr. A should have been able to apply the first time he called VHC. VHC granted another SEP, and Mr. A signed up for coverage.

2. Mr. B could not afford his medications because VHC did not process his change in circumstance (loss of income). He needed the medication to prevent seizures and he was afraid to skip it. His VHC plan had been cancelled for non-payment. In 2014, Mr. B had called VHC to let them know that he had lost his job. His lower income made him eligible for Medicaid. VHC, however, did not process the income change so Mr. B's Qualified Health Plan (QHP) was not cancelled and he was not enrolled in Medicaid. When VHC processed his renewal for 2015 it did not address the income change. This meant that Mr. B was auto-renewed onto the same QHP. Mr. B did not pay the premiums because he could not afford them after losing his job. The QHP was eventually closed for non-payment, but Mr. B was still not enrolled in Medicaid. Immediately after he called the HCA for help, the HCA advocate contacted VHC which activated Mr. B's Medicaid within hours so he was able to get his prescriptions that day.
3. Mr. C keeps his Medicaid coverage and gets his stepson onto insurance with assistance from the HCA. Mr. C received a notice from VHC saying that his Medicaid was going to be terminated because he was over income, and that he needed to enroll in a QHP through VHC. Mr. C called the HCA for help. He told his advocate that his stepson had just found a job, and that the income from that job had put the household over the Medicaid limit. He also noted that his stepson was uninsured. Upon investigation, the advocate learned that Mr. C did not claim the stepson as a dependent on his taxes. This meant that under Medicaid rules, the stepson's new income should not have been included in the eligibility calculations. Without the new income from the stepson's job, Mr. C remained eligible for Medicaid. The advocate also requested that the stepson be screened for a QHP with premium tax credits. In the end, Mr. C remained on Medicaid and his stepson got a plan with significant premium tax credits.
4. Ms. D called the HCA because she did not have any health care coverage, needed medical care, and was receiving calls from collection agencies for unpaid medical bills. She had applied for coverage through VHC six months earlier but her application had not been processed. The HCA advocate investigated and found that VHC had a record of

the March application. The advocate contacted VHC on Ms. D's behalf. Within days VHC found her eligible for Medicaid retroactively to March 1, so her providers could be paid.

M. Recommendations to the State of Vermont

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

VHC billing problems were the number 1 reason Vermonters contacted the HCA this quarter. This is the third quarter in a row in which VHC billing cases exceeded change of circumstance complaints. Billing problems can cause a cascade of hassles for consumers.

2. *Improve the grace period and termination notices for VHC plans.*

A work group has started meeting about this.

3. *Improve the VHC appeals process.*

A work group has started meeting about this.

III. Consumer Protection Activities

A. Rate Reviews

The HCA monitors all insurance carrier requests for changes in premium rates, which are usually rate increases. Carriers filed three rate review requests with the Green Mountain Care Board this quarter. The HCA entered Notices of Appearance in all three, and none were ready for hearing during the quarter.

Two important rate review cases were pending at the beginning of the last quarter: the two filings for plans to be offered on VHC in 2016 by Blue Cross Blue Shield of Vermont (BCBSVT) and MVP. The two carriers filed their requests for rate increases on May 15, 2015. The HCA worked closely with its independent actuary, Donna Novak of NovaRest, to analyze the exchange filings and to suggest questions that the Board's actuaries, Lewis and Ellis (L & E) should pose to the carriers. Ms. Novak also prepared an expert report and testified at the hearings held on July 28 and July 29, 2015, at the Green Mountain Care Board.

Members of the public testified orally at the BCBSVT hearing, and almost 500 members of the public submitted written comments. Most of these expressed concern about the affordability of health insurance products on VHC.

BCBSVT, which insures more than 65,000 Vermonters through VHC, requested an 8.6 percent average annual rate increase. The Board modified the request and approved a 5.9 percent

annual increase. The Board's actuary, L & E, and the HCA recommended a number of small decreases to the requested rate which were adopted by the Board. The Board made additional small adjustments to the requested rate as well. The HCA argued for, and the Board approved, a 1% contribution to surplus rather than the 2% contribution requested by the carrier.

MVP, which insures approximately 6,500 Vermonters through VHC, requested a 3 percent average annual rate increase. The carrier tried to keep its rate increase for 2016 low so that its products could be competitive with those offered by BCBSVT in the VHC marketplace. The Board approved a 2.4 percent increase for MVP based on recommendations from L & E and the HCA.

