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Demonstration Year: 12
(1/1/2017 – 12/31/2017)

Quarterly Report for the period
April 1, 2017 – June 30, 2017

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I. Background and Introduction

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

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

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

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

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

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

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

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

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

As Vermont's Medicaid Single State Agency and under the Terms and Conditions of the Global Commitment to Health Waiver, AHS has entered into an Inter-governmental Agreement (IGA) with the Department of Vermont Health Access (DVHA). The AHS/DVHA IGA functions similarly to a Medicaid Managed Care contract in that it delineates program requirements and responsibilities between AHS and DVHA and according to federal Medicaid Managed Care requirements found at 42 CFR §438. DVHA also has sub-agreements with the other State entities that provide specialty care for GC enrollees (e.g., mental health services, developmental disability services, and specialized child and family services).

One of the Terms and Conditions of the Global Commitment Waiver requires the State to submit progress reports 60 days following the end of each quarter. ***This is the second quarterly report for waiver year 12, covering the period from April 1, 2017 through June 30, 2017 (QE0617).***

II. Outreach/Innovative Activities

i. Provider and Member Relations

Key updates from QE0617:
- Non-Emergency Medical Transportation
- Dental Services

<u>Non-Emergency Medical Transportation</u>

The Non-Emergency Medical Transportation (NEMT) program ensures that Medicaid members who do not have access to transportation are able to get rides to and from medical appointments and daily dosing for opioid addiction treatment.

The Provider and Member Relations (PMR) Unit ensures members have access to appropriate health care for their medical, dental, and mental health needs. This also entails transportation to appointments as per Federal Rule 42 CFR §440.170(a), "Transportation includes expenses for transportation and other related travel expenses determined to be necessary by the agency to secure medical examinations and treatments for a recipient."

After a bidding process in Fall 2016, Vermont Public Transit Authority (VPTA) was awarded a contract to implement and operate a Medicaid NEMT system statewide for eligible Medicaid members. This contract included a 6 month transition period to allow for the creation of a call center and other new infrastructure. The transition period ended on June 30, 2017. As of July 1st, 2017, DVHA is contracted to work with only one transportation provider, VPTA, who has 7 subcontracted Brokers. This system of statewide coverage allows members to have streamlined coordination throughout the state for NEMT services. Prior to July 1, 2017, Medicaid members

had to call one of 8 regional Brokers for transportation. Now, members can dial one toll-free number statewide.

DVHA updated its NEMT Manual effective July 1, 2017, in order to come into full compliance with 42 CFR Part 455 subpart E – Provider Screening and Enrollment. The updated manual also reflects changes from the new contract with VPTA. The latest NEMT manual can be found on the DVHA website at http://dvha.vermont.gov/for-providers/1nemt-manual-7-1-17-final.pdf. No significant changes were made to the manual that impact Medicaid members.

Dental Services

With the expansion of Medicaid in 2014 and the elimination of the VHAP program, there has been a substantial increase to numbers of individuals eligible for the Medicaid adult dental benefit. DVHA recently lost an important dental provider in the White River Junction area who served only Vermont Medicaid patients. As of June 30, 2017, this provider retired leaving 572 Medicaid patients without a dental provider. Therefore, DVHA is currently struggling to ensure members have access to dental care. In addition to the above stressors, dental providers across Vermont continue to express concerns over provider rates, no-show costs, and the administrative burden of the Medicaid dental benefit.

In order to ensure all members have access to dental service, DVHA has met several times over the past six months with the Vermont Dental Society and dental network providers to brainstorm on how DVHA can assist them in terms of no-shows and burdensome administrative processes. As a result of these meetings, dental providers report a decrease in administrative burdens. Dental providers have noted on several occasions that DVHA willingness to work with them on processes to decrease no shows such as making reminder calls, information on non-emergency transporation if need has help with some of the administrative issues. However, DVHA continues to hear that multiple dental providers are considering withdrawal from the Medicaid program. DVHA continues to work with the Dental Colleges in New England and the Dental Society in order to solicit new dentists to practice in Vermont.

III. Operational/Policy Developments/Issues

i. Vermont Health Connect

Key updates from QE0617:

- More than 80,000 Vermonters were enrolled in a qualified health plan (QHP) – more than any prior year – including nearly 30,000 enrolled through Vermont Health Connect (VHC), more than 5,000 direct-enrolled with insurance carriers, more than 45,000 enrolled in a SHOP small business plan.
- New system functionality to support passive (ExParte) VHC Medicaid Renewals resulted in less burden on Vermonters and less processing work for Health Access Eligibility and Enrollment Unit (HAEEU) staff.
- In the spring of 2016, DVHA-HAEEU set a goal of completing 75% of customer requests within ten business days by October 2016 and 85% by June 2017; this goal was met ahead of schedule and 95% of requests were completed within ten days during QE0617.
- Operational metrics related to customer support, integration, reconciliation, work processing, and escalated cases – all of which had improved dramatically over the previous year – stayed strong throughout the quarter.

In early 2017, Vermont Health Connect completed its most successful Open Enrollment to date, both in terms of qualified health plan (QHP) enrollment and in terms of operational metrics. QE0617 showed continued strong performance on both counts.

On the enrollment side, as of June 2017 more than 220,000 Vermonters (more than one-third of the population) were enrolled in VHC health plans (approximately 80,000 in Qualified Health Plans and 140,000 in Medicaid for Children and Adults) either through the marketplace or directly through an insurance carrier. Of the 174,000 who did not receive coverage through a small business employer, 94% qualified for either Medicaid or financial help to lower the cost of coverage. While there have not yet been updates to last year's national studies, this enrollment data implies that Vermont has likely continued to build on the nation's second lowest uninsured rate (according to the National Center for Health Statistics) and the lowest uninsured rate for children (according to the State Health Access Data Assistance Center).

Enrollment data suggests that Vermont continues to make progress in enrolling "young invincibles." Young adults aged 26-34 comprised 25% of new enrollments, compared to 12% of re-enrollments.

Operationally, the Department of Vermont Health Access's Health Access Eligibility and Enrollment Unit (DVHA-HAEEU) kept up with incoming work, ending QE0617 with some of the shortest work queues in VHC's existence. In the spring of 2016, DVHA-HAEEU had set a goal of completing 75% of customer requests within ten business days by October 2016 and 85% by June 2017. DVHA-HAEEU met this goal ahead of schedule and continued to improve. In QE0616, fewer than 60% of requests were completed within ten days. In QE0617, 95% of requests were completed within ten days.

A year ago, the integration of cases across partner systems continued to pose significant challenges for VHC. After work last spring and summer addressed defects, the integration team set ambitious goals for 2017 and have met the mark nearly every month. The VHC-Carrier integration error rate was just 1.2% in QE0317, compared to 3.0% in QE0316. Just as importantly, the team maintained a low inventory of open errors by promptly addressing and staying on top of any issues that arose. At the end of QE0617, zero VHC-Carrier errors had been open for ten days or more, compared to 188 at the end of QE0616.

Similarly, the reconciliation team set ambitious goals for 2017, aiming to conduct monthly reconciliation across the VHC system, BlueCross BlueShield of Vermont's system, and payment processor WEX's system, and address at least 90% of data discrepancies between within 30 days. As of the end of QE0617, the reconciliation team had surpassed the goal every month.

The reconciliation team also tackled Medicaid reconciliation during QE0317, reviewing more than 4,600 cases to ensure alignment between the VHC system and the State's legacy ACCESS system.

Redeterminations for Medicaid for Children and Adults (MCA) and Medicaid for the Aged, Blind and Disabled (MABD), which had completed their first annual cycles in QE0317 and QE0916 respectively, continued on a normal annual cycle. DVHA-HAEEU promptly processed incoming applications, ending QE0617 with fewer than 150 open MCA applications (five of which were older than 45 days) and fewer than 300 open MABD (none of which were older than 45 days).

The MCA redetermination effort benefitted from new ExParte functionality that increased the number of MCA members who could be passively renewed in QE0617. More than two-thirds (68%) of income-based Medicaid customers in the most recent monthly batch of MCA Medicaid Renewals were able to be renewed without any action by the member, resulting in less burden on Vermonters and less processing work for DVHA-HAEEU staff. DVHA-HAEEU helped achieve the high success rate by prescreening relevant cases, identifying potential data issues, and working to clean the data in the weeks prior to the renewal.

Maximus continued to manage the VHC Customer Support Center (call center), utilizing 71 customer service representatives as of the end of QE0617. The call center serves Vermonters enrolled in both public and private health insurance coverage, providing Level 1 call center support, which includes phone applications, payment, basic coverage questions, and change of circumstance requests. Maximus is also the entry point for individuals requiring greater levels of assistance with case resolution. Maximus representatives transfer such calls to DVHA-HAEEU for resolution and log service requests, which are escalated to the appropriate resolver group. The Customer Support Center received more than 91,000 calls in the quarter and met its targets in all three months. Over the course of QE0617, the call center had an abandon rate of 2% and answered more than three-quarters (84%) of calls within 24 seconds.

Vermont Health Connect was supported throughout the state by 231 Assisters (40 Navigators, 113 Certified Application Counselors or CACs, and 78 Brokers) in QE0617, giving Vermont the

most Assisters it has ever had. In preparation for a planned July 2017 reduction in Navigators, the Assister program continued to network with hospitals, health centers, and other community organizations with a goal of recruiting and training even more CACs. Overall, in QE0617 Navigators and CACs largely focused on helping Vermonters with Medicaid renewals, particularly new Vermonters with limited English proficiency and others with accessibility challenges.

Health insurance literacy was also an outreach focus throughout QE0617. DVHA-HAEEU engaged health care providers, libraries, state offices, and legislators in helping Vermonters understand the importance of responding to Medicaid renewal notices and comparing options for qualified health plans. Vermont Health Connect's website continued to be a key source of information for current and prospective customers alike, receiving 125,000 visits in the quarter. The Plan Comparison Tool, which helps customers estimate total costs of coverage based on family members' age, health, and income, was used in nearly 10,000 sessions during the quarter – fairly typical traffic outside of Open Enrollment.

During QE0617, DVHA-HAEEU also promoted self-service options for customers to pay their bills, report changes, and access tax documents and other forms. Self-service leads to an improved customer experience as Vermonters can log in at their convenience. It also has the benefit of using automation to reduce staffing expenses. Year-over-year comparisons show that more customers are using self-service functions, including both online accounts and the options of paying premiums through monthly recurring payments rather than one-time payments. Nearly 20% more customers logged into their online account in QE0317 than did so in QE0316, and more than twice as many customers were signed up for recurring payments at the end of QE0617 than QE0616.

ii. Choices for Care

Key updates from QE0617:

- ERC rates increased May 1, 2017.
- Group Directed Attendant Care rate increased June 1, 2017.
- Companion Aide Pilot comes to an end June 30, 2017.
- Vermont updates LTC Ombudsman Statute to comply with new federal regulations.

<u>Rate Increases</u>

May 1, 2017, the Department of Disabilities, Aging and Independent Living (DAIL) implemented a rate increase for Enhanced Residential Care (ERC) services referred to in the previous quarterly report. This rate increase provides additional resources for ERC providers to fulfill their oblications under licensing regulations and improve access to ERC services for Medicaid beneficiaries. Public notice was issued through the Global Commitment Register.

June 1, 2017, DAIL increased the rate for a site-specific service called Group Directed Attendant

Care. The site-specific service operates at South Burlington Community Housing, an accessible apartment complex managed by Cathedral Square. This unique service provides shared caregivers from the Visiting Nurses Association (VNA) of Chittenden/Grand Isle Counties to residents in their own apartments 24 hours/day, 7 days/week. This rate increase accommodates the increase in the complexity and level of care needed by current residents. Without this service, residnets would be at risk of moving to a nursing facility. Public notice was issued through the Global Commitment Register.

Though the Vermont appropriations bill had not been signed by the end of this quarter, DAIL was preparing for a proposed 2% rate increase to be applied to Choices for Care home and community-based services in the SFY18 budget.

Companion Aide Pilot

In March 2015, Vermont implemented a Companion Aide Pilot Project to provide assistance to nursing facilities in advancing culture change with a focus on person-centered dementia care through July 1, 2017. The intent of the pilot was to provide an enhanced Medicaid rate to five interested and eligible facilities that were committed to person-centered dementia care through dedicated "Companion Aide" staff. The Companion Aide is a trained licensed nursing assistant (LNA) who champions person-centered dementia care with the goal of improving the lives of people with dementia, as evidenced by positive changes such as a reduction of the use of psychotropic drugs, incidence of resident to resident altercations, and improved staff satisfaction.

DAIL completed a preliminary evaluation of the results which show some reduction in use of anti-psychotics, a reduction in involuntary discharges and an increase in the Artifacts of Care scores. DAIL plans to survey the participating facilities and staff to identify future support for Companion Aide and dementia care.

For more information, refer to the Companion Aide Pilot Summary 2017.

Legislation

Vermont passed legislation (Act 23) to modify the State statute related to Long-Term Care Ombudsman services to align with new federal regulations (45 CFR Parts 1321 and 1327). Prior to 2015, federal regulations had not been promulgated that specifically focused on state implementation of the Long-Term Care Ombudsman program.

Wait List

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

Moderate Needs Group (MNG) services are not an entitlement and instead are limited by funding which is allocated to providers and managed at the local level. This requires that providers establish a wait list when funds are spent in their region. Currently, home health providers report that approximately 700 people are waiting for help to pay for homemaker services statewide and

zero people are waiting for help to pay for Adult Day services. Though total funding for MNG services was increased to eliminate the wait list in SFY2015, it is important to note that eligibly for Moderate Needs is quite broad which creates an opportunity for a very large number of Vermonters to be eligible. Therefore, it is expected that unless the eligibility criteria were to be modified, wait lists for the limited Moderate Needs funding will continue for the foreseeable future.

Moderate Needs Stakeholder Workgroup

DAIL initiated a stakeholder workgroup following a State initiative to evaluate opportunities for Medicaid payment and service delivery reform in Vermont. The workgroup will provide feedback on opportunities for improved management of Moderate Needs services with a focus on improving outcomes for Vermonters. The workgroup will meet into late summer/early fall.

iii. Developmental Disabilities Services Division

Key updates from QE0617:

- SFY 16 Reinvestments
- HCBS provider self-assessment tool created.
- Wait List

HCBS Provider Self-Assessment

Vermont has completed a provider self-assessment survey for developmental services in relation to milestones outlined in Vermont's Comprehensive Quality Strategy (CQS). The CQS is being used to demonstrate the state's compliance with the new HCBS rules - analogous to Statewide Transition Plans being developed by other states. The division Quality Service Review team will conduct follow up validation visits. An inter-agency team has been formed to collect information on the experiences of people who are being supported in settings that may isolate them. Based on the findings, a variety of improvement plans will be identified. These activities will serve to bring our system to full compliance with Home and Community-Based Settings rules by the due date of March 2023.

Wait List

DDSD collects information from service providers on individuals who request funding for Home and Community-Based Services (HCBS). The information is a reporting spreadsheet created by the State and used by Designated and Specialized Services Agencies and the Supportive Intermediary Service Organization (Supportive ISO) to collect information on individuals with developmental disabilities (DD) who are waiting for DD services but are not currently eligible. HCBS funding priorities are the method by which Vermont prioritizes who will receive caseload funding allocated annually by the legislature (managed by the State though the Equity Fund and Public Safety Fund) and existing funding (managed internally by the Agencies and Supportive ISO, and the State through Returned Caseload Fund). When these reports are created they include three categories:

1. New Applicants: Individuals with DD who are clinically and financially eligible but who do not meet a funding priority for HCBS and have been denied services in whole or in part.
2. Individuals Receiving Services: Individuals with DD currently receiving HCBS services whose requests for additional services is denied in whole or in part because the change in their circumstance does not result in meeting a funding priority.
3. Individuals who are clinically and financially eligible for Targeted Case Management (TCM), Family Managed Respite (FMR), Flexible Family Funding (FFF) or Post-Secondary Education Initiative (PSEI), but for whom there are insufficient funds.

There were no individuals who met a home and community-based services funding priority who were waiting for services that helps address the need related to the funding priority.

iv. Traumatic Brain Injury (TBI) Program

Key updates from QE0617:

- TBI program is a new addition to this report – program summary provided.
- No wait list for TBI services.

Program Summary

In 1991, the Department of Disabilities, Aging and Independent Living (DAIL) began the operation of a three-year pilot project offering community-based rehabilitative services for individuals with moderate to severe traumatic brain injury. The goal of this program was to divert people from facility placement and/or return Vermonters with a moderate to severe traumatic brain injury from out-of-state facilities. Prior to the development of this service, people were placed in expensive out of state facilities, often there for years, with little hope of returning to their home communities. The project demonstrated that individuals with a moderate to severe traumatic brain injury participating in the pilot were able to be served appropriately in community-based settings.

Today the Traumatic Brain Injury Program provides rehabilitation and life skills services in community based settings to approximately 90 Vermonters per year with a moderate to severe traumatic brain injury. This is a rehabilitation-based, choice-driven program intended to support people to achieve their optimum independence and help them return to work.

DAIL works closely with the Brain Injury Association of Vermont and a TBI advisory board, assuring Vermont's continued support for people living with a brain injury. For more information go to the Brain Injury Association of Vermont.

As people with long-term support needs are identified through the TBI program , efforts are being made to transition eligible people to the Choices for Care program for continued long-term services and supports. There is currently no wait list for TBI services in Vermont.

v. Global Commitment Register

Key updates from QE0617:

- Since the Global Commitment Register (GCR) launched in November 2015, 77 final GCR policies have been publicly posted.

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

The GCR listserv is a group of about 375 interested parties who have elected to receive periodic key updates about Vermont health care programs. All members of the Medicaid and Exchange Advisory Board are also on this listserv. GCR updates include policy changes to all Medicaid programs as well as policy changes to Vermont's Health Benefit Exchange. A policy change in the GCR could be a change made under the authority of the waiver, a proposed waiver amendment or extension, an administrative rule change or a State Plan Amendment. The GCR also contains policy clarifications for when an issue is identified that is not clearly answered in current policy.

Health care policy stakeholders are notified via email every time a proposed or final policy is posted to the GCR; an email is also sent when policy clarifications are posted. Stakeholders have an opportunity to provide comments on proposed GCR policies before the policies are made final. Comments received are posted in the GCR online.

A combined total of 20 policies were posted to the GCR this past quarter. This includes proposed and final changes, as well as four clarifications. Changes to rates and/or rate methodologies accounted for half of the changes, with the remainder being changes to administrative rules, policies, and State Plan Amendments.

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

IV. Expenditure Containment Initiatives

i. Vermont Chronic Care Initiative (VCCI)

Key updates from QE0617:

- The VCCI continues to work with the MMIS Enterprise Care Management team on system bugs/defects, end user training, user acceptance testing (UAT), data integrity and reporting; as well as new features to enhance case management performance. R2 deployment is scheduled for late July, 2017.
- The CMS certification 'customized check list' is in development for the VCCI utilization of the Enterprise MMIS/Care Management software system. Full deployment is anticipated late fall, with system certification application prior to calendar yearend.
- The VCCI leadership is working with DVHA legal counsel, MMIS care management technical colleagues, the MMIS care management vendor and Vermont Health Information Exchange (VHIE) to facilitate biomedical data transfers from the VHIE on Medicaid members, into the enterprise care management solution. The goal is to enhance identification of case management needs, clinical monitoring and evaluation, including for next generation ACO attributed members. A calendar year end interface and data transfers is anticipated.
- The DVHA next generation ACO contract with Vermont Care Organization precludes ACO attributed members from receiving VCCI case management services. New eligibility rules are being developed using the ACO member attribution file from the payment reform/data units. Retrospective claim files will be uploaded in the next quarter to support performance measurement.

The VCCI is a component of DVHA's health care reform goals and its supporting strategic plan. The goal of the VCCI is to improve health outcomes of Medicaid beneficiaries by addressing the increasing prevalence of chronic illness through various support and comprehensive case management strategies.