B. Certificate of Need Applications

The HCA monitored all CON proceedings before the Board. This quarter we focused primarily on the University of Vermont Medical Center's Inpatient Bed proposal and the new Green Mountain Surgery Center application.

- UVM Medical Center's Inpatient Bed: During the last quarter the Board released its decision approving this CON application with modifications. UVM MC responded by asking for clarification and modification of the order. We reviewed the Board's decision, attended two status conferences, reviewed UVM MC's motion to modify and request for clarification on the decision, attended the hearing on UVM MC's motion to modify where we submitted oral testimony, reviewed UVM MC's alternative financing plan submitted in September 2015, and submitted questions in response to UVM MC's financing plan.
- Green Mountain Surgery Center: This was a new CON application this quarter. We submitted a Notice of Appearance as an interested party, and submitted questions to the applicant. Our questions included requests for: more information regarding the applicant's plans for accreditation; peer reviewed support for the applicant's claims of cost, quality, and patient experience benefits resulting from this type of model; potential weaknesses with the proposed model; opportunities provided for patient input when planning the model; price transparency; and the facility's financial assistance policies.

C. Hospital Budgets

The HCA participated in the Board's hospital budget process this summer. Prior to the public hearings we reviewed the information each of the state's fourteen hospitals submitted to the Board, including their Community Health Needs Assessments (CHNAs). We also reviewed each hospital's financial assistance policy (FAP) in light of the new federal regulations on this topic which go into effect on January 1, 2016. We submitted suggested questions to the Board and

attended the three days of hearings in August. After the hearings we submitted comments on the hospital budgets which focused on: the hospitals' lack of compliance with the new FAP rules; hospital consolidation and integration; access to care; evidence-based medicine; and the hospitals' CHNAs.

D. Other Green Mountain Care Board Activities

In the last quarter, we attended the following Board events:

- Weekly GMCB meetings (8)
- Monthly Data Governance Meetings (3)
- Additional meetings with Staff (5) – some general meetings and others specifically focusing on the topic of the Board's work towards an all-payer model

E. Vermont Health Care Innovation Project

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

- Participated in 2 meetings as a member of the VHCIP Steering Committee
- Participated, along with representatives from other projects of Vermont Legal Aid, as “active members” in 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 5 VHCIP work group meetings
- Attended 2 meetings of the VHCIP Core Team as an interested party
- Attended the CMMI Site Visit Stakeholder Meeting
- Submitted formal comments to the VHCIP Core Team regarding Accountable Care Organization consumer engagement
- Submitted formal comments to the VHCIP Payment Models Work Group regarding the total cost of care for the Medicaid Shared Savings Program
- Submitted comments on a draft survey for people participating in the Care Management Learning Collaborative

F. Affordable Care Act Tax-related Activities

During this quarter, the HCA continued its tax-related advocacy and outreach efforts to ensure that consumers maintain access to affordable health care. Consumers who lack an understanding of how the tax system interacts with the health insurance system, or who have

difficulty navigating the tax filing process, are in danger of losing access to subsidized health insurance.

Eligibility for advance payments of the federal Premium Tax Credit (APTC) is contingent upon reconciliation of any prior year APTC. Consumers who received APTC for 2014 will not be eligible for APTC in 2016 unless they reconcile their APTC on a 2014 tax return. Vermont Premium Assistance also requires eligibility for APTC, so a consumer who does not reconcile APTC will have an unsubsidized QHP premium.

The reconciliation requirement is complicated by the problems consumers had in getting accurate and timely tax forms from VHC for 2014. The HCA is concerned that errors made by VHC or Benaissance, VHC's payment processing vendor, could prevent some consumers from reconciling their 2014 APTC in time to receive APTC for 2016.

In the spring of 2015 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). Unfortunately, as detailed in our last two quarterly reports, the new tax form got off to somewhat of a rocky start. 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.

In this quarter we continued to assist consumers with problems related to forms 1095-A from VHC. The HCA helped many consumers get account changes made and get amended tax forms from VHC. In the most complicated cases, consumers' reconciliation problems may affect their access to APTC for 2016. HCA is monitoring this issue closely.