The VCCI employs 27 licensed and non-licensed professional staff operating in a decentralized model statewide, so resources are available where members need them. The VCCI is designed to identify and assist high risk/high cost, medically complex Medicaid members with chronic health conditions in accessing clinically appropriate health care information and services; coordinate the efficient delivery of health care by attempting to remove barriers, bridge gaps, and avoid duplication of services; and educate, encourage and empower members to eventually self-manage their chronic conditions. A significant effort is placed on facilitating and supporting Medicaid member identification, access and use of a Medical Home for receipt of primary care.

The VCCI uses a holistic model of evaluating and supporting improvement in medical and behavioral health, as well as identification of socioeconomic issues that are barriers to sustained health improvement. The top 5% of VCCI-eligible Medicaid members account for approximately 39% of Medicaid costs and a disproportionate number of hospital admissions and readmissions.

The VCCI's strategy of embedding staff in high-volume hospital sites to support population engagement at the point-of-need in areas of high service utilization and prior to claim

adjudication continues, and supports direct referral at the point of need. By targeting high risk/cost members, resources can be allocated to areas representing the greatest opportunities for member engagement, clinical improvement and cost savings.

The model of embedding staff in high volume provider practice sites is under review as necessitated by the decline in eligible practice site members, concurrent with the launch of the next generation ACO in 2017. Excluded populations currently include dually eligible individuals, those receiving other waiver services and CMS-reimbursed clinical case management, including 'next generation' ACO attributed Medicaid members.

As a result of the ACO launch, VCCI is in the process of updating eligibility criteria with exclusion of ACO attributed members in the four pilot communities. The VCCI target population will expand to now include members in the top 10%, and with high anticipated future cost, based on predictive analytics.

The VCCI continue to strive for strategic alignment with other important State health care reform efforts, such as the DVHA Blueprint for Health, NCQA certified advance practice medical homes and local Community Health Teams (CHTs) funded by pubic and commercial payers. The VCCI staff function as extensions of the local CHT and support coordinated care planning with local partners. The VCCI generally supports the highest risk population and performs home visiting, while the carrier funded CHT's have historically focused on less acute Medicaid members, often seen in the PCP office site. In pilot communities, the ACO, via PCP and carrier funded local CHT staff, will be accountable for case management of *all* Medicaid members attributed, including high and very high risk.

MOMS (Medicaid Obstetrical and Maternal Supports) for Pregnant Women

The VCCI initially launched the case management service line for at risk pregnant women as a pilot, which has steadily evolved based on staff and partner input. The service line has been refocused to a single centralized resource/expert available to the field staff as well as community and statewide partners. The MOMS case manager also has a case load of pregnant women. Since this change in structure the initiative had been able to move forward on a more accelerated rate. VCCI staff are subsequently trained on the MOMS services and accept local at-risk women on their case load. The primary focus is on women with a history of mental health and substance use/abuse and related management of these conditions during pregnancy, to improve birth outcomes and limit NICU and/or inpatient stays for both baby and mother. The MOMS staff liaison and case manager, is an important resource to the statewide VCCI team as well as to our partners supporting at risk pregnant women and women of child bearing years. The expansion of pregnancy case management assessment tools is anticipated in the new eQH system in 2017 as part of Release 3/4, now scheduled for fall 2017. While the position has been vacant for the first two quarters of calendar 2017, a new staff is scheduled to start in early August 2017. A challenge in VCCI hiring remains, as the starting state nursing salaries for experienced nurses- remains less than other community case management positions, even with a 35% market factor adjustment. Elimination of the policy for 'hire into range' for nurse case managers prevents consideration of 'experience' in any new hire offer. The VCCI has 2 additional vacancies at the close of Q2 with recruitment underway for both positions.

Enterprise Care Management System

The vision of enhanced local coordination and a single plan of care remains a component of the long-term state vision toward an all payer model. The AHS Enterprise MMIS Care Management system supports this opportunity as part of the 'future state'. Specifically, release two (R2) is expected to have both provider and consumer portals. Policies to support portal access and related role based user permissions are being developed prior to activation of these features.

Case management will be enhanced for Medicaid members with impending access to biomedical data on enrolled members via the data interface between the VHIE and the State Enterprise Care Management system for Medicaid members. The data interface is expected to enhance clinical and financial reporting capabilities on Medicaid members consistent with DVHA priorities for focus: enhancing information technology, results based accountability (RBA) and performance based payment. This MMIS enterprise care management technology will leverage and maximize the CMS investments to the State for evaluation and reporting of clinical and financial outcomes on Medicaid members in areas of investment which include technology and payment reform via the next generation ACO pilot.

The new AHS Enterprise MMIS/care management vendor utilizes the Johns Hopkins evidence based predictive modeling and risk stratification software to support population selection and related eligibility for services. This new model will enhance VCCI's ability to identify members based on both past cost profiles (top 5%) and anticipated future utilization, risks and costs, and intervene earlier in order to track the clinical and financial improvements.

The VCCI staff continue to support User Acceptance Testing (UAT) of system features as well as bug/defect identification, backlog 'grooming' for vendor resolution, concurrent with testing requirements and review of written deliverables for Release 2 acceptance. Release 2 has had a change in deliverable requirements with the exclusion of VCCI business reporting requirements as a separate 'workstream'. Release 2 full deployment into the production environment and required deliverable acceptance has been pushed back to late July, 2017. The business operating/evaluation 'reports' work effort will be concurrent with Release 3 and 4 planning and integrated in the CMS customized certification check list for VCCI. Report delivery is anticipated to occur as a progressive deployment (agile) as priority reports are developed and ready for testing and delivery. A full time clinical analyst is indicated to develop the required business reports from disparate data models in the Tableau environment, as the system reports will not fully meet the business operating needs.

The UAT part time effort by roughly 6 VCCI clinical staff (and 2 non-clinical team members) continues, along with staff development and/or review of system training materials and related training time. This, plus the reduction of nurse FTE's in 2016 due to the sunset of our previous vendor, VCCI staff vacancies in 2017, and ineligibility of ACO attributed members in CY 2017, all contributed to the decline in the overall VCCI case load in SFY 2017 and an adjustment in our approach. New eligibly rules are underway for Q3 which will exclude next generation ACO attributed members and include a 12 month look back of the top 10% high risk members who also have future predictive risk.

With the continued support of the Organizational Change Management (OCM) team at the state and with eQH, VCCI is continuing to develop and expand on training materials and guides for the team, supplemented by phone sessions, monthly staff meeting agenda items, 'trained trainer' sessions followed by small group hands on training with supplemental practice sessions and materials in the training environment to assure expertise. Knowledge assessment and application of documentation standards outlined in our workflow are monitored by monthly audits with a staff goal of 90% accuracy. At the end of quarter two, staff averages are over 90% of audit. User surveys supplement other information sources in evaluation of ease of system use, staff knowledge and overall operating satisfaction. Post deployment 'end user' surveys with each release are planned.

To address the high volume of tickets for system bugs and defects the VCCI restructured and assigned staff to a liaison role with the UAT /quality team and close the gap among the outstanding tickets in reduction. Resultantly, hundreds of production tickets were closed in the backlog cleanup, others prioritized for immediate resolution and still others, moved out of 'governance review' for a change request and/or into 'sprints' for vendor resolution. End user satisfaction was increased with the vendor addressing system speed and the plan of care documentation procedures, toward greater efficiency and fewer workarounds. Backlog grooming sessions are in progress, however priority work schedule from the vendor remains a challenge. Service Level Agreements (SLAs) have been further assessed.

The VCCI clinical SME who is also a regional manager, reduced hours to 20% MMIS effort, effective quarter two, in order to support clinical field operations. Another MMIS/VCCI staff who is a 'super user' was 100% allocated in a SME role, along with the Director at roughly 80%. Focus will be on assuring end user needs are being addressed and communicated, training documents reviewed, edited and streamlined for VCCI workflow; and related staff training and monitoring of adherence via audits, and impending system reports are in place. Additionally, this resource is also responsible for working on the new functionality for R2 and related test cases, testing and related supports to operationalize (i.e. portals for consumer/providers) in partnership with the VCCI Director and AHS leadership to assure HIPAA privacy and security standards and policy development and/or alignment.

System training documents and policies continue to be updated to reflect system enhancements, and fixes. Direct referral systems continue to be refined with referrals internally from the DVHA Clinical Operations Unit and the Quality Improvement Units. Both units utilize the enterprise software regularly to support direct referral of members being discharged from the hospital to support reduction in 30 day readmission rates for members who are transitioning from hospital settings for mental health and/or substance use/abuse; or other long term hospital stays (13 days or greater).

The VCCI management team, analyst and care management technical team continue to work on the bio-medical data feeds from the Vermont Health Information Exchange and the Care Management vendor. This data resource for 100% of Medicaid members will enhance the clinical staff ability to effectively identify need and manage care based on member treatment and management to evidence based care goals and clinical results. Trending is anticipated at the member, provider, and hospital service area level, as well as by ACO attribution. The HIE

vendor had been fairly unresponsive, however conversations are anticipated to become more robust in Q3 with clarity of HIPAA needs, HIE provider contract language and DVHA/HIE contract extensions. Work effort will be shared by the HIE and the Case Management software vendor, with a 2017 year end interface anticipated.

CMS certification

Meetings with the CMS certification team to review requirements and related check lists, artifacts and operational criteria will continue be in Q3 of calendar year 2017. Initial check list reviews are in process and will be updated to reflect functionality that will be delivered in Releases 2, 3 and 4; as well as completion of the Reports workstream efforts toward business reporting, finalizing of Gap in Care functionality and delivery of these individual and population based system features concurrent with reduction in bugs/defects. Resultantly, the timeline for submission of the certification letter is likely year end with anticipated CMS review 6 months after request for certification review.

ii. Blueprint for Health

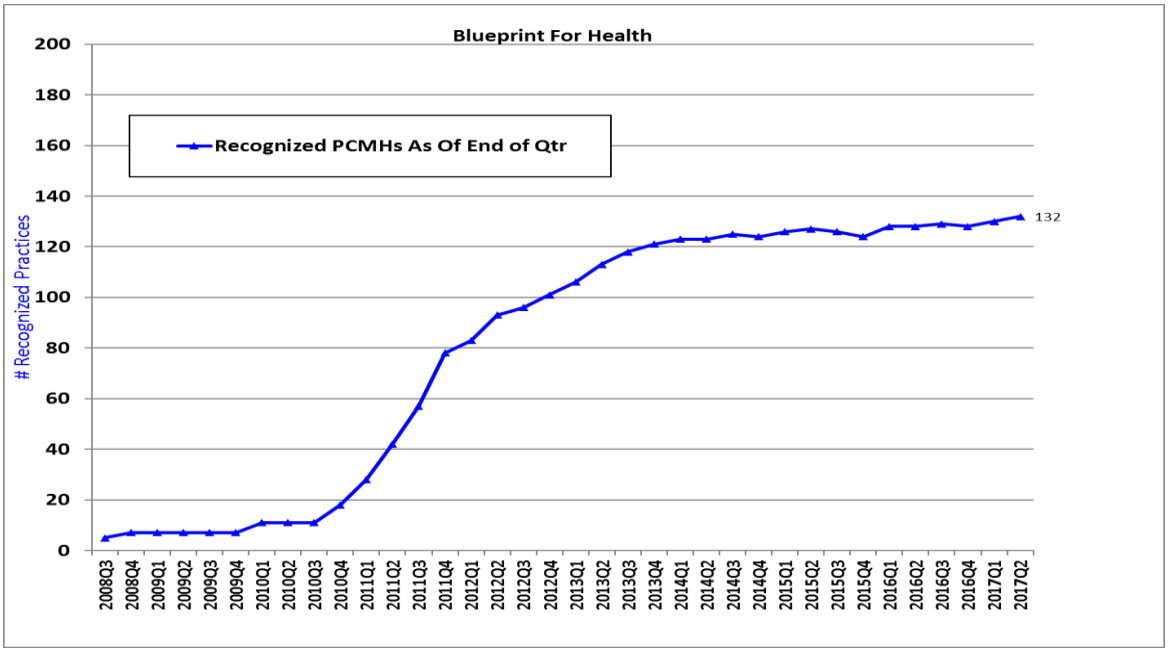
Key updates from QE0617:

- Two new practices joined the Blueprint for Health program as of 7/1/2017, bringing the total number of Patient-Centered Medical Homes in Vermont up to 132.
- Practice and HSA profiles for the data period 07/2015 – 06/2016 were produced and distributed in June 2017.
- The Opioid Treatment Program in Northwestern Vermont has opened, increasing treatment access within that region of the State and improving treatment capacity within Chittenden County as a result.
- Increased access to treatment for patients with opioid use disorder: 3,114 clients enrolled in Regional Opioid Treatment Programs (OTPs) and 2,600 Medicaid beneficiaries were served by Office-Based Opioid Treatment (OBOT) programs as of June 2017.
- Increased access to enhanced health and psychosocial screening along with comprehensive family planning: within two quarters, the Blueprint enrolled 19 WHI practices that represent half of the total OB/GYN practices in Vermont and serve 11,323 WHI patients.

Patient Centered Medical Homes

In the past quarter, the Blueprint for Health program has had a net increase of two NCQA-recognized primary care practices. Both practices qualified and joined the Blueprint as of 7/1/2017. The Blueprint has approached a saturation point where the program has recruited most of the available primary care practices in the state, and the rate of onboarding of new practices has generally plateaued. The number of Blueprint PCMH practices as of the end of the quarter was 132.

Figure 1. Patient Centered Medical Homes



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

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

i. 01/2013 - 12/2013.

ii. 07/2013 - 06/2014.

iii. 01/2014 - 12/2014.

iv. 07/2014 - 06/2015

v. 01/2015 – 12/2015.

vi. 07/2015 – 06/2016.

Practice and HSA profiles for the data period 07/2015 – 06/2016 were produced and distributed in June 2017. The information in those profiles give practices an overview of total utilization and expenditures as compared to peers and the rest of the state. Vermont HSA data profiles, including the latest ones for the data period 07/2015 – 06/2016, are posted at http://blueprintforhealth.vermont.gov/reports_and_analytics/hospital_service_area_profiles.

Hub & Spoke Program

The "Hubs" are regional specialty addictions treatment programs. The “Spokes” are counselors, nurses and social workers who provide support for patients in the primary care setting, and are members of the local Community Health Teams. The Hub & Spoke model has increased access to treatment for patients with opioid use disorder: 3,114 clients enrolled in Regional Opioid Treatment Programs (OTPs) and 2,600 Medicaid beneficiaries were served by Office-Based Opioid Treatment (OBOT) programs as of June 2017. Medication assisted treatment is being offered across more than 80 different practices and by 203 medical doctors and 62.5 FTE registered nurses and Master’s-prepared, licensed mental health / substance use disorder clinicians working as a team to offer Office-Based Opioid Treatment (as of June 2017). The Opioid Treatment Program in Northwestern Vermont has opened, increasing treatment access within that region of the State and improving treatment capacity within Chittenden County as a result.

Learning collaboratives were convened in April and June for providers and practice teams new to Office-Based Opioid Treatment (OBOT) and for advanced providers and practice teams to address best practices and emerging topics. Participating providers and practice teams received education on topics such as diversion, noncompliance and other substance use by Medication Assisted Treatment patients and relationship management with Opioid Treatment Programs in order to identify and improve transition issues, including referral and consultation, between the Opioid Treatment Programs (OTP) and Office-Based Opioid Treatment (OBOT) practices.

The Blueprint for Health, in collaboration with an analytics contractor, Onpoint Health Data, developed and published data profiles that provide valuable information regarding demographic and health status information, health service utilization, and expenditures for Medicaid beneficiaries served by Opioid Treatment Programs (OTPs, “Hubs”) and Office-Based Opioid Treatment (OBOT, “Spokes”). The data from these profiles have been presented in a multitude of forums (e.g. Mental Health and Substance Abuse Advisory Committee, Spoke Learning Collaborative, Women’s Health Steering Committee, Tobacco Control Program) to encourage a quality improvement approach to improving healthcare delivery through increased coordination of initiatives. For example, coalitions developed under the Women’s Health Initiative are working on formalizing referral agreements amongst partners within their health service areas to provide enhanced access, increased communication and increased coordination of care, including referral to treatment for substance use disorder.

The Blueprint for Health continues to work collaboratively with the Division of Alcohol and Drug Abuse Programs of the Vermont Department of Health on many initiatives, including the Initiation and Engagement in Treatment and Opioid Prescribing Project, in order to provide an interagency, comprehensive and data-driven approach to addressing the opioid crisis in the State of Vermont. The Vermont Department of Health, University of Vermont – College of Medicine, and the Blueprint for Health just designed, and released the registration for, two regional learning collaboratives designed to offer an opportunity for provider education on topics such as the Vermont Prescribing Monitoring System (VPMS) and best practices for treatment of chronic

pain and to encourage a practice team-based approach to improving opioid prescribing within the practice environment.

Community and State partners continue to work within the established committees, Prevention & Enforcement and Treatment & Recovery, of the Opioid Coordination Council to identify recommendations for system improvements that will positively impact the prevalence of opioid use disorder and number of drug-related fatalities observed within the State of Vermont.

Figure 2. MAT-SPOKE Implementation January 2013 – June 2017 Staffing

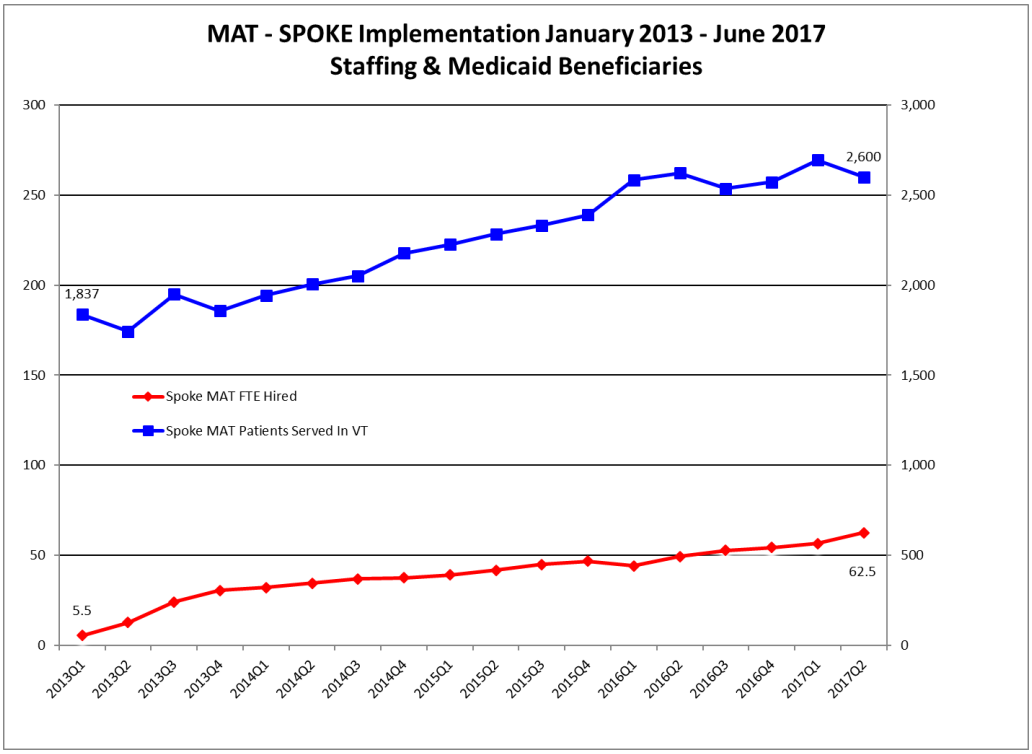


Figure 3. MAT-SPOKE MDs Prescribing Buprenorphine Jan 2013 – June 2017

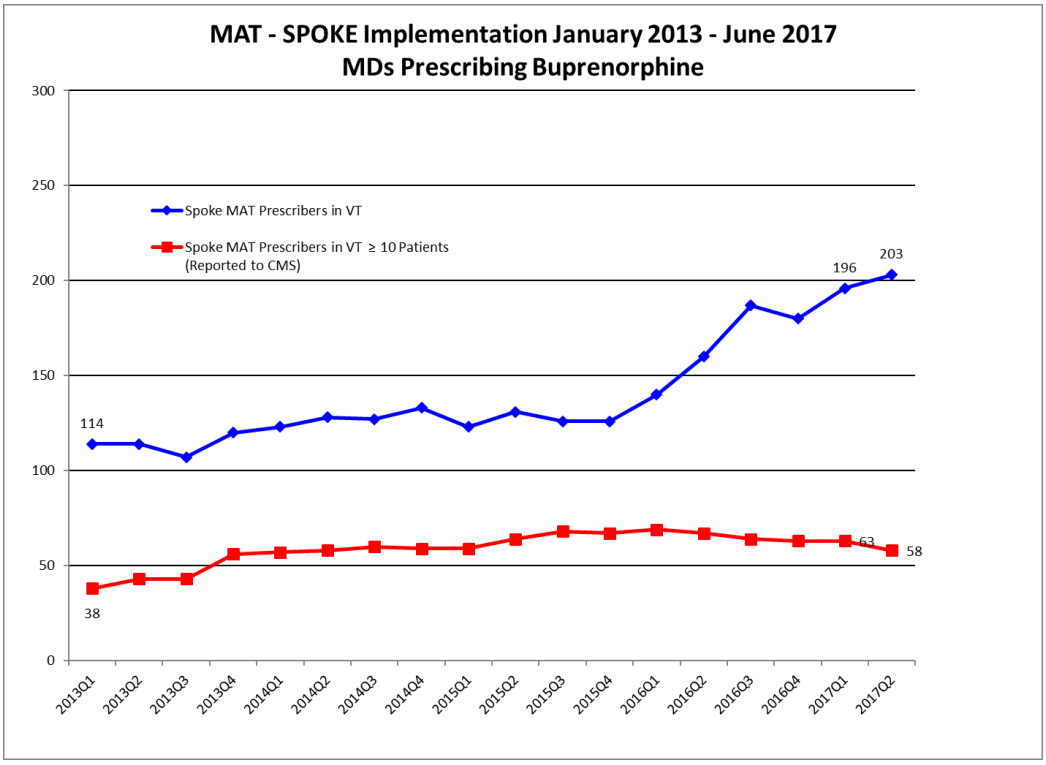
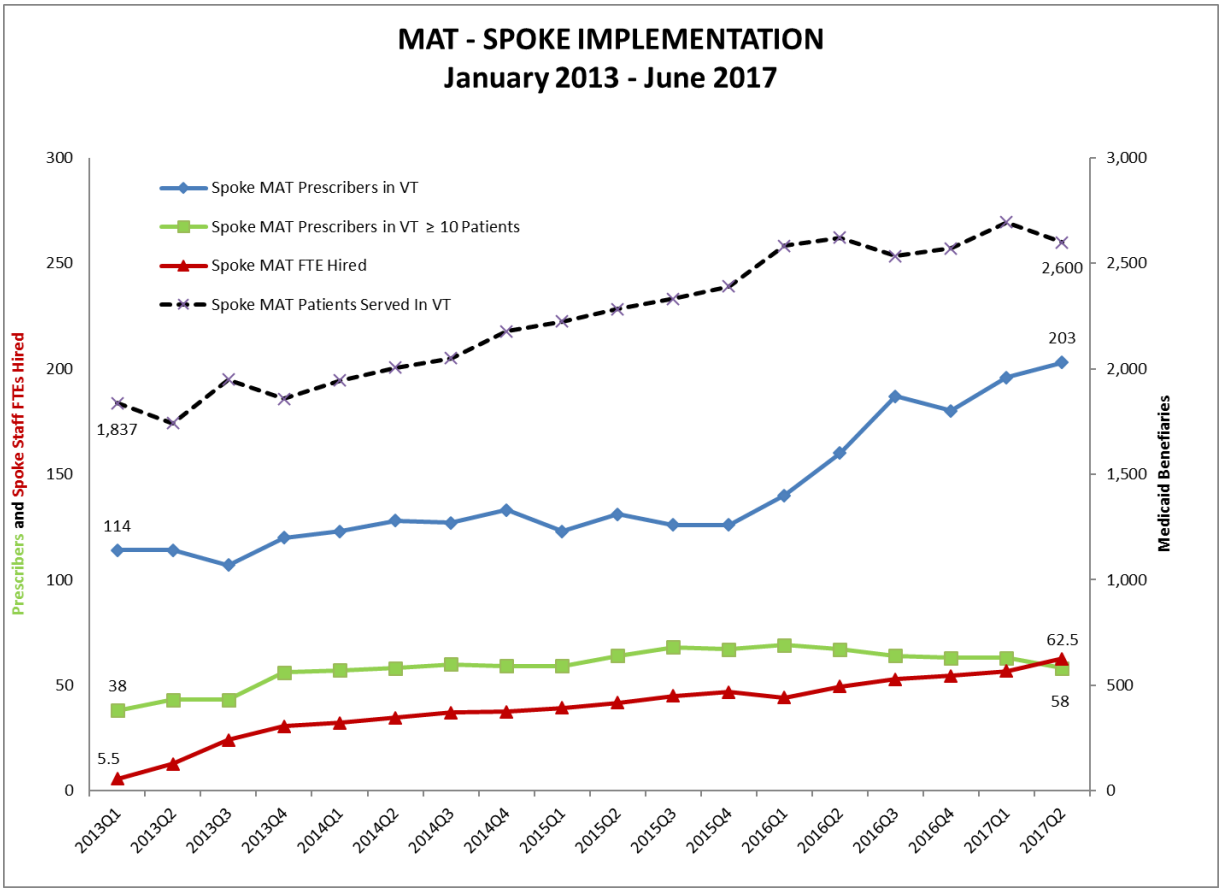


Figure 4. MAT-SPOKE Implementation Jan 2013 – June 2017



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

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

Table 1. Hub Implementation as of May 31, 2017

(Note: Figures as of June 30, 2017 were not available as of the date of this report)

Region	# Clients	# Buprenorphine	# Methadone	# Vivitrol	# Receiving Treatment but Not Yet Dosed
Chittenden, Franklin, Grand Isle & Addison	1021	306	714	0	1
Washington, Lamoille, Orange	472	191	281	0	0
Windsor, Windham	410	140	270	0	0
Rutland, Bennington	436	104	309	7	16
Essex, Orleans, Caledonia	775	213	557	4	1
Total	3114	954	2131	11	18

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 2. Spoke Implementation as of June 30, 2017

Region	Total # MD prescribing pts	# MD prescribing to ≥ 10 pts	Staff FTE Hired	Medicaid Beneficiaries
Bennington	10	3	5.2	239
St. Albans	14	8	9.1	384
Rutland	18	7	5.3	304
Chittenden	78	12	14.8	513
Brattleboro	10	6	3.7	138
Springfield	4	2	1.5	54
Windsor	9	4	4	212
Randolph	6	4	3.1	89
Barre	21	7	5.5	254
Lamoille	15	5	4.8	239
Newport & St Johnsbury	13	2	2	92
Addison	5	2	2	65
Upper Valley	5	0	1.5	17
Total	203*	58*	62.5	2,600

Table Notes: Beneficiary count based on pharmacy claims April – June, 2017; an additional **251** Medicaid beneficiaries are served by **31** out-of- state providers. Staff hired based on Blueprint portal report 7/25/17. *5 providers prescribe in more than one region.

Women's Health Initiative

Through the Women's Health Initiative, women's health specialty providers provide enhanced health and psychosocial screening along with comprehensive family planning counseling and timely access to long acting reversible contraception (LARC). New staff, training, and payments support effective follow-up to provider screenings through brief, in-office intervention and referral to services for mental health, substance abuse, trauma, partner violence, food and housing. The Women's Health Initiative ensures women's health providers have the resources they need to help women be well, avoid unintended pregnancies, and build thriving families.

Women identified as at-risk are immediately connected to a social worker for brief intervention and counseling and referral to more intensive treatment as needed. Each social worker is a member of the Community Health Team and available to connect women with the local network of health, social, economic and community service providers.

Women also receive comprehensive family planning counseling and services. Those who tell their providers they do not want to have a baby in the coming year have immediate and affordable access to LARC and other forms of contraception. Women who wish to become pregnant receive pre-conception counseling and services.

Quality Improvement Practice Facilitators work with participating practices to design practice workflows to support the enhanced screening, comprehensive contraceptive counseling, and same-day LARC insertion. Practice Facilitators also help practices integrate the social worker into their practice. Three payments support women's health care providers participating in this initiative. These three payments are:

- Recurring per member per month (PMPM) payments to WHI practices
- Recurring payments to support WHI Community Health Team (CHT) staff to the CHT administrative entities
- A one-time per member payment (PMP) to assist WHI practices in initiating WHI strategies and specifically provide support to the practices as they design and implement processes to provide evidence-based family planning counseling on the full spectrum of birth control options, stock LARC devices, and offer patients who choose LARC same-day insertion.

Each participating community builds a coalition including the participating women's health practices, primary care practices, and community organizations serving youth and women at risk of unintended pregnancy. Together, they develop referral pathways that get clients quicker access to necessary services.

Learning collaboratives were convened in May and June for community teams participating in the Women's Health Initiative to hear from Vermont providers regarding the best practices, emerging topics, and lessons learned pertaining to screening, brief intervention, referral to treatment (SBIRT) for mental health and substance use disorder and a trauma-informed approach to addressing intimate partner violence. In addition, the learning sessions offered opportunities

for collaborative community-based partnerships to evolve, identification of specific roles and responsibilities for each partner involved, and determination of partners that should be involved but were not currently.

Extension of the one-time per member payment (PMPM) to current Blueprint Patient-Centered Medical Homes was approved in the second quarter of 2017 to be implemented on July 1. Practices who received this payment in July attested to:

1. implementing enhanced screening, comprehensive contraceptive counseling, and same-day insertion for those women who choose LARC as their preferred birth control method;
2. increasing affordable access to LARC and other forms of contraception; and
3. developing referral protocols for at least 3 community-based organizations to see patients within one week of being referred for family planning services.

The Blueprint for Health continues to work collaboratively with the Vermont Department of Health, community organizations, providers, and practices to support Vermont women to have healthier lives through increasing the number of intentional pregnancies by increasing access to comprehensive family planning counseling, long acting reversible contraceptives for same-day insertions, and psychosocial screening and referral to treatment and services for mental health, substance use disorder, trauma, intimate partner violence, food insecurity and housing instability.

The Blueprint for Health, in collaboration with an analytics contractor, Onpoint Health Data, is working to develop data profiles that will provide valuable information regarding demographic and health status information, health service utilization, expenditures and outcome measures for the Women's Health Initiative.

Figure 5. Women's Health Initiative Practices

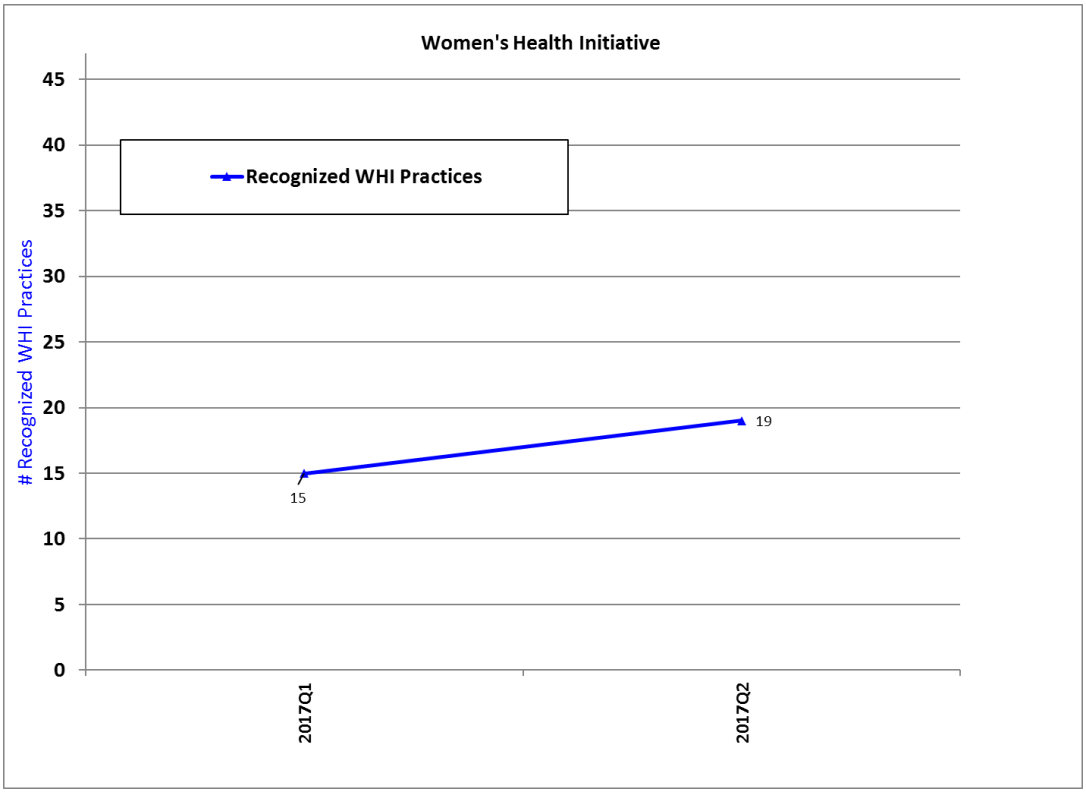


Figure 6. WHI Implementation Jan 2017 – June 2017

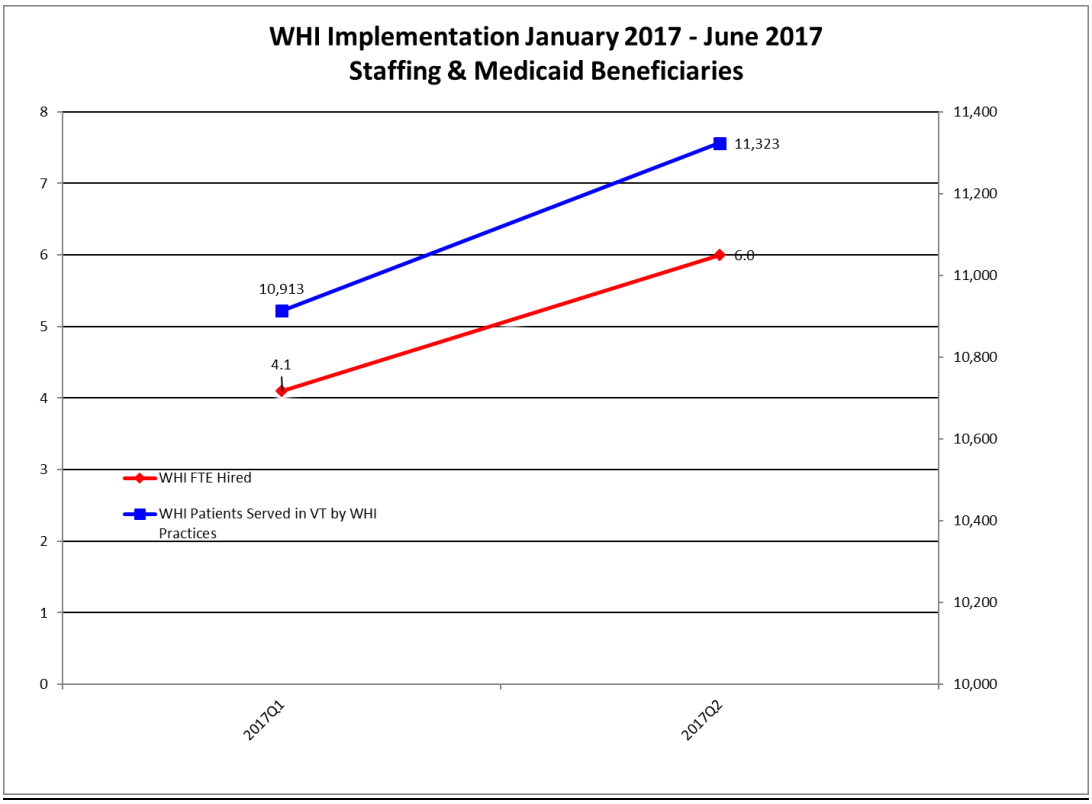


Table 3. WHI Implementation as of June 30, 2017

Region	Total # WHI Practices	Staff FTE Hired	Medicaid Beneficiaries
Barre	1	0.7	966
Bennington	1	0.5	910
Brattleboro	0	0	0
Burlington	4	2	2,692
Middlebury	1	0.5	594
Morrisville	1	0.5	479
Newport	1	0	873
Randolph	4	0.5	528
Rutland	2	1	1,590
St. Albans	2	1	1,379
St. Johnsbury	1	0.75	889
Springfield	1	0.5	423
Upper Valley	0	0	0
Windsor	0	0	0
Total	19	7.2	11,323

iii. Behavioral Health

Key updates from QE0617:

- Paper review process initiated for substance abuse residential facilities
- Applied Behavior Analysis benefit moves forward
- Pilot project for inpatient psychiatric care for children
- Substance abuse residential level of care authorization procedure solidified
- Team Care program revitalized

The Behavioral Health Team is responsible for concurrent review and authorization of inpatient psychiatric, detoxification, and substance abuse residential services for Medicaid primary beneficiaries. In 2016, the team moved to paper reviews for psychiatric and detoxification services to ensure member confidentiality and improve interrater reliability. This practice has been expanded to include substance abuse residential facilities. As a result, the clinical documentation to support authorization requests has improved significantly. Training sessions with residential facilities have been provided. There has been a sharp decline in requests for reconsideration. Review of the data suggests a very low discrepancy rate. The team has developed a system to ensure internal consistency and educate providers on documentation requirements. Inter-rater reliability testing was completed for the year with a 100 percent success rate. All team members passed the test with the required greater than 85%. The average score was 93%. Team members work closely with discharge planners at inpatient and residential facilities to ensure timely and appropriate discharge plans. The unit has been expanding collaboration efforts with sister Departments supporting coordination of care. Weekly status calls with sister departments ensure ongoing communication. The pilot project for administrative authorization for inpatient psychiatric care for children has been in effect for one year. Data is being reviewed to assess benefits and challenges of project continuance. The protocol that was developed for referral to VCCI for services and to ensure continuity of care for members already enrolled with VCCI that have been admitted to inpatient or residential care facilities has been modified and the process seems to be working well.

The Team Care program (formally the lock-in program) is also managed by the Unit. A thorough clinical review of all available data allowed for an accurate assessment of current enrollees' need to remain in the program. Those members no longer requiring oversight have been disenrolled from the program. Standards for inclusion in and removal from Team Care are being developed/manualized. Research into other models continues. The process for referring Team Care program members to VCCI has been implemented. Outreach with providers and pharmacies is planned for the upcoming year.

Behavioral Health Team members continued involvement in the AHS Substance Abuse Treatment Coordination Workgroup. This workgroup strives to standardize substance abuse screening and referral processes throughout the Agency of Human Services. Team members also participate in monthly meetings with the VDH's Alcohol and Drug Abuse Prevention Division to

coordinate efforts between the two departments to provide substance abuse services to Vermont Medicaid beneficiaries. Team members also participated in the SFI Interagency Team, the Criminal Justice Capable Workgroup, Youth Service System Enhancement Council (a collaborative with ADAP, DMH, VCRIP, Vocation Rehabilitation, DCF etc.), and the MAT learning collaborative. Data is being gathered and analyzed to determine the level of involvement DVHA has in substance related treatment and to avoid duplication of services. The Managed Care Medical Committee is currently reviewing Buprenorphine clinical guidelines.