In July and August, many Vermont consumers received IRS notification that they had failed to reconcile their 2014 APTC, and would not be eligible for 2016 APTC unless they remedied the error. Some of these consumers had actually filed tax returns, but had failed to include Form 8962 to reconcile their APTC. These consumers generally did not understand the reconciliation requirement or why they had received the IRS notice. HCA engaged in significant consumer education on APTC reconciliation issues.

During this quarter, the HCA continued to employ a half-time tax attorney, who also staffs the Low Income Taxpayer Project at VLA. This allowed the HCA to stay up to date on tax law developments and support our staff to effectively field calls related to the ACA and VHC. The tax attorney consulted with HCA advocates when particularly difficult IRS-related issues arose in individual HCA cases.

HCA continued to communicate with VHC regarding substantive tax issues as they arose. One issue we discussed this quarter was the extent to which consumers who enroll in a Qualified

Health Plan directly through the carriers for 2016 coverage⁴ will be able to switch to coverage through VHC in order to receive APTC if their income decreases during the year.

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

G. Other Activities

Article on the ACA and Indian Health Care

The HCA's tax attorney published an article in the American Bar Association (ABA) Section of Taxation's *NewsQuarterly*, exploring the impact of the ACA on American Indian and Alaska Native consumers. *The ACA, the Service, and the Indian Health Care Delivery System* was co-authored with Heather Erb, an attorney in private practice in Washington State. The article addresses the intersection of the ACA and Indian tax issues and offers recommendations for addressing the unique Indian tax issues related to enrollment in the state and federal health insurance marketplaces. All members of the ABA Section of Taxation receive a copy of the *NewsQuarterly*.

Rule 09-03 Work Group

The HCA is actively involved in this work group which was set up in Act 54 of the 2015 legislative session. The work group's purpose is to help the Agency of Administration, the Green Mountain Care Board and the Department of Financial Regulation evaluate the necessity of maintaining provisions for regulating insurers in Rule 09-03, which contains consumer protection and quality requirements for managed care organizations, and other regulations governing quality and consumer protection. The group is also assessing which state entity is the appropriate one to be responsible for functions set forth in the regulations. The group met twice during the quarter.

2017 Qualified Health Plan Work Group

The HCA is participating in this stakeholder group which was convened by DVHA to help develop any recommended changes to benefit design for Qualified Health Plans offered on Vermont Health Connect in 2017. The group met twice during the quarter.

Legislative Activities

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

This quarter, we:

- Testified before the House Health Care Committee

⁴ Previously individuals could only enroll in QHPs through VHC. This year the legislature mandated that individuals who are not eligible for APTC may enroll directly through the carriers.

- Attended 2 meetings of the Joint Fiscal Committee
- Attended 3 meetings of the Health Reform Oversight Committee
- Met and collaborated with other advocates on legislative initiatives, including participation in a 2-day meeting of the Oral Health Care for All leadership team

Administrative Advocacy

This quarter, the HCA:

- Submitted 1 formal comment suggesting changes to a confusing IRS notice
- Submitted formal comments on the IRS Taxpayer Advocate Service's Employer Shared Responsibility Estimator Tool
- Submitted formal comments on a draft DVHA rule on direct enrollments and QHP certification.
- Met with AHS to discuss Vermont's long-term care programs and their relationship to AHS's Health Benefits Eligibility and Enrollment (HBEE) rule, which implements the Affordable Care Act in Vermont. HCA advocated for clearer public guidance and emphasized the need to address outdated regulations that conflict with the HBEE rule.
- Participated in 1 meeting about VHC fair hearings
- Corresponded with the Human Services Board (HSB) about its new VHC appeal form
- Submitted comments on a HSB VHC appeal form
- Participated in 1 meeting about VHC notices
- Participated in 1 meeting about VHC direct enrollment
- Participated in 8 meetings about the VHC case escalation path
- Submitted formal comments on VHC regulations
- Submitted two sets of comments on VHC notices
- Submitted comments on a draft billing and enrollment timeline document addressing VHC's new enrollment and recurring billing and dunning policy
- Submitted comments on VHC's "Introduction to VHC" booklet
- Submitted numerous complaints and suggestions to VHC
- Met with DVHA Commissioner Steven Costantino about stakeholder engagement

Other Boards, Task Forces, and Work Groups

This quarter the HCA participated in:

- 2 Rule 09-03 Review Work Group meetings
- 2 Qualified Health Plan Stakeholder Work Group meetings
- 2 Medicaid and Exchange Advisory Board (MEAB) meetings
- 2 MEAB Improving Access Work Group meetings (a subgroup of the MEAB which works on improving access to Medicaid services, which the Chief Health Care Advocate Chairs)
- 2 VHC Consumer Experience Work Group meetings
- 1 informal meeting with Community Health Accountable Care
- 1 Community Health Accountable Care Consumer Advisory Board meeting
- 1 conference call with Community Catalyst and consumer advocacy organizations in other states

- 1 conference call with the Agency of Administration *et al.*, about the Rule 09-03 Work Group
- 2 State HIT Plan Workshops
- 2 UVM Medical Center Mental Health Program Quality Committee meetings
- 1 42 CFR Part 2 Advisory Group meeting
- 1 Act 75 Unified Pain Management Advisory Council meeting

Additionally, the HCA submitted:

- Comments to Community Health Accountable Care providing feedback on its first Consumer Advisory Board meeting
- Comments to AHS on the Global Commitment to Health Comprehensive Quality Strategy
- 2 sets of federal comments on ACA provisions

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
- Bi-State Primary Care Association
- Community of Vermont Elders
- Families USA
- Iowa Legal Aid
- IRS Taxpayer Advocate Service
- Northwest Health Law Advocates
- 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 Dental Hygienists' Association
- Vermont Health Connect
- Vermont Information Technology Leaders
- Vermont Low Income Advocacy Council
- Vermont Public Interest Research Group
- Voices for Vermont's Children

Trainings

The HCA participated in the following trainings:

- 7/9: The Lewin Group Consumer Advisory Committees Webinar - Recruiting and Retaining Members for Engagement
- 7/15: Consumer's Union Rate Review Conference Call
- 7/21: Appeals in the Marketplace
- 8/11: IRS Webinar - Information Reporting by Applicable Large Employers on Employer-Sponsored Health Coverage

- 8/20: IRS Webinar - Affordable Care Act: Employer Shared Responsibility Provisions and Information Reporting
- 8/26: IRS Webinar - The Affordable Care Act: Information Reporting of Minimum Essential Coverage
- 8/27: The Affordable Care Act and Its Impact on Family Law
- 9/16: NASHP Webinar - From Engagement to Evidence: Using PCOR and CER to Inform State Policymaking
- 9/18: Consumer's Union All Payer Claims Database Webinar
- 9/18: Employment Law and the ACA
- 9/25: Panelist at the Vermont Bar Association Fall Meeting
- 9/30: Vermont Information Technology Leaders Summit

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 72% in the reporting quarter ending September 30, 2015 (5,764 pageviews), compared with the same quarter in 2014 (3,350 pageviews).
- The number of people seeking information about [dental services](#) continued to increase significantly (600%) over last year, as it has the past two quarters. (217 pageviews this quarter, compared with 31 in the same period last year)
- This quarter, again like the previous two quarters, showed a large increase over last year in the number of people seeking information about [Medicaid income limits](#) (1,301 pageviews this quarter, compared with 248 in the same quarter in 2014, an increase of 425%). The consistently high numbers indicate that search engines are delivering this page as a high-ranking source of information about Medicaid income limits.
- The health home page had the second largest number of pageviews (887), an increase of 50% over last year's 591.
- Six of the 10 topics with the largest number of pageviews focused on Medicaid or long-term care Medicaid (Choices for Care).
- Other popular topics included:
 - [Health Insurance, Taxes and You](#) (New this year/no comparative data)

- [Medical Decisions, Advance Directives and Living Wills](#) (+60%)
- [Federally Qualified Health Centers \(FQHCs\)](#) (+147%)
- While the number of people searching for information about [Buying Prescription Drugs](#) (+9%) and [Complaints](#) (things to consider before making a complaint against a provider) (+50%) still increased, those pages fell out of the top 15 to 17th and 29th, respectively.