Following the initiation of the Applied Behavior Analysis (ABA) benefit, the Autism Specialist, a member of the Behavioral Health Team, worked collaboratively with the AHS Policy Unit and sister Departments throughout the year to evaluate and improve the program. The Autism Specialist surveyed consumers and elicited feedback from providers to strengthen and improve the prior authorization process. As a result, there was an approved rate increase. It is hoped that the increase will help to attract new providers. There have been new providers enrolled during this quarter. A follow up survey was conducted and the satisfaction rating is reflected in a Scorecard. There were billing/coding issues identified and a need for provider education became apparent. That service was delivered by the Autism Specialist. Exploration of alternative payment methods continues as we would like to increase the number of members receiving services. The Autism Specialist participates in the Autism Workgroup, which strives toward increasing and improving services for children with autism. The Applied Behavior Analysis Clinical Practice Guideline has been completed and is available to providers. Currently, the Autism Specialist is conducting research for expansion of the benefit.

iv. Mental Health System of Care

Key updates from QE0617:

- Proposals to develop secure residential recovery program solicited and received.
- Major legislation focused on addressing wait times for inpatient beds and improving mental health system of care passed (Act 82).

Secure Residential Recovery Program

During this quarter, the Department of Mental Health requested and received proposals from interested parties for the development and operation of a staff-secure[1] and facility-secure (locked) residential recovery (SRR) programming that would replace the temporary SRR psychiatric facility owned and operated by the State of Vermont in Middlesex, Vermont and potentially serve additional populations in need of a therapeutic, secure residential treatment settings.

Background

In the wake of Tropical Storm Irene and the closing of the Vermont State Hospital in 2011, the

[1] A staff secure facility may be defined as a residential facility in which the movements and activities of individual residents may, for treatment purposes, be subject to oversight through the use of intensive staff supervision. This may include design features to keep staff informed of resident movement in and out of the facility, such as silent alarms.

Vermont Legislature, through Act 79[2], authorized the Commissioner of the Department of Mental Health (DMH) to establish and oversee a secure seven-bed residential facility owned and operated by the state for individuals no longer requiring acute inpatient care, but who remain in need of treatment within a secure setting for an extended period of time. In June of 2013 DMH successfully opened a seven-bed SRR in a temporary location in Middlesex with plans to assess the capacity needed for a permanent SRR replacement over the following two years.

The development and purpose of the SRR was originally conceptualized as part of the Vermont Futures Project, which sought to design and develop an array of investments in the essential community capacities and reconfigure the Vermont State Hospital into a new system of inpatient, rehabilitation, and residential services for adults. As part of this new system, the SRR was designed to serve individuals who would otherwise remain hospitalized due to a high risk of self-harm or neglect, or pose a danger to others.

The temporary locked SRR program in Middlesex currently serves individuals who do not require inpatient acute psychiatric services, but their care needs exceed local community resources. Some of these individuals are suicidal with a high risk of self-harm. Other individuals manifest a high incidence of aggressive behaviors and are dangerous to others but are not in an *acute psychotic crisis.* Another smaller group includes those who are no longer clinically severely symptomatic, but must remain in a secure environment for prolonged periods of time awaiting resolution of a judicial process. Given the facility's licensing as a Therapeutic Community Residence (TCR) and space limitations, the program does not serve individuals who require emergency involuntary procedures (i.e. seclusion and restraint).

In January 2015, a report was submitted to the House Corrections and Institutions Committee based upon requirements of Act 178[3] that *"the Commissioner of Buildings and General Services, in consultation with the Commissioners of Mental Health and Corrections, shall develop a proposal to establish a permanent secure residential facility no later than January 15, 2015."* The report submitted put forward a potential multi-year planning process and possible maximum capacity that such a facility might provide to the current system of care. The report development drew upon earlier secure residential size and costing models to project a potential cost for a permanent secure residential facility for further consideration. The report recommended the creation of a 14-bed, involuntary, secure (locked) residential facility located within the state of Vermont on lands to be acquired for construction or renovation. As proposed, the program would require a waiver of current TCR standards to include the potential need for and use of brief involuntary interventions with residents served. Residents of the facility would include those people who remain in acute care settings due to a high risk of self-harm, or neglect, or pose a danger to themselves or others. They would be individuals who do not require inpatient acute psychiatric services, but whose care needs exceed local community program resources. The cost to develop the program, excluding land acquisition costs, was estimated to be approximately $12 million, with a projected annual operating cost of $5.1 million using Global Commitment funding with some private pay.

Based on that report and subsequent discussions between the Agency of Human Services (AHS)

[2] http://www.leg.state.vt.us/docs/2012/acts/act079.pdf
[3] http://legislature.vermont.gov/assets/Documents/2014/Docs/ACTS/ACT178/ACT178%20As%20Enacted.pdf

and the Vermont Legislature regarding other high-need populations being served by other AHS departments (e.g. Department of Corrections and the Department of Disability, Aging and Independent Living) that may require secure residential treatment, the legislature subsequently directed the Secretary of AHS to "conduct an examination of the needs of the Agency of Human Services for siting and designing a secure residential facility. The examination shall analyze the operating costs for the facility, including the staffing, size of the facility, the quality of care supported by the structure, and the broadest options available for the management and ownership of the facility" (Act 26[4]). As part of that examination, AHS was asked to assess how the development of an SRR Facility may address or overlap with the needs of individuals who are currently being served by other departments but have similar needs for secure residential treatment. The report also recommended further analysis of development and operational costs within the context of potential public-private partnership agreements.

Request for Proposals

As a follow-up to the expectations of Act 26 and an initial analysis of potential programming, DMH issued the Request for Proposals for the development and operation of permanent Staff-Secure and Facility Secure residential program(s) that allow for and support further exploration of public-private partnership efficiencies and more detailed cost projections in order to determine overall cost benefits for both quality and service delivery to the population to be served.

Based on a thorough analysis of the potential populations to be served, compatibility of programming potentials, siting potentials, and funding mechanisms to be considered given the renewal of Vermont's Global Commitment to Health Waiver, DMH indicated in the RFP that it is exploring the possible development of multiple programs as replacement options for the SRR. Per the RFP, proposed programs would be expected to be "No Refusal" for admission of eligible individuals and operate in full collaboration with the Department of Mental Health. Proposed programs would also be limited to residents who have mental illness and treatment needs for this setting. If staff-secure, the program would be voluntary, have a maximum of no more than 16 beds, and would likely be eligible for Federal Financial Participation (FFP). Proposed programs would need to clinically manage voluntary specialty populations through further division into care clusters or units of a program as well.

Additionally, proposed programs could operate as a locked facility (facility-secure) and serve an involuntary population that would continue to benefit from a sub-acute rehabilitation environment until clinically or legally discharged to a voluntary program. DMH does not expect this type of program would be eligible for FFP and could be more than 16 beds. Within the RFP, DMH discouraged this type of facility-secure program from blending voluntary and involuntary populations, as such a combination would likely result in the entire program being ineligible for FFP during the period of involuntary sub-acute treatment in the community.

The RFP solicited two potential types of programs for development: 1) Staff Secure Residential and 2) Facility Secure Residential.

Staff Secure Residential: This type of program model would target individuals who would be under the care and custody of the DMH Commissioner and treatment programming would

[4] http://legislature.vermont.gov/assets/Documents/2016/Docs/ACTS/ACT026/ACT026%20As%20Enacted.pdf

maximize opportunities for traditional Medicaid participation and minimize Global Commitment MCO Investment[5] funding. This program model is comparable to existing Staff Secure Intensive Residential Recovery programs (e.g. Second Spring) operating currently within Vermont. The proposed program would draw from eligible individuals such as:

- individuals in inpatient care with complex treatment needs ready for transition from a hospital who are willing to reside in the program as part of their course of recovery prior to return the community;
- eligible individuals ready for release without conditions from the Department of Corrections as part of their reintegration into the community;
- eligible individuals who may be clinically decompensating in the community and are willing to engage voluntarily in residential support services for stabilization and return to the community;
- eligible individuals who may require assisted living or enhanced residential care and support services who have been unable to access the necessary levels of transitional supports to retain independence in the community;
- eligible individuals amenable to voluntary community-based traumatic brain injury supports and services transitionally, pending development of individualized programming by the Department of Disabilities, Aging, and Independent Living.

Facility Secure Residential: This program model would target eligible individuals who would be under the care and custody of either the DMH Commissioner or Department of Corrections Commissioner and would forego FFP given population clinical complexity and/or legal limitations imposed in order to serve a sub-acute population that continues to afford secure treatment alternatives and safeguards in the community. This program could be expected to utilize episodic emergency involuntary interventions when clinically indicated for safety of the individual or other residents. The program could also be expected to serve as a designated facility for court-ordered medication in the community if so authorized by the court.
The proposed program would draw from eligible individuals such as:

- individuals in inpatient care with complex treatment needs ready for transition from a hospital who are unwilling to reside in the program, but determined either clinically or by the court to require 24/7 supervised, sub-acute treatment prior to a less-restrictive residential option in the community;
- convicted offenders with a serious mental illness who do not meet criteria for involuntary hospitalizations but require a more therapeutic setting than is available through existing Department of Corrections (DOC) health services.
- eligible individuals ready for release from the Department of Corrections with appropriate 24/7 supervised residential supports and active limitations imposed, based upon documented history and/or risk assessment, in conditions of release prior to reintegration into the community;
- eligible individuals who are clinically decompensating in the community, not engaging with voluntary community services, not yet meeting inpatient admission criteria, subject to revocation of orders of non-hospitalization when medication is identified as a necessary treatment component for ongoing stability, and known to require re-

[5] Vermont's current "Global Commitment" Medicaid waiver provides the state with expenditure authority to invest in health-related services and activities, and draw federal receipts, for costs that would not otherwise be Medicaid matchable. These initiatives are known as "MCO (Managed Care Organization) Investments."

hospitalization and reinstatement of medication when cessation of medication occurs before returning to the community;

- eligible individuals who may require assisted living or enhanced residential care and support services who have been both unable and unwilling to access the necessary levels of supports to retain independence in the community;
- eligible individuals who are unable and/or unwilling to voluntarily engage in voluntary community-based traumatic brain injury supports and services transitionally, pending development of individualized programming by the Department of Disabilities, Aging, and Independent Living.

The RFP also specified that new program service capacity could be developed through new construction or through program modifications of existing community-based program capacity intended to meet the target population needs. The new service capacity could also target construction and/or services to specific cohorts of the target populations in one or more programs in order to most appropriately address the environment of care and programmatic/oversight management needs for the sub-groups. Depending on model, program capacity to effectively address episodic behavioral dysregulation and emergency involuntary procedures emergently for individual and other resident safety would need to be addressed. Proposed program staffing would also need to identify both clinical personnel, security personnel, and physical environment of care for program and/or facilities.

Proposals

The Department of Mental Health received four proposals in response to the RFP. Three of the proposals were from Vermont-based non-profit mental health organizations, and one proposal was from a developer interested in partnering with the state or other organizations to develop, design and construct one or more facilities. DMH is in the process of reviewing each proposal and will be including information from these proposals in its broader system of care planning based on Act 82 (see below).

Act 82

During this quarter, the Vermont Legislature passed a major piece of legislation (Act 82[6]) focused on improving the mental health system of care. The findings of Act 82 included:

1) Since Tropical Storm Irene flooded the Vermont State Hospital, Vermont has experienced a dramatic increase in the number of individuals in mental health distress experiencing long waits in emergency departments for inpatient hospital beds.
2) Currently, hospitals average 90 percent occupancy, while crisis beds average just under 70 percent occupancy, the latter largely due to understaffing.
3) Issues related to hospital discharge include inadequate staffing in community programs, insufficient community programs, and an inadequate supply of housing.
4) Individuals presenting in emergency departments reporting acute psychiatric distress often remain in that setting for many hours or days under the supervision of hospital staff, peers, crisis workers, or law enforcement officers, until a bed in a psychiatric inpatient unit becomes

[6] http://legislature.vermont.gov/assets/Documents/2018/Docs/ACTS/ACT082/ACT082%20As%20Enacted.pdf

available. Many of these individuals do not have access to a psychiatric care provider, and the emergency department does not provide a therapeutic environment.
5) Due to these conditions, some individuals experience trauma and worsening symptoms while waiting for an appropriate level of care.
6) Hospitals are also strained and report that their staff is demoralized that they cannot care adequately for psychiatric patients and consequently there is a rise in turnover rates.
7) Many hospitals are investing in special rooms for psychiatric emergencies and hiring mental health technicians to work in the emergency departments.

In response to these and other findings, the act set forth the following requirements:

1) The Agency of Human Services (AHS), in collaboration with the Department of Mental Health (DMH) and the Green Mountain Care Board (GMCB), providers, and person affected by current services, must produce an analysis and action plan for the adult and children's mental health system of care. The analysis and action plan must:
    - specify steps to develop common, long-term vision of how integrated, recovery- and resiliency-oriented services shall become part of a comprehensive and holistic health care system;
    - identify data not currently gathered that are necessary for future planning, long-term evaluation of the system, and for quality measures;
    - identify causes underlying increased referrals and self-referrals for emergency services;
    - identify gaps in services that affect ability of individuals to access emergency psychiatric care;
    - determine whether appropriate types of care are being made available as services in Vermont, including intensive and other outpatient services and services for transition age youths;
    - determine availability and regional accessibility of involuntary and voluntary hospital admissions, emergency departments, intensive residential recovery facilities, secure residential recovery facility, crisis beds and other diversion capacity, crisis intervention services, peer respite and support services, and stable housing;
    - identify barriers to patient care at levels of supports that are least restrictive and most integrated, and opportunities for improvement;
    - incorporate existing information from research and from established quality metrics regarding emergency department wait times;
    - incorporate anticipated demographic trends, the impact of the opiate crisis, and data that indicate short- and long-term trends;
    - identify the resources necessary to attract and retain qualified staff to meet identified outcomes required of designated and specialized service agencies and specify timelines for achieving those levels of support.

2) AHS must complete a comprehensive evaluation of the overarching structure for the delivery of mental health services within a sustainable, holistic health care system in Vermont. This long-term evaluation must address:

- whether the current structure is succeeding in serving Vermonters with mental health needs and meeting goals of access, quality, and integration of services;
- whether quality and access to mental health services are equitable throughout Vermont;
- whether the current structure advances the long-term vision of an integrated, holistic health care system;
- how the designated and specialized service structure contributes to the realization of the long-term vision;
- how mental health care is being fully-integrated into health care payment reform;
- any recommendations for structural changes to the mental health system that would assist in achieving the vision of an integrated, holistic health care system.

3) The analysis, action plan, and long-term evaluation described above must also address the following additional subjects:
    - potential benefits and costs of developing regional navigation and resource centers, including consideration of other coordination models identified during the analysis;
    - effectiveness of the Department of Mental Health's care coordination team in providing access to and accountability for coordination and collaboration among hospitals and community partners for transition and ongoing care, including an assessment of potential discrimination in hospital admissions and the extent to which individuals are served by their medical homes;
    - use and potential need to expand crisis diversion throughout the State;
    - whether the components of Act 79 that were not fully implemented remain necessary and whether components fully implemented remain necessary;
    - opportunities for and removal of barriers to implementing parity in the manner that individuals presenting at hospitals are received, regardless of whether for a psychiatric or physical condition;
    - opportunities for and removal of barriers to implementing parity in the manner that individuals presenting at hospitals are received, regardless of whether for a psychiatric or physical condition;
    - the extent to which additional support services are needed for geriatric patients in order to prevent hospital admissions or to facilitate inpatient discharges;
    - the extent to which additional services or facilities are need for forensic patients;
    - to the extent the analysis indicates need for additional units or facilities, whether there are any units or facilities that the State could utilize for a geriatric skilled nursing or forensic psychiatric facility, additional intensive residential recovery facilities, expanded secure residential recovery, or supportive housing;
    - how designated and specialized service agencies fund emergency services to ensure maximum efficiency and availability to all individuals within a specific catchment area.

4) AHS, in collaboration with DMH and the Chief Superior Judge, must develop a report for the General Assembly regarding role of involuntary treatment and medication in

emergency department wait times, including concerns arising from judicial timelines and processes and the interplay between staff and patient rights.

5) The GMCB must review the ACO model of care and integration with community providers, including the designated and specialized service agencies, regarding how model of care promotes coordination across the continuum, business or operational relationships, and any proposed investments or expansions to community-based providers.

6) AHS, DMH and the Department of Disabilities, Aging, and Independent Living must develop a plan to integrate multiple sources of payments to the designated and specialized service agencies.

7) AHS must continue with its budget development processes enacted in legislation during the first year of the 2015–2016 biennium to unify payment for services, policies, and utilization review of services within an appropriate department.

8) AHS must coordinate the work of a *Mental Health, Developmental Disabilities, and Substance Use Disorder Workforce Study Committee* to examine best practices for training, recruiting, and retaining health care providers, particularly with regard to the fields of mental health, developmental disabilities, and substance use disorders.

While Act 82 included additional requirements, the findings and expectations described above should have the greatest impact on future planning, development and improvement of the mental health system of care going forward. Results of this planning process will be included in future reports as appropriate.

v. Pharmacy and 340B Drug Discount Program

Key updates from QE0617:

- The Drug Utilization Review Board held meetings on April 4, 2017, May 9, 2017 and June 20, 2017. Fourteen new drugs and nineteen therapeutic classes were reviewed, five RetroDUR reviews and ten safety alerts were presented.
- DVHA sent six provider communications out on topics of Specialty Pharmacy Network Changes, Preferred Drug List Changes, Point-of-Sale (POS) System Testing, CHC Common Helpdesk Questions, Opioid Day's Supply Changes Effective 07/05/17 and Point-of-Sale Blackout Period.

<u>Pharmacy Benefit Management Program</u>

DVHA's Pharmacy Unit manages the pharmacy benefits for all of Vermont's publicly-funded pharmacy benefit programs. Our goal is to provide the highest quality prescription drug benefits in the most cost-effective manner possible. We accomplish this by providing broad coverage of prescription and over-the-counter pharmaceuticals, controlling pharmacy expenditures through

managing cost, brand and generic utilization, and reducing state administrative costs. The State of Vermont utilizes the pharmacy benefit management company, Change Healthcare (CHC), to provide an array of operational, clinical and programmatic support in addition to managing a call center in South Burlington, Vermont, for pharmacies and prescribers. The Pharmacy Unit is responsible for overseeing the contract with Change Healthcare (CHC) as well. The Pharmacy unit manages over $185 million in gross drug spend, and routinely analyzes national and DVHA drug trends, reviews drug utilization, and seeks innovative solutions to delivering high-quality customer service, assuring optimal drug therapy for DVHA members while managing drug utilization and cost.

Pharmacy Operations

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

Clinical

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

Drug Utilization Review Board (DURB)

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

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

4) Recommend and evaluate educational intervention programs.

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

Meetings of the DURB occur eight times per year. In QE0617, the DURB held 3 meetings. Information on the DURB and its activities in 2017 is available: http://dvha.vermont.gov/advisory-boards.

340B Drug Discount Program

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

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

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

- Reduce Medicaid program expenditures;

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

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

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

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

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

vi. Integrating Family Services (IFS) Initiative

Key updates from QE0617:

- Several regions are consolidating regional teams so they have a strong IFS Core Team which will be responsible for implementing the Collaborative Leadership Framework, holding themselves accountable to the IFS population indicators and performance measures and increasing collaboration and coordination across agencies.
- IFS is aligning its payment reform efforts with the larger healthcare reform to ensure coordination across the state.

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 GC. Several such projects have emerged in the Children's and early periodic screening diagnostic and treatment (EPSDT) service area.

Specifically, children's Medicaid services are administered across the IGA partners so work continues to enhance integration. Programs historically evolved separately 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 the Global Commitment and other changes at the federal level these siloed structures no longer need to exist. Global Commitment has allowed for one overarching regulatory structure (42 CFR § 438) and one universal EPSDT continuum. This allows for efficient and effective coordination with other federal mandates such as Title V, IDEA part B and C, Title IV-E, Federal early childhood programs and others.

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

choices for self-managed services. This integration is an ongoing process that is evolving into a very positive direction for children and families.

The initial IFS implementation site in Addison County began on July 1, 2012, and the second pilot region in Franklin/Grand Isle counties began on April 1, 2014. These pilots included consolidation of over 30 state and federal funding streams into one unified whole through one AHS Master Grant agreement. The State has created an annual aggregate spending cap for two providers in Addison and one in Franklin/Grand Isle (this provider houses the Designated Agency and Parent Child Center). This has created a seamless system of care to ensure no duplication of services for children and families

Successes of the two pilots include:

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

IFS continues to provide support and leadership regarding several efforts that cut across multiple agency departments such as:

- enhanced teaming for families with complex needs,
- turning the curve on the number of children and youth in residential settings,
- coordinating autism services and supports,
- coordinating and supporting Act 264, and
- implementation of a common tool for progress monitoring to know if children and families are better off due to our efforts (the CANS-Child and Adolescent Needs and Strengths).

The following performance measures were finalized in FY2016 and have been embedded in FY17 grants which means we will have data to analyze by winter 2017.

IFS Accountability and Oversight Framework (Outcome Metrics)

Population-Level Outcomes and Indicators

1. Vermont statute Act 186 (2014) establishes outcomes and indicators that are intended to align programs and strategies across the state toward the same ends.
2. Population indicators will be available to IFS regions through an AHS Scorecard. This information will be used by IFS Regional Core Teams to inform how they target supports and services to best meet the needs of children, youth and families in their communities
3. An entire community, not just IFS grantees, is responsible for the IFS population-level indicators, bending the curve on population indicators. However, IFS grantees' performance measures will positively impact the health and well-being of the whole population.

Act 186 Outcomes	1. Pregnant women and young children thrive/Children are ready for school	2. Families are safe, stable, nurturing and supported	3. Youth choose healthy behaviors/Youth successfully transition to adulthood	4. Communities are safe and supportive
Population Indicators	a. % of children who are ready for kindergarten in all five domains of healthy development	a. Rate of child abuse and neglect b. Number of Vermont families with one or more children who are experiencing homelessness	a. % of high school seniors who have a plan following high school b. % of adolescents in grades 9-12 who drank alcohol before age 13 c. Number of youth (12-21) who have adolescent well-care visits with a PCP or Ob/Gyn	a. Rate of children living below the 200% poverty rate b. % of infants and toddlers likely to need care who do not have access to a high quality, regulated child care program

Performance Measures for IFS Grantees

These performance measures were embedded in the FY17 IFS grants and data will be available in the fall 2017.

How Much?	How Well?	Is Anyone Better Off?
1. Number of children served by fiscal quarter 2. Number of children served by age 3. Number of hours of service 4. % of services provided to child/youth with Medicaid	5. % of children with a plan developed collaboratively with families 6. Satisfaction measure from family perspective 7. % of children with a plan completed within 90 days of referral 8. % of children (Prenatal to 6) that received initial contact within 5 calendar days 9. % of children (Prenatal to 6) that had a transition plan (30 or 90 days before transition) upon discharge 10. % of children/youth receiving non-emergency service within 7 days of emergency service 11. % of children/youth living at home or close to home in a family-like setting	12. % of children/youth that have shown improvement on the CANS or an approved assessment tool 13. % of children whose CANS score shows improvement in the family domain *OR* % of families who show improvement on an approved assessment tool
14. Report any novel, innovative and successful initiatives taken in any arena (such as: quality, teaming, services, system, fiscal, or data sharing) in your region.		

vii. Vermont Medicaid Shared Savings Program

Key updates for QE0617 (CY 2016 final results):

- CY17 saw the conclusion of the VMSSP's third program year (CY 2016).
- Final ACO financial and quality performance results will be included in the 2017 Global Commitment Annual Report.

The Vermont Medicaid Shared Savings Program (VMSSP) was a three-year program (2014-2016) to test if the accountable care organization (ACO) model in Vermont could help to 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 was supported by a State Innovation Model (SIM) testing grant and overseen by the Green Mountain Care Board (GMCB) and AHS. Contracts were signed between Vermont Medicaid and the two participating ACOs (OneCare Vermont and Community Health Accountable Care) in February, 2014. The program concluded December 31, 2016. Financial and quality performance results from the 2016 performance year (in addition to results from the 2014 and 2015 performance years) will be summarized in the 2017 Global Commitment Annual Report.

viii. All Payer Model: Vermont Medicaid Next Generation Program

Key updates from QE0617:

- On February 1, 2017 DVHA executed a contract with OneCare Vermont as a risk-bearing Accountable Care Organization (ACO) for participation in a population-based payment model that is based on the Centers for Medicare and Medicaid Services (CMS) *Next Generation* ACO Model.2017 is the pilot year of implementation for the Vermont Medicaid Next Generation ACO program; approximately 29,000 Vermont Medicaid beneficiaries are attributed through this model in four risk-bearing communities.
- Quarterly reporting to the legislature began in Q2; the program's first report submitted on June 15, 2017.
- DVHA and OneCare began discussions of potential modifications to the program for a 2018 performance year.
- Future program implementation will be in support of Vermont's broader efforts to develop an integrated health care delivery system under an All Payer Model.

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

goal of this agreement is to improve the quality and value of the care provided to the citizens served by the State of Vermont's public health care programs.

DVHA and OneCare entered into an agreement for the 2017 performance year as a pilot year with four possible one-year extensions to the program. Four risk-bearing hospital communities are participating in the *Vermont Medicaid Next Generation* (VMNG) model for the pilot year: the University of Vermont Medicaid Center, Central Vermont Medical Center, Northwestern Medical Center, and Porter Hospital, with additional participation from FQHCs/independent practices, home health providers, Designated Agencies, and skilled nursing agencies in the four communities.

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

DVHA submitted its first report on the VMNG program to the Vermont legislature on June 15, 2017, and will submit reports on a quarterly basis through the life of the program. Legislation requires that DVHA report to the legislature on implementation activities and program performance, including data on financial performance, quality performance, operational timeline adherence, utilization monitoring, changes to provider network or size of attributed population, and statistics on member complaints, grievances, and appeals. While information on performance and utilization is helpful to understand how patterns generally compare for members who are attributed to OneCare and members who are not attributed to OneCare, caution should be exercised when using the information presented in this first report to evaluate 2017 program performance. At the time the report was written, the second quarter of program performance was not yet complete, meaning the pilot program was not yet halfway through its performance year. Furthermore, the program is subject to claims lag, which means that DVHA will not have complete information on what services were provided to the attributed population during the reporting period until later in 2017. The full report can be found here: http://legislature.vermont.gov/assets/Legislative-Reports/DVHA-ACT-25-VMNG-ACO-Report-to-Legislature-June-15-2017.pdf.

Though 2017 is a pilot year, DVHA and OneCare have entered into discussions of potential modifications for a CY 2018 program year. Program implementation will continue to support and align with Vermont's broader efforts to develop an integrated health care delivery system under an All Payer Model.

V. Financial/Budget Neutrality Development/Issues

AHS paid DVHA 1/12 of the legislative budget for Global Commitment on the first business day of every month during the June 2017 quarter. This payment served as the proxy by which to draw down Federal funds for Global Commitment. The State prepared the CMS-64 based upon actual allowable Medicaid expenditures (program, investments and admin; please note admin is now claimed outside of GC neutrality) for the given quarter. After each quarterly submission, we reconciled what was claimed on the CMS-64 versus what we made for payments to DVHA.

The new set of Special Terms and Conditions (STCs) under the approved waiver extension for Global Commitment to Health began January 1, 2017. For purposes of the demonstration, DVHA

will operate as if it were a non-risk pre-paid inpatient health plan (PIHP) and AHS, as the Single State Agency, will provide oversight of DVHA in that capacity. In the negotiations, it was agreed upon that AHS would continue to use FFY 16 per member per month rates for the period 10/01/2016 – 03/31/2017. And, as outlined in the Waiver extension STCs, new per member per month rates were established for the period 04/01/2017 – 12/31/2017.

In respect to the new STCs, AHS is having difficulty interpreting STC #65. Part of this language was in the previous version of the GC waiver STCs, however it only applied to the New Adult Group. It is unclear if STC #65 applies to the entire demonstration and how it should be calculated.

Several prior quarter adjusting (PQAs) entries were made on the CMS 64 for QE0617. We corrected two PQAs from last quarter which were entered incorrectly (reversed), revised a calculation for Agency of Education and most of the remaining entries were necessary due to cost allocation program revisions. Finally, we are still researching the Hub & Spoke adjustments noted last quarter so we did not make any additional corrections during QE0617.

In the previous quarter, CMS Regional Office conducted a review of eligibility for VIII Group, also known as the Childless New Adult population. Vermont is entitled to receive enhanced FFP for this group of beneficiaries. The initial review found that two of the thirty individuals sampled were not eligible for the VIII Group. This resulted in a disallowance of $488 in FFP. AHS entered this as a Prior Quarter Adjustment on the QE0617 CMS-64 report.

AHS continued to work with our contracted actuarial consultant, Milliman, Inc., on the 2018 PMPM rate setting process. We have provided Milliman Inc., with our historical claims and eligibility data for the purposes of setting per member per month rates for the following Medicaid Eligibility Groups (MEGs):

- Aged Blind Disabled Non-Medicare Adult
  - Blind Disabled Non-Medicare Child
  - Aged Blind Disabled Dual (Medicaid and Medicare)
  - Non-Aged Blind Disabled Adult (General Adult)
  - Non-Blind Disabled Child (General Child)
  - Global Rx
  - New Adult Medical Only
  - Moderate Needs

VI. Member Month Reporting

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

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

The table below contains Member Month Reporting for QE0617. Please note that although the New Adult Budget Neutrality is calculated, it is not included in the waiver saving summary in Attachment

1. Please further note the Medicaid Expansion counts in this table are not used to calculate the waiver saving summary. Finally, please note that the long-term care (LTC) population in the table below is a subset of two Medicaid Eligibility Groups.

Table 4. Member Month Reporting – Calendar Year 2017

Member Month Reporting								
Demonstration Population	**Medicaid Eligibility Group**	**Total CY 2017**	**2017 01**	**2017 02**	**2017 03**	**2017 04**	**2017 05**	**2017 06**
1, 4*, 5*	ABD - Non-Medicare - Adult	**48,198**	8,376	8,288	8,113	7,912	7,790	7,719
1	ABD - Non-Medicare - Child	**13,408**	2,312	2,281	2,270	2,203	2,184	2,158
1, 4*, 5*	ABD - Dual	**126,695**	21,201	21,172	21,204	21,120	21,049	20,949
2	ANFC - Non-Medicare - Adult	**84,220**	14,320	14,246	14,197	13,879	13,838	13,740
2	ANFC - Non-Medicare - Child	**366,620**	60,934	61,269	61,292	61,129	61,037	60,959
	Medicaid Expansion							
7	Global RX	**42,791**	7,177	7,170	7,109	7,144	7,085	7,106
8	Global RX	**24,107**	4,120	4,034	3,992	3,983	3,988	3,990
6	Moderate Needs	**1,462**	235	235	241	248	247	256
	New Adults							
3	New Adult with out child	**248,972**	41,255	41,715	41,822	41,577	41,415	41,188
3	New Adult with child	**112,102**	18,140	18,439	18,656	18,901	18,925	19,041
	Total	**1,068,575**	**178,070**	**178,849**	**178,896**	**178,096**	**177,558**	**177,106**
*** Long Term Care Group**		**Total CY 2017**	**2017 01**	**2017 02**	**2017 03**	**2017 04**	**2017 05**	**2017 06**
4 only	ABD Long Term Care Highest Need	**17,481**	2,979	2,963	2,932	2,909	2,878	2,820
5 only	ABD Long Term Care High Need	**6,481**	1,096	1,082	1,092	1,084	1,065	1,062

PMPM Capitated Rates

The PMPM rates as set for 04/01/17 – 12/31/17 are listed below.

Table 5. PMPM Capitated Rates QE0617

		04-01-17-12/31/17
Medicaid Eligibility Group		
ABD Adult	**$**	**1,620.46**
ABD Child	**$**	**2,642.56**
ABD - Dual	**$**	**1,959.12**
non-ABD Adult	**$**	**587.93**
non-ABD Child	**$**	**428.33**
GlobalRx	**$**	**85.13**
New Adult	**$**	**507.66**

Moderates	**$**	**458.29**

Investments totaled $33,184,769 for QE0617.

VII. Consumer Issues

AHS and DVHA have several mechanisms whereby consumer issues are tracked and summarized. The first is through Health Access Member Services. This is a contracted function for providing information on health care programs, assisting with the eligibility process, and helping beneficiaries to understand the benefits and responsibilities of their particular program. The complaints received by Member Services are 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.

VIII. Quality Improvement

Key updates from QE0617:

- The MCE's formal CMS PIP topic that focused on improving substance use disorder treatment is making progress with engaged community champions and intervention efforts underway.
- The DVHA Quality Unit hired a full time Quality Assurance Manager.
- The MCE Quality Committee requested TA so that we can take on a new role in understanding and using rapid cycle evaluation.

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 the Agency of Human Services and community providers. The unit is responsible for instilling the principles of quality throughout DVHA and helping everyone in the organization to achieve excellence. The Unit's goal is to develop a culture of continuous quality improvement throughout DVHA.

MCE Quality Committee

The MCE Quality Committee remained active during QE0617 and consists of representatives from all Departments within the Agency of Human Services that serve the Medicaid population. The committee continues to structure its work around the triple aims of health care: improving the patient experience, improving the health of populations, and reducing the per capita cost of health care.

During this time period, the Committee began an annual review of the Global Commitment Core Performance Measure Set, including confirmation that our Ambulatory Care ED Visit measure would be broken out by our special health needs sub-populations and that we will work to add a social determinant of health measure to the Core Set in 2018. Our Global Commitment Core Measure Set results for CY 2016 will be validated during QE0917.

Additionally, the Committee outreached CMS earlier in the year for technical assistance in regard to rapid cycle evaluation of payment reform models. A sub-group of the Committee has been created to focus on this topic and report back to the larger group before the end of the year.

Formal CMS Performance Improvement Project (PIP)

The DVHA Quality Unit continues to partner with the Vermont Department of Health's (VDH) Alcohol and Drug Abuse Program (ADAP), the Blueprint for Health and the Vermont Medicaid Next Generation ACO on a formal Performance Improvement Project (PIP) focused on initiation and engagement in alcohol and other drug treatment. Quality Unit staff continue to attend the monthly All Field staff meetings (a joint meeting of state-wide Quality Improvement Project Managers) and to work with partners to develop intervention strategies and evaluation measures. The Year One PIP Summary is due to our external quality review organization (EQRO) during QE0917. Annual Metric = HEDIS Initiation of Alcohol and Other Drug Dependence Treatment (IET) measure.

Quality Measure Reporting

- CMS Medicaid Quality Core Sets - During QE0617 Quality Unit staff continued to collaborate with the Blueprint for Health on the eventual reporting of the Health Home Core measure set to CMS. We are expected to report out on FFY 2014 – FFY 2016 by 7/31/17.

- HEDIS - During this time frame the Quality Unit received preliminary HEDIS measure results from our nationally certified vendor. These rates will be validated by our EQRO during QE0917.

- VT Medicaid Global Commitment Core Measure Set – the MCE Quality Committee began an annual review of the Global Commitment Core Performance Measure Set during QE0617, including confirmation that our Ambulatory Care ED Visit measure would be broken out by our special health needs sub-populations and that we will work to add a social determinant of health measure to the Core Set in 2018. Our Global Commitment Core Measure Set results for CY 2016 will be validated during QE0917.

- Experience of Care Measures – the Quality Unit worked with the Blueprint for Health and the Quality Committee during Q1 CY2017 to review bids and contract with a vendor for the CAHPS Health Plan 5.0 survey to be fielded later this year. The Quality Unit reports out on CAHPS survey results using a scorecard tool on the public-facing website.

Collaborative Quality Improvement Projects

The Quality Unit staff lead and participate in additional collaborative QI initiatives across the Agency. Current projects include:

- The QI Administrator continues to participate on a joint payer quality improvement project aimed at increasing follow-up care after hospitalization for mental illness. The Quality Unit has connected with the Policy Unit to explore the status of coverage for behavioral health telemedicine visits, which could have a big impact on this and other performance measures. This work group is hosting a half day meeting in September for insurer and hospital clinical case managers entitled "Improving the Quality and Continuity of Care for Vermonters Hospitalized with Mental Illness". Barriers to follow-up care and ideas for improvement will be discussed. Metric = HEDIS Follow-Up After Hospitalization for Mental Illness (FUH) measure.
- The QI Administrator continues to participate with VDH and the Data Unit on a joint payer quality improvement project aimed at increasing adolescent well care visits. Four (4) additional practices are currently being recruited to participate in Cohort 2 of this project. Metric = HEDIS Adolescent Well Care Visit (AWC) measure. Both Medicaid and BCBS AWC rates increased by approximately 4 percentage points between CY 2015 and CY 2016 measurement periods.
- The Quality Assurance Manager continues to collaborate with the VDH All Payer Joint Project. Medicaid, MVP & BCBSVT have been sending similarly formatted quarterly gap-in-care reports to 29 Blueprint practices since 2015. The reports show the entire panel of female Medicaid beneficiaries ages 50-64 served at the practice and whether they have received a mammogram in the last 2 years. An evaluation of the project is being planned and will be completed by September 2017. Metric = HEDIS Breast Cancer Screening (BCS) measure.
- Quality Unit staff met with QI facilitators from the Blueprint for Health and OneCare to learn about a new hypertension peer learning collaborative. This is an exciting new collaboration that the Quality Unit was welcomed to take part in and involves in-person trainings for participating practices as well as a series of webinars and help with data collection.
- The DVHA Quality Unit and the Vermont Department of Health's Health Promotion and Disease Prevention (HPDP) division created a partnership during 2016 to work together on multiple cancer screening quality improvement projects (QIPs):
  - Cancer screening brochures were sent to Medicaid beneficiaries and Medicaid providers.
  - Mammogram gap-in-care reports are sent quarterly to 29 Blueprint for Health practices. This was a joint payer project, including MVP and BCBS along with Medicaid. Reports were sent in January 2017 and will be sent again in July 2017. An evaluation of this project is being planned for July 2017.
  - Ongoing monthly mammogram reminder letters to female Medicaid beneficiaries state-wide.
  - Ladies First in-person outreach by clinic "champions" to Medicaid beneficiaries focused on breast cancer screening.
  - Ladies First two-step screening reminder project for cardiovascular, breast and cervical cancer screening. The first step is a postcard reminder, followed by a motivational follow-up call from a clinic champion.

  Results of these QIPs are currently being evaluated.

Results Based Accountability (RBA) Scorecards

Results Based Accountability (RBA) scorecards are being developed at DVHA for both internal and external performance management purposes. The use of this performance management framework and corresponding presentation tool has been spearheaded by the Agency's Central Office QI staff for the past few years. The DVHA Quality Unit staff received training and has used this tool to create a Global Commitment Core Measure scorecard, as well as Experience of Care and certain other performance budgeting scorecards. New scorecards actively under development are related to the Applied Behavior Analysis (ABA) benefit, the Adult and Child Medicaid Quality Core Measure Sets, and an overall DVHA performance accountability scorecard - which will include key performance measures for each unit within the Department for use by the Management Team to evaluate programs and services.

Vermont Medicaid *Next Generation* ACO Model

In 2016, the DVHA Quality Unit staff were integral in the development of a set of metrics with which to measure the cost and quality of care provided to the Medicaid population by the newly contracted Accountable Care Organization. Additionally, the Quality Unit staff advised on a quality reporting matrix to be used for monitoring and oversight. The DVHA Quality Unit participated in internal DVHA readiness review preparation and continue to join monthly operations meetings.

Quality Unit staff received, reviewed and approved the first round of VMNG ACO quality management reports during QE0617. Following that, the quality management staff from DVHA and the ACO met together to refine reporting requirements, recognize opportunities for collaboration on quality improvement projects and generally build on existing relationships.

AHS Performance Accountability Committee

During this quarter, the AHS Performance Accountability Committee (PAC) continued to focus on advancing organizational competencies associated with monitoring and evaluating performance. As a next step, sub-competencies, evidence of achieving the competency, and deliverables will be identified. During the next quarter, the group will prioritize deliverables associated these sub-competencies.