PDF Downloads

Thirty-five out of 84 or 41% of the unique PDFs downloaded from the Vermont Law Help website were on health care topics. Of those 35 health-related PDFs:

- 20 were created for consumers. The top consumer-focused downloads were:
 - Advance directive, short and long forms
 - Vermont dental clinics chart
 - Blue Cross Blue Shield of VT Annual Report 2014
 - Vermont Medicaid Coverage Exception Request – 10 Standards and Provider Request Form
- 8 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
 - Affordable Care Act - 2014 Tax Returns and Beyond
 - Premium Tax Credit - Marriage, Separation and Divorce
- 7 covered topics related to health policy. The top policy-focused downloads were:
 - Accountable Care Organizations - What is the Evidence? (and supporting documents)
 - Health Literacy and Plain Language

Our [Vermont Dental Clinics Chart](#) was the 6th most downloaded of all PDFs downloaded from the Vermont Law Help website.

B. Education

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

Flyers, Letter Templates, Other Printed Material

We wrote two articles for the July issue of Vermont Legal Aid's newsletter, *Justice Quarterly*. The first article explained two different forms of late-payment forgiveness available from the IRS for consumers affected by ACA implementation problems. It included links to two template letters that consumers can use to request abatement of late payment penalties. The second

article raised awareness that Vermont Health Connect's six-month delay in using the 2015 Federal Poverty Level guidelines to determine eligibility for Medicaid and Dr. Dynasaur had likely resulted in some people being incorrectly denied coverage.

In July, we published an article in the American Bar Association (ABA) Section of Taxation's *NewsQuarterly*, exploring the impact of the ACA on American Indian and Alaska Native consumers. The article was co-authored with Heather Erb, an attorney in private practice in Washington State.

Also in July, the *Journal of Tax Practice & Procedure* published a revised excerpt of the chapter on the Affordable Care Act that was co-authored by our tax attorney. The chapter was originally published by the ABA in the 6th edition of its manual, *Effectively Representing Your Client Before the IRS*.

Promoting Plain Language in Health Communications

In September, the HCA suggested major revisions to two important communications for consumers from the state:

- Reasons for Appeal Form – this form is being used by the Human Services Board in an effort to decrease the number of no-shows for scheduled Fair Hearings of Vermont Health Connect appeals. The HCA does not condone the use of this form, but we understand the volume of cases compared with the staffing levels at the HSB. We worked with the HSB to improve the form by rewriting difficult language and removing other requirements that would make the form an obstacle to the consumer's right to a Fair Hearing.
- Welcome to VHC Booklet – this booklet will be sent to new Vermont Health Connect customers. The HCA re-organized and edited the booklet to make it easier for the general public to understand.

Additionally in September, the HCA suggested a number of edits to add clarity and increase the readability level of Vermont Health Connect's one-pager explaining Full-Cost Individual Direct Enrollment.

Presentations

During this quarter, the HCA provided education directly to approximately 110 individuals, many of whom serve populations that will likely benefit from the information and education provided.

Low-Income Tax Clinic Network (July 7)

The HCA's tax attorney gave a presentation to 10 legal services attorneys on the IRS Taxpayer Advocate Service's (TAS) primary concerns related to the ACA, as presented in TAS's most recent Report to Congress. The attorney also presented and distributed the template IRS penalty waiver forms developed by the HCA in April and June 2015.

Trans Town Hall, Pride Center, Burlington (August 21)

The HCA presented on a panel with a peer support advocate and the Safe Space coordinator at the Pride Center about transitional medical services, the process for getting insurance coverage for transitional services, and resources that are available. There were 12 attendees, including trans individuals as well as Pride Center staff and community partners. We handed out 15 brochures.

American Bar Association Tax Section Webinar (September 9)

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 42 tax attorneys and tax professionals via webinar. Topics included tax assessment and collection issues related to the Premium Tax Credit and the Individual Shared Responsibility penalty, controversy issues for practitioners, APTC renewals, IRS communications and partner resources, and the Taxpayer Advocate's leading concerns.

American Bar Association Tax Section Meeting (September 18)

The HCA's tax attorney was featured on a panel discussion of current issues related to tax filing status. The HCA's presentation focused on the intersection of ACA and tax filing status issues. The presentation, sponsored by the Individual and Family Taxation Committee, was given to 25 tax attorneys and tax professionals at the September meeting of the ABA Tax Section.

Vermont Bar Association Annual Meeting (September 25)

The HCA presented to 22 members of the Vermont Bar Association as part of a panel discussing Health Care Reform and Regulation in Vermont. The HCA presentation provided an overview of our statutory authority to work on behalf of consumers in the areas of health care advocacy, public policy, and rate review.

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

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	FOHC 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