The group also continued to discuss an Executive Order from Vermont's new governor, Phil Scott, creating the Program to Improve Vermont Outcomes Together (PIVOT). In addition to discussing the deliverables and timelines associated with the program, the group began to craft recommended roles/responsibilities that they might play with program implementation. To date, much of the conversation has focused on how the group might leverage monitoring performance competencies to support PIVOT activities.

MCO Investment Review

As per STC #88 of the GC to Health Waiver, Vermont needs to include in their quarterly and annual reports to CMS any "monitoring and evaluation" activities conducted by AHS departments relative to their approved investments. During this quarter, individual AHS department meetings were initiated with group discussions and decisions focusing on the monitoring and evaluation requirements in the new Special Terms and Conditions (STCs). To date, the group has discussed the following elements: definition of monitoring and evaluation data, frequency and format of reports, as well as, the reporting

process. Beginning next quarter, each department will submit financial monitoring data to AHS. In addition, departments will submit evaluative data that highlights the performance of a subset of their investments. Evaluative data will include the following: investment description, performance measures and results, and an interpretation of the results. Monitoring and Evaluation of investments will be conducted following a periodic schedule. Durning the next quarter, criteria will be finalized and communicated. The Vermont Department of Health has agreed to initiate investment monitoring and evaluation reporting in the subsequent quarterly report.

Comprehensive Quality Strategy/State Transition Plan

Vermont has conducted continuous public engagement regarding the CQS/STP with multiple public comment periods and public hearings. Efforts to date are documented on this website:

http://dvha.vermont.gov/global-commitment-to-health/comprehensive-quality-strategy.

The table below contains a summary of activities to date.

Table 6. Summary of CQS Activities to Date

DATE	ACTIVITY
08/2015	Initial public comment period and public hearing held. Comments and responses are posted online.
12/2015	CMS responses and recommended revisions to the CQS/STP received
02/2016	CQS/STP reposted with revisions based on combined CMS and stakeholder feedback
03/2017	CQS/STP reposted for public comment period
04/2017	Public hearing held

While no individuals from the community attended the most recent public hearing – AHS did receive three pieces of written feedback during the public comment period. Vermont is currently finalizing their responses to comments received during the most recent public comment period and plans to modify the CQS/STP based on the feedback received. Also during this quarter, the HCBS implementation team reviewed a draft HCBS milestone document from CMS. The group agreed with the milestones offered – but suggested alternative due dates. This document will be shared with CMS during the upcoming quarter – and uploaded to the Liberty system once it is finalized.

Finally, during this quarter, the HCBS Implementation Team continued to work on implementing the site-specific setting assessments developed in the previous quarter. The team reviewed individual program response rates and suggested next steps. The Developmental Services survey response rate was 100%. Next steps include item specific analysis by quality improvement staff to determine level of compliance with the new regulations and any necessary corrective action. Response rates for the Choices for Care and Traumatic Brain Injury programs were lower than expected. Next steps for these programs include a survey generated follow up email – reminding providers to complete the survey along and telephonic outrearch by state staff to determine barriers to completing the survey.

IX. Compliance

Key updates from QE0617:

- EQRO audit document submission completed
- New IGA with VDH signed

External Quality Review Organization (EQRO) Audit Document Submission Completed

Durign this quarter, the EQRO initiated the Compliance Review, Performance Measure Validation, and Performance Improvement Project Validation activities. Letters outlining the scope, requirements, and process were sent to DVHA at the beginning of the quarter. In response to the inquiries, DVHA coordinated and completed the submission of documents demonstrating our compliance with approximately 100 mandatory standards. The compliance and performance measure documents will be reviewed by the EQRO contractor so they can plan for their onsite review in July. The performance improvement documents will be reviewed by the EQRO contractor via an off-site desk review. All document submissions included participation from five AHS departments.

New Intra-Governmental Agreement (IGA) signed between DVHA and VDH

A new agreement has been signed between the Department of Vermont Health Access (DVHA) and the Vermont Department of Health for the purpose of delegating certain responsibilities related to our Global Commitment to Health waiver. This new IGA contains updated language to reflect new statutory citations, new Global Commitment waiver requirements and new language in the agreement between the Agency of Human Services and DVHA. Similar updates are being circulated for agreements between DVHA and other AHS departments.

The new AHS DVHA IGA also contains language describing the coordination of services provided by Medicaid (Title XIX) and Maternal and Child Health (Title V). In addition, Section 3.4: Oversight and Performance Evaluation of the new IGA identifies procedures for monitoring that need to be in place before December 31, 2017. The Compliance Committee will review these requirements and develop a timeline for their implementation.

X. Demonstration Evaluation

During this quarter, AHS received a 1115 PMDA notice that the final evaluation plan was past due. Prior to receiving this notice, AHS had submitted the draft evaluation design to CMS, posted a waiver evaluation RFP, received CMS feedback on the draft design, reviewed RFP responses, and selected an independent party to conduct the evaluation of the demonstration. In response to the notice, AHS requested a 60-day extension of the final evaluation plan due date that would allow time to fully execute a contract with the vendor and subsequently work with them to modify the draft evaluation design - before submitting it as final. The extension was granted by CMS and the new due date for the final evaluation plan is on or before Wednesday, August 30, 2017.

XI. Reported Purposes for Capitated Revenue Expenditures

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

- Reduce the rate of uninsured and/or underinsured in Vermont;

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

Attachment 6 is a summary of Investments, with applicable category identified, for QE0617.

XII. Enclosures/Attachments

Attachment 1: Budget Neutrality Workbook
Attachment 2: Enrollment and Expenditures Report
Attachment 3: Complaints Received by Health Access Member Services
Attachment 4: Medicaid Managed Care Entity Grievance and Appeals Report
Attachment 5: Office of the Health Care Advocate Report
Attachment 6: QE0617 Investments
Attachment 7: Companion Aide Pilot Summary 2017

XIII. State Contact(s)

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

Date Submitted to CMS: August 29, 2017

ATTACHMENTS

Budget Neutrality New Adult
New Adult (w/ and w/o Child) Medical Costs Only

	DY 12 – PMPM	
	QE0317	**QE0617**
(A) New Adult Group PMPM Projection	$518.26	$518.26
(B-1) eligible member months w/ Child	55,235	56,867
(B-2) eligible member months w/o Child	124,792	124,180
(C-1 = (A x B-1) Supplemental Cap 1 w/ Child	$ 28,626,091.10	$ 29,471,891.42
(C-2 = (A x B-2) Supplemental Cap 1 w/o Child	$ 64,674,701.92	$ 64,357,526.80
(D-1) New Adult FMAP w/ Child	54.46%	54.46%
(D-2) New Adult FMAP w/o Child	86.89%	86.89%
(E-1 = C-1 x D-1) Federal Share of Supplemental Cap 1 w/ Child	$ 15,589,769.21	$ 16,050,392.07
(E-2 = C2 x D-2) Federal Share of Supplemental Cap 1 w/o Child	$ 56,195,848.50	$ 55,920,255.04
Subtotal Federal Share Supplemental Cap 1	$ 71,785,617.71	$ 71,970,647.10
Total FFP reported for New Adult Group	$62,816,665.28	61,830,391.33
Supplemental Budget Neutrality Test 1		
over/(under) - report any negative # under main GC budget neutrality	$ 8,968,952.44	$ 10,140,255.77

State of Vermont Global Commitment to Health
Budget Neutrality PMPM Projection vs 64 Actuals Summary
August 7, 2017

ELIGIBILITY GROUP	DY 12	DY 13	DY 14	DY 15	DY 16	Total
	JAN - DEC 2017	JAN - DEC 2018	DAN - DEC 2019	JAN - DEC 2020	JAN - DEC 2021	
Without Waiver (Caseload x pmpms)						
ABD - Non-Medicare - Adult	$ 72,764,039	$ -	$ -	$ -	$ -	$ 72,764,039
ABD - Non-Medicare - Child	$ 39,649,869	$ -	$ -	$ -	$ -	$ 39,649,869
ABD - Dual	$ 329,362,657	$ -	$ -	$ -	$ -	$ 329,362,657
ANFC - Non-Medicare - Adult	$ 54,252,840	$ -	$ -	$ -		$ 54,252,840
ANFC - Non-Medicare - Child	$ 197,003,257	$ -	$ -	$ -	$ -	$ 197,003,257
Total Expenditures Without Waiver	**$ 693,032,661**	**$ -**	**$ -**	**$ -**	**$ -**	**$ 693,032,661**
With Waiver						
ABD Non Medicare Adult	$ 192,617,400	$ -	$ -	$ -	$ -	$ 192,617,400
ABD - Non-Medicare - Child	$ 39,260,753	$ -	$ -	$ -	$ -	$ 39,260,753
ABD - Dual	$ 123,019,745	$ -	$ -	$ -	$ -	$ 123,019,745
ANFC - Non-Medicare - Adult	$ 45,888,886	$ -	$ -	$ -	$ -	$ 45,888,886
ANFC - Non-Medicare - Child	$ 166,868,591	$ -	$ -	$ -	$ -	$ 166,868,591
Premium Offsets	$ (361,072)	$ -	$ -	$ -	$ -	$ (361,072)
Moderate Needs Group	$ 715,139	$ -	$ -	$ -	$ -	$ 715,139
Marketplace Subsidy	$ 3,338,082	$ -	$ -	$ -	$ -	$ 3,338,082
VT Global Rx	$ 4,936,331	$ -	$ -	$ -	$ -	$ 4,936,331
VT Global Expansion VHAP	$ 181,351	$ -	$ -	$ -	$ -	$ 181,351
CRT DSHP	$ 5,575,627	$ -	$ -	$ -	$ -	$ 5,575,627
Investments	$ 65,963,060	$ -	$ -	$ -	$ -	$ 65,963,060
Total Expenditures With Waiver	**$ 648,003,895**	**$ -**	**$ -**	**$ -**	**$ -**	**$ 648,003,895**
Supplemental Test: New Adult (Gross)						
Limit	$ 187,130,211	$ -	$ -	$ -	$ -	$ 187,130,211
With Waiver Expenditures	$ 159,799,836	$ -	$ -	$ -	$ -	$ 159,799,836
Surplus (Deficit)	*$ 27,330,375*	*$ -*	*$ -*	*$ -*	*$ -*	*$ 27,330,375*
Waiver Savings Summary						
Annual Savings	$ 45,028,767	$ -	$ -	$ -	$ -	$ 45,028,767
Shared Savings Percentage	30%	25%	25%	25%	25%	
Shared Annual Savings	$ 13,508,630	$ -	$ -	$ -	$ -	$ 13,508,630
Total Savings	$ 13,508,630	$ -	$ -	$ -	$ -	$ 13,508,630
Cumulative Savings	***$ 13,508,630***	***$ 13,508,630***	***$ 13,508,630***	***$ 13,508,630***	***$ 13,508,630***	***$ 13,508,630***

New Adult Waiver Savings Not Included in Waiver Savings Summary
See Budget Neutrality New Adult tab (STC#64)
See CY2017 Investments tab
See EG MM CY 2017 Tab for Member Month Reporting

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

[Phone] 802-879-5900

Agency of Human Services

Medicaid Program Enrollment and Expenditures Report

Q3 SFY 2017

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

Al Gobeille, Secretary
Vermont Agency of Human Services

Cory Gustafson, Commissioner
Department of Vermont Health Access

June 5, 2017

Glossary of Terms

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

The Department of Vermont Health Access

Caseload and Expenditure Report ~ DVHA Only Medicaid Spend

DVHA YTD '17

Friday, May 26, 2017

	SFY '17 Appropriated			SFY '17 Actuals thru March 31, 2017			
	Caseload	Expenses	PMPM	Caseload	Expenses	PMPM	% of Approp. Spent to Date
ABD Adult	8,791	$ 70,363,336	$ 666.98	8,932	$ 52,799,872	$ 656.80	75.04%
ABD Dual	17,758	$ 57,665,231	$ 270.61	17,510	$ 39,308,593	$ 249.43	68.17%
General Adult	15,848	$ 82,715,184	$ 434.93	15,518	$ 57,888,921	$ 414.48	69.99%
New Adult	59,021	$ 255,945,079	$ 361.38	59,261	$ 191,353,645	$ 358.78	74.76%
Exchange Premium Assistance #	15,831	$ 6,065,475	$ 31.93	17,633	$ 4,500,776	$ 28.36	74.20%
Exchange Cost Sharing #	5,358	$ 1,232,289	$ 19.17	5,725	$ 963,831	$ 18.71	78.21%
ABD Child	3,190	$ 24,874,655	$ 649.79	2,441	$ 17,084,216	$ 777.69	68.68%
General Child	60,003	$ 153,506,519	$ 213.19	59,550	$ 113,846,926	$ 212.42	74.16%
Underinsured Child	833	$ 1,210,126	$ 121.09	831	$ 810,170	$ 108.30	66.95%
SCHIP	5,280	$ 9,400,484	$ 148.37	5,168	$ 5,809,071	$ 124.89	61.80%
Pharmacy Only	11,640	$ 6,266,029	$ 44.86	11,538	$ 1,859,558	$ 17.91	29.68%
Choices for Care	4,310	$ 223,201,934	$ 4,315.94	4,285	$ 166,376,298	$ 4,314.51	74.54%
Total Medicaid Claims Paid	207,863	$ 892,446,342	$ 357.79	208,393	$ 652,739,062	$ 348.03	73.14%

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

The Department of Vermont Health Access

Caseload and Expenditure Report ~ All AHS Medicaid Spend

All AHS YTD '17

Friday, June 02, 2017

	SFY '17 Appropriated			SFY '17 Actuals thru March 31, 2017			
	Caseload	Expenses	PMPM	Caseload	Expenses	PMPM	% of Approp. Spent to Date
ABD Adult	8,791	$ 157,169,654	$ 1,489.83	8,932	$ 113,468,465	$ 1,411.49	72.19%
ABD Dual	17,758	$ 229,528,791	$ 1,077.12	17,510	$ 161,665,152	$ 1,025.84	70.43%
General Adult	15,848	$ 95,676,736	$ 503.08	15,518	$ 67,241,034	$ 481.44	70.28%
New Adult	59,021	$ 285,046,469	$ 402.47	59,261	$ 213,823,045	$ 400.91	75.01%
Exchange Premium Assistance #	15,831	$ 6,065,475	$ 31.93	17,633	$ 4,500,776	$ 28.36	74.20%
Exchange Cost Sharing #	5,358	$ 1,232,289	$ 19.17	5,725	$ 963,831	$ 18.71	78.21%
ABD Child	2,490	$ 66,398,766	$ 2,222.18	2,441	$ 40,997,245	$ 1,866.23	61.74%
General Child	60,003	$ 264,618,665	$ 367.51	59,550	$ 189,319,306	$ 353.24	71.54%
Underinsured Child	833	$ 1,971,880	$ 197.31	831	$ 1,537,237	$ 205.49	77.96%
SCHIP	5,280	$ 10,766,803	$ 169.93	5,168	$ 7,215,106	$ 155.12	67.01%
Pharmacy Only	11,640	$ 6,266,029	$ 44.86	11,538	$ 1,859,558	$ 17.91	29.68%
Choices for Care	4,310	$ 225,779,225	$ 4,365.78	4,285	$ 168,050,632	$ 4,357.93	74.43%
Total Medicaid Claims Paid	207,163	$ 1,350,520,781	$ 543.26	208,393	$ 970,778,276	$ 517.60	71.88%

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

The Department of Vermont Health Access

Caseload and Expenditure Report ~ All AHS and AoE Medicaid Spend

All AHS and AoE YTD '17

Friday, June 02, 2017

	SFY '17 Appropriated			SFY '17 Actuals thru March 31, 2017			
	Caseload	Expenses	PMPM	Caseload	Expenses	PMPM	% of Approp. Spent to Date
ABD Adult	8,791	$ 158,618,312	$ 1,503.56	8,932	$ 114,389,556	$ 1,422.95	72.12%
ABD Dual	17,758	$ 229,776,003	$ 1,078.28	17,510	$ 161,745,330	$ 1,026.35	70.39%
General Adult	15,848	$ 95,900,502	$ 504.26	15,518	$ 67,348,135	$ 482.21	70.23%
New Adult	59,021	$ 285,093,609	$ 402.53	59,261	$ 213,868,571	$ 400.99	75.02%
Exchange Premium Assistance #	15,831	$ 6,065,475	$ 31.93	17,633	$ 4,500,776	$ 28.36	74.20%
Exchange Cost Sharing #	5,358	$ 1,232,289	$ 19.17	5,725	$ 963,831	$ 18.71	78.21%
ABD Child	2,490	$ 83,165,401	$ 2,783.31	2,441	$ 51,266,774	$ 2,333.70	61.64%
General Child	60,003	$ 295,934,148	$ 411.00	59,550	$ 209,764,476	$ 391.39	70.88%
Underinsured Child	833	$ 2,415,745	$ 241.72	831	$ 1,796,773	$ 240.18	74.38%
SCHIP	5,280	$ 12,130,576	$ 191.45	5,168	$ 8,266,208	$ 177.72	68.14%
Pharmacy Only	11,640	$ 6,266,029	$ 44.86	11,538	$ 1,859,558	$ 17.91	29.68%
Choices for Care	4,310	$ 225,786,465	$ 4,365.92	4,285	$ 168,052,647	$ 4,357.99	74.43%
Total Medicaid Claims Paid	207,163	$ 1,402,384,554	$ 564.12	208,393	$ 1,003,959,525	$ 535.29	71.59%

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

VERMONT

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Agency of Human Services

Questions, Complaints and Concerns Received by Health Access Member Services
April 1, 2017 – June 30, 2017

April 3 – April 7
- No issues to report

April 10 – April 14
- VPharm Reviews & Reinstatements

April 17 – April 21
- Medicare Savings Program closures

April 24 – April 28
- VPharm Reviews & Reinstatements

May 1 – May 4
- VPharm Reviews & Reinstatements

May 8 – May 12
- VPharm Reviews & Reinstatements

May 15 – May 19
- VPharm Reviews & Reinstatements

May 22 – May 26
- VPharm Reviews & Reinstatements

May 29 – June 2
- No issues to report

June 5 – June 9
- VPharm/VPharm Review/Reinstatements

June 12 – June 16
- VPharm/VPharm Review/Reinstatements

June 19 – June 23

- VPharm/VPharm Review/Reinstatements

June 26 – June 30

- VPharm/VPharm Review/Reinstatements

VERMONT

Agency of Human Services

Grievance and Appeal Quarterly Report
Medicaid Managed Care Model
All Departments Combined Data
April 1, 2017 – June 30, 2017

The Medicaid Managed Care Model is composed of various administrative areas within the Agency of Human Services (AHS). These include: the Department of Vermont Health Access (DVHA), the Department for Children and Families (DCF), the Department of Mental Health (DMH), the Department of Disabilities, Aging and Independent Living (DAIL), and the Department of Health (VDH). Also, included in the Medicaid Managed Care Model are the Designated Agencies (DA) and Specialized Service Agencies (SSA) that provide service authorizations for DMH and DAIL. Each entity should have at least one assigned grievance and appeal coordinator who enters data into the centralized grievance and appeals database. This report is based on data compiled on July 19, 2017, from the centralized database that were filed from April 1, 2017 through June 30, 2017.

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

During this quarter, there were 12 grievances filed; eight were addressed during the quarter. Grievances must be addressed within 90 days of filing, so having pending cases at the end of the quarter is to be expected. Acknowledgement letters of the receipt of a grievance must be sent within five days; the average was four days. Of the grievances filed, 78% were filed by beneficiaries, 5% were filed by a representative of the beneficiary and 17% were filed by another source. Of the 12 grievances filed, DMH had 75%, DAIL has 17% and DVHA had 8%. There were no grievances filed for VDH or DCF during this quarter.

There were no Grievance Reviews filed this quarter.

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

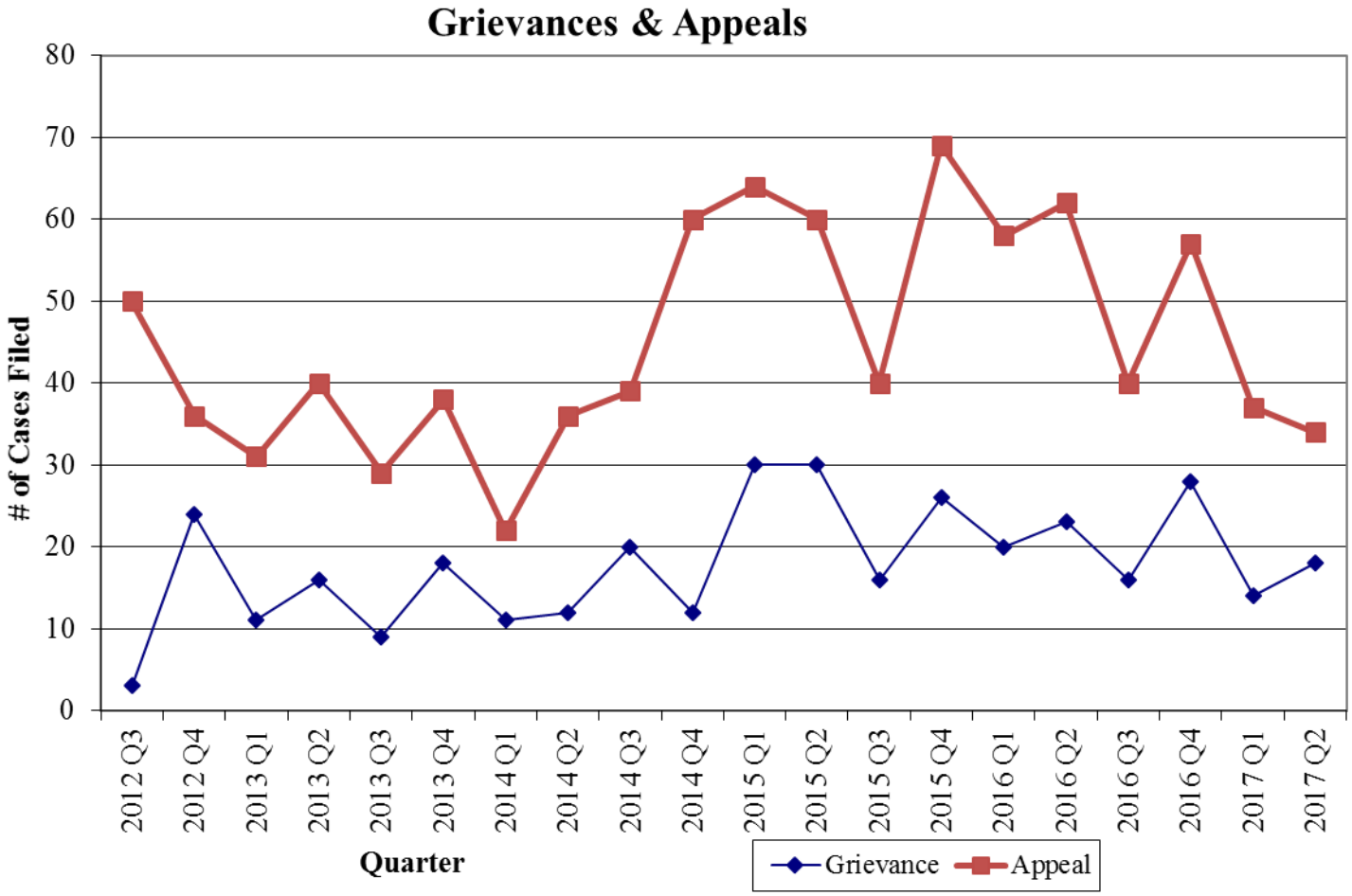
1. denial or limitation of authorization of a requested covered service or eligibility for service, including the type, scope or level of service;
2. reduction, suspension or termination of a previously authorized covered service or a service plan;
3. denial, in whole or in part, of payment for a covered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

During this quarter, there were 29 appeals filed; 11 requested an expedited decision with seven of them meeting criteria. Of these 29 appeals, 23 were resolved (79% of filed appeals), 5 were still pending (17%), and one was withdrawn (4%).

Of the 29 appeals that were resolved this quarter, 100% were resolved within the statutory time frame of 45 days; 76% were resolved within 30 days. The average number of days it took to resolve these cases was 29 days. Acknowledgement letters of the receipt of an appeal must be sent within five days; the average was two days.

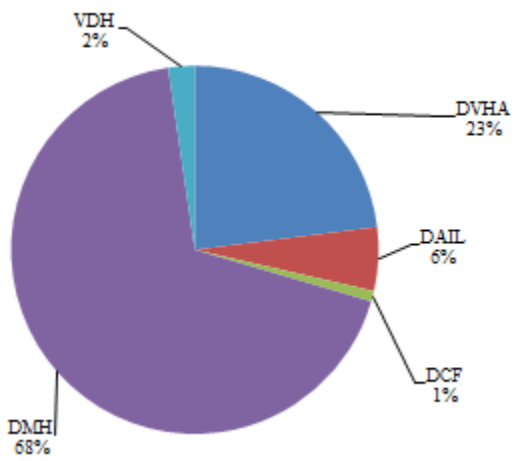
Of the 29 appeals filed, 8 were filed by beneficiaries (28%), 20 were filed by a representative of the beneficiary (69%) and 1 was filed by the provider (3%). Of the 29 appeals filed, DVHA had 14 appeals filed (48%), and DAIL had 15 (52%), DMH and VDH had none.

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

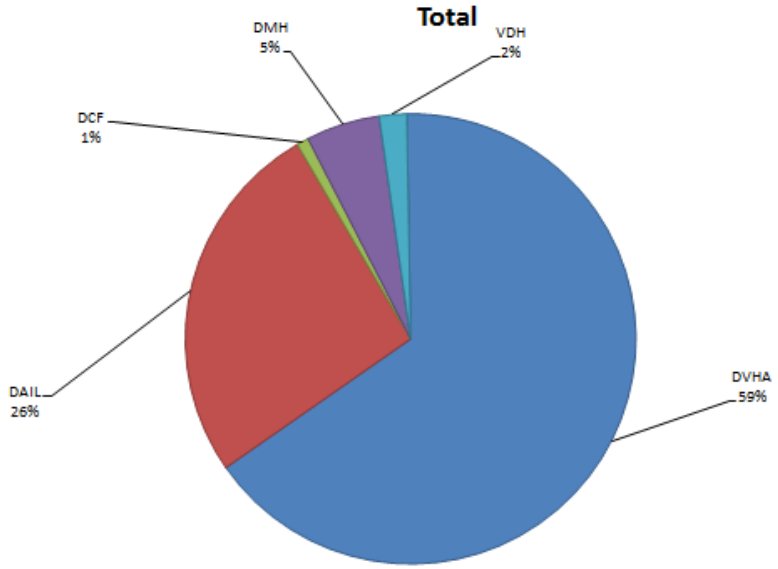


Grievance & Appeals by Department
From January 1, 2008 through June 30, 2017

Grievances



Appeals



Vermont Legal Aid

Office of the Health Care Advocate

Quarterly Report

April 1, 2017- June 30, 2017

to the

Agency of Administration

submitted by

Michael Fisher, Chief Health Care Advocate

Office of the Health Care Advocate

July 21, 2017

Vermont Legal Aid

Working for Justice

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Introduction

The Office of the Health Care Advocate (HCA) provides a key role by combining individual consumer assistance and consumer advocacy on issues related to health insurance and health care. We engage in a wide variety of consumer protection activities on behalf of the public, including appearing before the Green Mountain Care Board, other state agencies and the state legislature to promote improvements in health care access, quality and affordability.

Helping Vermonters navigate Vermont Health Connect (VHC) has been a significant task for the HCA over the last 3 and a half years. This report shows continued improvement and stabilization at VHC. The number of VHC calls dropped by 24% this quarter. VHC calls, however, still represent 35% of the calls to the HCA. VHC cases also tend to be more complicated and time-consuming. This quarter, 44% of VHC cases were "complex interventions" that took more than two hours of an advocate's time to resolve.

During this time period, the HCA has also seen increased usage of our website, particularly the Medicaid eligibility pages. Medicaid eligibility cases represent 21% of our total cases, and it has been the top issue for the last three quarters.

We have continued to work on our website to make it accessible to more Vermonters. This quarter we also launched a new online health care tool. This tool gives consumers a way to get an answer to their specific health questions. It is clear to us that there are many Vermonters who have real struggles with access to care, but who do not know about our services. This quarter we also reached out to child care workers; small farmers, self-employed workers; and newly-released prisoners.

This continues to be an uncertain time for consumers, health care providers, and carriers, given the ongoing discussions at the federal level of possible repeal and replacement of the ACA, possible cuts to Medicaid funding, and administrative changes that could have a real impact on Vermonters. We regularly receive calls from Vermonters who express anxiety about how these possible changes will impact their families' access to care. Today's uncertainty has an impact on Vermont consumers and makes the role of the HCA even more essential.

A key strength of the HCA is our continued support for Vermonters through individual advocacy as well as at the legislative and administrative policy level. We are able to provide policy makers with feedback informed by our daily work with Vermonters facing challenges accessing the care they need, such as Richard's experience described in the case narrative above. We work to control unnecessary costs and make the health care system sustainable, and to ensure that Vermont consumers are heard by providers and policy-makers.

Richard's Story

Richard had been hitchhiking to his daily appointments at the substance abuse clinic. He had no insurance coverage and no car, and his only income was from disability payments. He had no friends or family who could help him get to his appointments.

He was afraid he'd miss an appointment and relapse. When Richard called the HCA for help, the HCA advocate realized that Richard was eligible for Medicaid for the Aged Blind and Disabled (MABD). She helped him complete his application, submitted his application for him, and asked for it to be expedited. He was found eligible the same day the application was submitted. This meant that he would be able to get his prescriptions with low copayments and would not have to pay out of pocket for his medical appointments at the clinic

With this Medicaid coverage, Richard was entitled to transportation to his appointments at the substance abuse clinic. The HCA advocate intervened with the transportation office, and was able to quickly set up rides for him.

Individual Consumer Assistance

Case Examples

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

Evelyn's Story

Evelyn needed to make an appointment for an MRI, but she had no insurance coverage and couldn't afford to pay for it. She had been on Qualified Health Plan (QHP) through Vermont Health Connect (VHC), but it closed even though she was paying her monthly premium. When the HCA advocate investigated, he found that Evelyn was eligible for Premium Tax Credits (PTC) to help pay for her monthly premium, which meant her monthly payment was under $50 a month. Since she received PTC, she was also eligible for a three month grace period. However, Evelyn was terminated for QHP after only two months. In addition, VHC had not given her PTC for one of the months for which she was eligible. This made it look like she was behind on her payments, even though she had paid her monthly premiums on time. The HCA advocate was able to get Evelyn's PTC applied and her coverage reinstated.

Levi's Story

When Levi went to the emergency room, he found out that he did not have any insurance. He was surprised because he thought that he was on Medicaid. The HCA looked into the issue, and found that Levi's Medicaid had been closed at the end of 2016. This meant that he had been without insurance coverage for nearly six months—an issue because under the Affordable Care Act consumers must pay a penalty for the months they go uninsured unless they qualify for an exemption. The advocate discovered that VHC closed Levi's Medicaid without sending the required closure notice. The advocate worked to get his Medicaid reinstated back to January, meaning that Levi's trip to the emergency room would be covered, and that Levi would not owe a penalty for not having insurance coverage for the first half of the year. Between the hospital claims and the penalty, the HCA saved Levi nearly one thousand dollars.

Spencer's Story

Spencer called the HCA because he couldn't afford a necessary prescription. He'd been on VPharm, the state pharmacy assistance program, which kept his co-payments between $1 and $2, but his VPharm closed for nonpayment. Talking with Spencer, the HCA advocate learned that he'd been hospitalized for several weeks after a surgery. While hospitalized, he could not pay his premiums. Under VPharm rules, if non-payment is caused by medical incapacity, it is possible to reinstate the coverage if you can show proof of the incapacity. The HCA advocate intervened and helped Spencer submit a medical incapacity form signed by his doctor. Because the evidence showed that Spencer was incapacitated and unable to send the premium, the state of Vermont agreed to reinstate V-Pharm. He was once again able to pick up the prescriptions he needed.

Emme's Story

Emme called the HCA because her family's monthly premium for her QHP had increased by nearly $400 per month. She could not afford to pay it, but she needed health insurance because she was pregnant. When the HCA advocate investigated, she found that VHC had calculated the family's income incorrectly, which meant that the family was not getting as much financial help as they were eligible for. This had happened because they reported increased income for only one month, but

VHC believed it was for the full year. Talking with VHC, the advocate was able to get the proper amount of PTC restored. The advocate also discovered that, in the time being, the family's income had decreased even further. When their fully-accurate income was reported to VHC, Emme also became eligible for Dr. Dynasuar for pregnant women.

Henry's Story

Henry called the HCA because he received a 1095-A from VHC showing that he had coverage for all of 2016. The 1095-A is a tax form that shows what months you had coverage and how much premium tax credit (PTC) you received each month. Henry's problem was that he had been able to sign up for his work insurance earlier in the year, and thought his VHC coverage would close when he stopped making payments. However, VHC did not close the coverage, and kept him on the plan for the entire year. Henry was going to have to pay back all of the PTC he received, as well as his unpaid premiums. When the HCA advocate looked into this, she found that VHC had not followed its own rules that allow for a three-month grace period. After this grace period, if you are not completely caught up, your coverage should be terminated. Instead, VHC had kept Henry's coverage open for well beyond the grace period. The advocate requested that the grace period rules be enforced and that the 1095-A be revised to show that his coverage had ended in June. This saved Henry from having to pay back nearly $2000 in PTC.

Grace's Story

Grace needed dental work done, but her dentist would not schedule an appointment without a down payment, which she could not afford. When the HCA advocate talked to Grace, he realized that she was eligible for Medicaid. She had already applied, but the coverage was not active because VHC was trying to verify her income. The HCA advocate intervened with VHC to show that Grace did not have any monthly income at all, so she could not produce pay stubs for verification. VHC agreed to activate the coverage immediately. With the Medicaid coverage, Grace was now entitled to some dental coverage. It was unfortunately not nearly enough to cover all of her dental needs, but it allowed her to get started on her dental work.

Elaine's Story

Elaine called because she received a closure notice from the State of Vermont. Elaine had been on the Breast and Cervical Cancer Treatment Program (BCCTP), a type of Medicaid for women undergoing treatment for breast or cervical cancer. The notice didn't explain why the State was closing her coverage—it simply gave a date for when the coverage was supposed to end. The HCA advised Elaine that this was not an adequate notice. When the HCA advocate investigated, she found that the State was closing Elaine's coverage because it believed that Elaine did not meet the coverage criteria that require that the beneficiary be getting treatment for breast or cervical cancer. The advocate spoke to Elaine and her doctor, and confirmed that she was in active treatment. The advocate then intervened with the State and argued that Elaine still met the eligibility requirements for the program. As a result, Elaine's coverage was reinstated.

Overview

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

The HCA received 861 calls[1] this quarter. We divided these calls into five issue categories. The figures below are based on the All Calls data. The percentage and number of calls in each issue category, based on the caller's primary issue, were as follows:

- **23.93 %** (206) about **Access to Care**
- **12.66%** (109) about **Billing/Coverage**
- **1.16%** (10) about **Buying Insurance**
- **11.85%** (102) about **Consumer Education**
- **27.53%** (237) about **Eligibility** for state and federal programs
- **22.88%** (197) 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 237 of our cases had eligibility for state and federal healthcare programs listed as the primary issue, a total of 454 cases had eligibility listed as a secondary concern.

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

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

The full quarterly report for April 1 - June 30, 2017 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**: 861 calls (compared to 979 last quarter)

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

- **Department of Vermont Health Access (DVHA) beneficiaries**: 278 calls (274 calls last quarter)
- **Commercial plan beneficiaries**: 155 calls (224 calls last quarter)
- **Uninsured Vermonters**: 113 calls (111 calls last quarter)
- **Vermont Health Connect (VHC)**: 301 calls (394 calls last quarter)
- **Reportable Activities (Summary & Detail)**: 74 activities and 27 documents (106 activities, 17 documents)

Highlights

- The HCA launched a new web tool to help consumers access health care information.
- The HCA advised on 46 appeals this quarter. Of the 46 appeals, 33 were fair hearings.
- The HCA saved consumers $65,688 this quarter.
- The HCA assembled a stakeholder group of representatives from payers, provider organizations and consumer groups as well as representatives from the Scott Administration, to facilitate better communication for the purpose of understanding each organization's positions on prospective policies on both the State and Federal level. This group met weekly during the second half of the legislative session. We also facilitated a joint statement in opposition to the US House health care bill.
- The HCA continued to promote the use of plain language in VHC notices, so the information is more accessible and understandable to consumers. The HCA provided comments on plain language and content on 7 different VHC notices.
- The total number of health pageviews increased by 27% in the reporting quarter ending June 30, 2017 (10406 pageviews), compared with the same quarter in 2016 (8176 pageviews). This is especially noteworthy because traffic to the Vermont Law Help website as a whole was nearly even when compared with the same period last year.
- The ***Health home page*** again had the second largest number of pageviews (1,151), up 29% over last year's 895. The home page tells consumers how we can help them and provides our contact information, including an online form that can be filled out and submitted 24/7.
- Five of the top 20 health pages with the largest number of pageviews focused on ***Long-Term Care Medicaid (Choices for Care)***. All of these pages saw increases when compared with the same quarter in 2016.

Priorities & Projects

A. The HCA discovered a problem with a VHC notice and pushed for resolution.

This quarter, the number of calls about terminations more than doubled (48 vs. 22). While advising consumers on the termination cases, HCA advocates noticed that multiple people had received an incorrect and confusing notice. The notice told consumers that VHC had received a partial payment, and that they needed to make another payment to become current. However, the notice also included an incorrect line stating that if you "had sent another payment since October 18, 2016 you can disregard this notice." Based on this notice, a consumer could reasonably believe that because they sent a payment since October 18, 2016, they were not in danger of termination. That was not the case. The HCA contacted VHC to alert them of the incorrect notice, and requested that VHC take corrective action. VHC corrected the glitch that caused the incorrect statement. Ultimately we learned that 4000 QHP households received the incorrect notice; as a result, over 100 plans were terminated. The HCA worked to reinstate the consumers they were already working with, and advocated that VHC reach out to all terminated households, offering them a chance to reinstate coverage. These efforts and discussions with VHC are ongoing.

B. The HCA introduced a new health care online help tool: Search, Learn & Ask for Help

The HCA developed a new online tool to help consumers get answers to their specific health care questions. The online help tool (accessible by clicking the button on the home page of the Vermont Law Help website, pictured at right) adds a new way to access helpful information – at all hours of the day and night.

The tool asks website visitors a few questions. For example, it will ask if you need help with a Vermont Health Connect, Medicare or Medicaid question. After you answer this, it asks specific questions about your problem. By the end, the goal is that each visitor has more specific information about their issue. For visitors with more complex questions, the tool also offers an online request to get personal help from an advocate. The regular HCA hotline is still active, and will continue to operate as normal. The online tool incorporates all of the HCA's most frequently asked questions, and uses plain language to make each explanation accessible. The HCA plans to expand the tool in the coming months.

C. The HCA launched outreach efforts to reach vulnerable populations.

The HCA launched outreach efforts to more effectively reach vulnerable populations this quarter. The outreach efforts were aimed particularly at child care workers, self-employed workers, small farmers, and newly-released prisoners. Many individuals in these groups do not have a human resource officer to help with insurance questions. As a result, they may be uninsured, or unaware of all the programs that could help. A new study of farmers from ten states including Vermont also found that health insurance was a significant concern for farmers. (See: *http://digital.vpr.net/post/uvm-study-finds-health-insurance-tops-farmers-concerns#stream/0*) We have already seen an uptick of calls from these groups, and we plan to expand our outreach in the next quarter.

D. Vermont Health Connect calls about grace periods increased significantly (42 cases vs. 12 last quarter).

The HCA received significantly more calls about grace period notices this quarter. Consumers receiving Premium Tax Credit (PTC) are entitled to a three-month grace period. For consumers who started 2017 current with their premiums, the three-month grace period ended on March 31st. Consumers not caught up by March 31st were terminated. Many consumers called when they received the termination notice, or after they were denied a prescription at the pharmacy. We also had a corresponding jump in cases about terminations (48 vs. 22). When we get these calls, the HCA reviews the case to make sure that the individual received the three required grace period notices. It also studies the payment history to make sure all the payments have been applied correctly, and that the person has received accurate and timely invoices. If the HCA finds an error in these areas, it asks for reinstatement. This quarter, the HCA was able to prevent termination of insurance in 31% of these cases. (48 termination cases total/ 15 insurance terminations prevented.)

E. Overall call volume dropped this quarter.

The total call volume dropped slightly this quarter (861 vs. 978). Of those calls, nearly 12% involved the HCA either preventing someone from losing insurance, or helping someone get new insurance coverage. We saved consumers $65,688 this quarter.

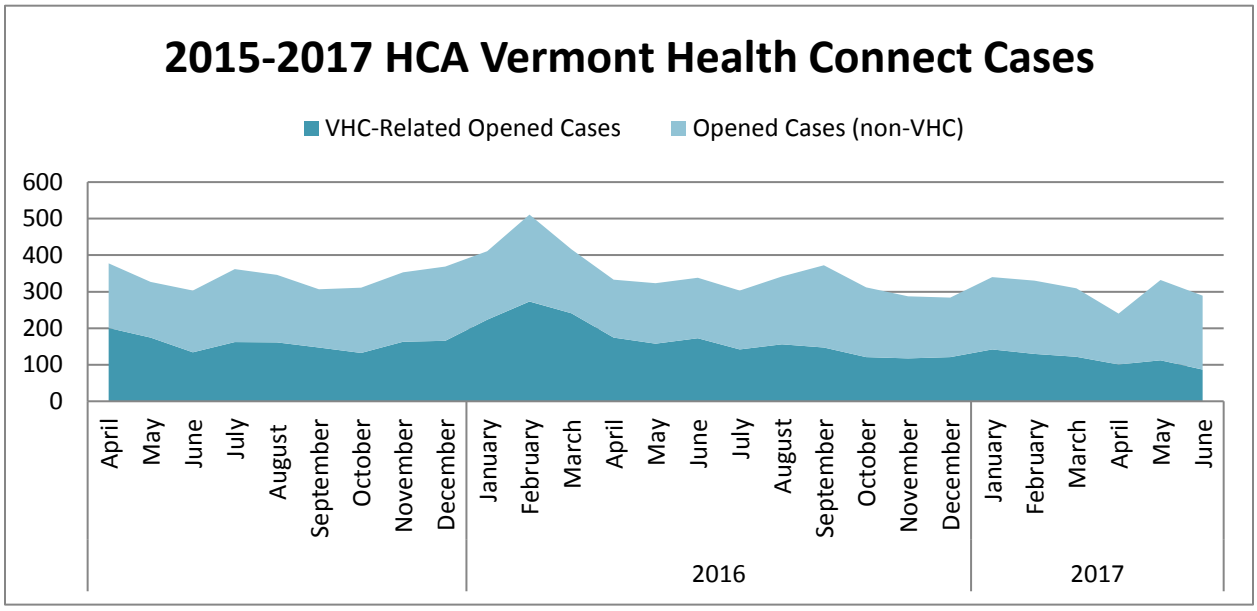
	All Calls (2007-2017)										
	2007	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**
January	280	309	240	218	329	282	289	428	470	411	340
February	172	232	255	228	246	233	283	304	388	511	330
March	219	229	256	250	281	262	263	451	509	416	308
April	190	235	213	222	249	252	253	354	378	333	240
May	195	207	213	205	253	242	228	324	327	325	332
June	254	245	276	250	286	223	240	344	303	339	289
July	211	205	225	271	239	255	271	381	362	304	-
August	250	152	173	234	276	263	224	342	346	343	-
September	167	147	218	310	323	251	256	374	307	372	-
October	229	237	216	300	254	341	327	335	311	312	-
November	195	192	170	300	251	274	283	306	353	287	-
December	198	214	161	289	222	227	340	583	369	284	-
Total	2560	2604	2616	3077	3209	3105	3257	4526	4423	4237	1839

F. Calls concerning Vermont Health Connect dropped significantly.

The volume of calls concerning Vermont Health Connect decreased by 24%, compared to the previous quarter (301 vs. 394). This decrease in VHC cases reflects that VHC is functioning more consistently and resolving problems more quickly. VHC cases still represent 35% of all HCA calls. Of all VHC cases this quarter, 44% required complex interventions that took more than two hours of an advocate's time to

resolve (132 complex interventions out of 301 total VHC cases). We remain concerned about consumers who are trying to navigate VHC to resolve problems on their own.

The HCA continues to resolve its cases by working directly with Tier 3 Health Access Eligibility Unit (HAEU) workers, who are trained to resolve all aspects of complex cases. In addition, the HCA meets with VHC each week to discuss cases as needed, and has regular email contact with Tier 3. This quarter, the HCA escalated 49 complex cases (compared to 52 last quarter); 44 were resolved within the quarter. This next quarter, the HCA and VHC plan to expand the types of cases that the HCA resolves with Tier 3. Next quarter, Tier 3 will also work on resolving Green Mountain Care cases (VPharm, Medicaid for Aged Blind and Disabled, Medicare Saving Programs, Medicaid Spenddowns). Because of the expansion of these types of cases, we expect that the number of escalated cases we receive will increase. We will continue meeting weekly with VHC to make sure that the cases are resolved quickly and efficiently.



G. Medicaid eligibility calls represented 21% of all our cases (185 calls/ 861 total calls). Consumers need assistance with all types of Medicaid eligibility.

For the third quarter in a row, Medicaid eligibility was the top issue of all calls. We had 84 calls about eligibility for MAGI (expanded) Medicaid, 72 about eligibility for Medicaid for the Aged Blind and Disabled (MABD), and 29 about Medicaid Spenddowns. MAGI Medicaid and MABD Medicaid have different eligibility and income rules, and HCA advocates assess and advise on eligibility for both programs. Consumers frequently have questions about what counts as income, who should be counted in their household, what expenses can be used to meet a Spenddown, how to complete renewal paperwork, and whether their eligibility decision is correct.

Case Results

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 861 (compared to 978 last quarter)

1. MAGI Medicaid eligibility 84 (126)
2. Complaints about providers 78 (103)
3. Medicaid eligibility (non-MAGI) 72 (44)
4. Termination of insurance 63 (38)
5. VHC Premium Tax Credit eligibility 55 (94)
6. Access to prescription drugs 53 (55)
7. Other: Not health related 50 (41)
8. Information/applying for DVHA programs 48 (41)
9. Buy-in programs/Medicare Savings Programs 47 (40)
10. VHC complaints 45 (64)
11. Fair hearing appeals 44 (36)
12. Eligibility for VHC grace periods 43 (12)
13. Special enrollment periods (eligibility) 40 (36)
14. Affordability affecting access to care 39 (37)
15. VHC invoice/billing problem affecting eligibility 39 (36)
16. Consumer education about Medicare 37 (30)
17. Change of Circumstance 34 (64)
18. Information about VHC 31 (34)
19. Medicaid spend down (eligibility) 29 (30)
20. HAEU mistake 28 (50)
21. DVHA/VHC premium billing 27 (35)

Vermont Health Connect Calls 300 (compared to 393 last quarter)

1. MAGI Medicaid eligibility 74 (120)
2. Premium Tax Credit eligibility 55 (92)
3. Termination of insurance 48 (22)
4. VHC complaints 43 (64)
5. Eligibility for VHC grace periods 42 (12)
6. VHC invoice/payment/billing problem affecting eligibility 39 (36)
7. Fair hearing appeals 34 (21)
8. Information about VHC 28 (32)
9. Change of Circumstance 27 (61)
10. Consumer education about IRS reconciliation 26 (39)

DVHA Beneficiary Calls 278 (compared to 274 last quarter)

1. MAGI Medicaid eligibility 36 (44)
2. Medicaid eligibility (non-MAGI) 35 (16)
3. Complaints about providers 25 (41)

4. Access to prescription drugs 21 (17)
5. Buy-in programs/Medicare Savings Programs 20 (10)
6. Information/applying for DVHA programs 17 (21)
7. Consumer education about Medicare 13 (3)
8. Fair hearing appeals 12 (10)
9. PA denial 12 (11)
10. Pain management (access to care) 12 (17)
11. Choosing/changing providers 10 (9)
12. Access to transportation 10 (19)
13. Affordability affecting access to care 10 (7)
14. Medicaid balance billing 9 (13)
15. Medicaid/VHAP Managed Care Billing 9 (12)
16. Provider billing problems 9 (9)
17. Information about VHC 9 (8)
18. Change of Circumstance 9 (18)
19. Long Term Care Medicaid 9 (5)

Commercial Plan Beneficiary Calls 155 (compared to 223 last quarter)

1. Premium Tax Credit eligibility 27 (50)
2. MAGI Medicaid eligibility 18 (27)
3. Change of Circumstance 17 (32)
4. Consumer education about IRS reconciliation 16 (16)
5. VHC complaints 16 (27)
6. VHC invoice/payment/billing problem related to eligibility 15 (26)
7. Information about VHC 13 (10)
8. Eligibility for VHC grace periods 12 (8)
9. Eligibility for special enrollment periods 11 (9)
10. 1095-A problems 11 (27)
11. DVHA/VHC premium billing 10 (20)
12. Affordability affecting access to care 9 (9)

Insurance Status of Callers

The HCA received 861 total calls this quarter. Callers had the following insurance status:

- **DVHA program beneficiaries** (Medicaid, Medicare Savings Program also called Buy-In program, VPharm, or both Medicaid and Medicare also known as "dual eligible"): 32% (278 calls), compared to 28% (274 calls) last quarter
- **Medicare[2] beneficiaries (**Medicare only, Medicare Advantage Plans, Medicare and a Medicare Supplemental Plan aka Medigap, Medicare and Medicaid also known as "dual eligible," Medicare and Medicare Savings Program also called Buy-In program, Medicare and Part D, or Medicare and VPharm): 27% (232 calls), compared to 22% (217 calls) last quarter

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

- **Commercial plan beneficiaries** (employer-sponsored insurance, small group plans, or individual plans): 18% (155 calls), compared to 23% (223 calls) last quarter
- **Uninsured:** 13% (113 calls), compared to 11% (110 calls) last quarter

Dispositions of Closed Cases

All Calls

We closed 898 cases this quarter, compared to 981 last quarter:

- 30% (272 cases) were resolved by brief analysis and referral
- 27% (240) were resolved by brief analysis and advice
- 25% (223) of the cases were complex interventions involving complex analysis, usually direct intervention, and more than two hours of an advocate's time
- 9% (82) were resolved by direct intervention, including calling an insurance company, calling providers, writing letters, gathering supporting medical documentation, etc.
- In the remaining cases (61), clients withdrew, resolved the issue on their own, or had some other outcome.

Appeals: The HCA assisted 46 individuals with appeals: 33 Fair Hearings, 6 Medicaid MCO Internal Appeals, 3 Commercial Insurance – Internal 2nd Level appeals, 2 Medicare Part D Appeals, 1 Commercial Insurance – Internal 1st Level appeal, and 1 Commercial Insurance – External appeal.

DVHA Beneficiary Calls

We closed 273 DVHA cases this quarter, compared to 266 last quarter:

- 31% (84 cases) were resolved by brief analysis and/or referral
- 30% (83) were resolved by brief analysis and/or advice
- 19% (53) were considered complex intervention, which involves complicated analysis, usually direct intervention, and more than two hours of an advocate's time
- 12% (33) were resolved by direct intervention on the caller's behalf, including advocacy with the carrier and providers, writing letters, and gathering medical information
- In the remaining cases clients withdrew, resolved the issue on their own, or had some other outcome.

Appeals: The HCA assisted 14 DVHA beneficiaries with appeals: 7 Fair Hearings, 6 Medicaid MCO Internal appeals, and 1 Medicare Part D appeal.

Commercial Plan Beneficiary Calls

We closed 189 cases involving individuals on commercial plans, compared to 218 last quarter:

- 28% (53 cases) were resolved by brief analysis and/or advice
- 19% (36) were resolved by brief analysis and/or referral
- 34% (64) were considered complex intervention, which involves complicated analysis, usually direct intervention, and more than two hours of an advocate's time
- 13% (24) were resolved by direct intervention on the caller's behalf, including advocacy with the carrier and providers, writing letters, and gathering medical information
- In the remaining cases clients withdrew, resolved the issue on their own, or had some other outcome.

Appeals: The HCA assisted 37 commercial plan beneficiaries with appeals: 29 Fair Hearings, 3 Commercial Insurance – Internal 2nd Level appeals, 2 Medicaid Part D appeals, 1 Commercial Insurance – External appeals, 1 Commercial Insurance – Internal 1st Level appeal, and 1 Medicaid MCO Internal Appeal.

All Calls Case Outcomes

The HCA helped 89 people get enrolled in insurance plans and prevented 15 insurance terminations or reductions. We obtained coverage for services for 19 people. We got 23 claims paid, written off, or reimbursed. We estimated VHC insurance program eligibility for 32 more. We provided other billing assistance to 13 individuals. We provided 514 individuals with advice and education. Twelve people were not eligible for the benefit they sought, and six were responsible for the bill they disputed. We obtained other access or eligibility outcomes for 66 more people.

Consumer Protection Activities

Rate Reviews

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

Two new cases were filed during the quarter, and the HCA has entered appearances in these cases. In addition, five cases were pending at the beginning of the quarter.

The pending cases involve rates for MVP's small group grandfathered plans, MVP's large group PPO plans, Blue Cross and Blue Shield of Vermont (BCBSVT)'s large group manual rates, The Vermont Health Plan (TVHP)'s large group manual rates and MVP's Large Group HMO plans.

The BCBSVT and TVHP filings affected 15,908 members (8,159 subscribers) in 67 groups. Because of the impact of these filings on many Vermonters, the HCA worked with an independent actuary to review the filings. The HCA submitted suggested questions for BCBSVT and TVHP at the end of the January to March quarter. During the last quarter, the HCA and the carrier submitted memoranda and the Board issued decisions on the filings. The HCA argued for reductions in the requested rates. The Board modified the requested medical and pharmacy trend leading to a reduction in the manual rate increase from approximately 10.7% to 9.4%. BCBSVT requested reconsideration of the decision, but the Board denied this motion.

The HCA also argued for rate reductions in the three MVP cases. The Board approved the rate increases requested in the Small Group and Large Group PPO filings except that it disapproved MVP's proposed manual rate cap for use in Vermont. MVP was also ordered to adjust its rates if the 2018 Health Insurer Fee is reduced. The Board modified the Large Group HMO proposed rates by the amount of the increase attributable to its proposed age and gender factors, resulting in a rate change modification from 8.2% for members enrolling in the first quarter of 2017 and a modification from 9.3% to 5.3% for those enrolling in the second quarter of 2017.

The two new rate review cases filed during the quarter on May 12, 2017 are the filings for plans to be offered on Vermont Health Connect (VHC) in 2018 by BCBSVT and MVP. BCBSVT, which expects to insure more than 70,000 Vermonters through VHC in 2018, is requesting a 12.7% average annual rate

increase. MVP**,** which expected to insure approximately 6800 Vermonters through VHC, is requesting a 6.7% average annual rate increase.

The HCA worked closely with its independent actuary to analyze the VHC filings and to suggest questions that the Board's actuaries, Lewis and Ellis, should pose to the carriers. The hearings on the filings will be held in the Vermont State House on July 19 and July 20, 2017.

Certificate of Need

In the last quarter, the HCA participated in the two-day Certificate of Need (CON) hearing for the proposed Green Mountain Surgery Center (GMSC) before the Green Mountain Care Board. As a party to the proceeding on behalf of Vermonters, the HCA asked the GMSC about its cost and quality management policies. We also asked the other interested parties in the proceeding, who wanted the Board to deny the CON (Northwestern Vermont Medical Center and the Vermont Association of Hospitals and Health Systems), about their abilities to address concerns of unsustainable cost increases and lack of patient choice in Vermont's healthcare system. We submitted a post-hearing memo in the proceeding where we asked the Board to approve the GMSC's CON with strong conditions to ensure access to care and accountability to Vermonters. We also supported GMSC's request for additional hearing time to answer questions from the new Board Chair and member.

Additionally, the HCA also participated in the Brattleboro construction and renovation project CON. A consumer contacted us expressing concern that the project had not accurately incorporated the cost of fuel into its choice of a new boiler in the project. We submitted questions to the applicant, requesting in part that the applicant submit a new energy efficiency assessment on the project.

This quarter the HCA also participated in a stakeholder meeting with the Board on ways to improve the certificate of need process through statutory changes. We submitted written comments after the meeting with suggestions to improve the process. In our comments we asked the Board to simplify the timeline for applying for interested party status to ensure that potential interested parties have a clear and efficient process by which to apply.

Other Green Mountain Care Board Activities

In the last quarter, the HCA attended seven weekly Green Mountain Care Board meetings. In addition, we participated in the Green Mountain Care Board's bi-weekly stakeholder meetings to develop the Board's proposed Rule 5.000: Oversight of Accountable Care Organizations (ACOs) (see below) and to provide feedback on other topics related to ACOs and Vermont's All-Payer Model (APM).

This quarter we also attended a meeting with Board staff to discuss the certificate of need expedited process, a meeting with Board staff to discuss the timeline for the ACO budget review process, and a Board meeting on the upcoming hospital budget process.

Hospital Budget Review

The HCA continues to participate in the Green Mountain Care Board's Hospital Budget Review process. In the last quarter, we attended one Green Mountain Care Board meeting related to the hospital budget review process.

Accountable Care Organization Rule

The Board continues to hold bi-weekly meetings with a stakeholder group including the HCA to develop the Accountable Care Organization Rules required by Act 113 of 2016. We submitted four separate sets of written comments on the rule and one on the associated ACO budget guidelines asking for stronger oversight and consumer protections. A significant number of changes were made to the proposed rule in response to our comments, including requiring ACOs to allow the HCA to meet yearly with the ACO's consumer advisory committee to learn whether the ACOs are effectively utilizing their consumer advisers to improve health care cost and quality.

During the last quarter the Board submitted its proposed Rule 5.000: Oversight of Accountable Care Organizations to the Secretary of State. The HCA began reviewing the final proposed rule and drafting comments, which are due next quarter.

All-Payer Model

As noted above, the Board continues to hold its bi-weekly stakeholder meetings on the proposed ACO rule and other topics related to the All-Payer Model. In addition to soliciting feedback on the proposed rule, the Board requested feedback on All-Payer Model quality measures during the last quarter. The HCA submitted comments with suggestions for the measure set. We then reviewed a proposed set of measures and submitted comments asking the Board to add additional quality measures on areas including patient experience, pediatric care, and maternity care. The HCA continues to advocate strongly for robust quality measurement as health care providers begin to accept financial risk for patient care.

Earlier this year, the Department of Vermont Health Access (DVHA) entered into a contract with OneCare Vermont, the state's largest Accountable Care Organization, to manage the care of approximately 30,000 Medicaid beneficiaries. DVHA and OneCare are now negotiating a similar contract for 2019. This quarter the HCA reviewed the 2018 contract and submitted comments to DVHA advocating for the inclusion of additional consumer protections in the 2019 contract, such as stronger quality measures and a robust ACO grievance and appeal process. We met with DVHA staff to review the topics covered in our comments and answer questions.

Vermont Health Care Innovation Project (SIM Grant)

This quarter, activities of the Vermont Health Care Innovation Project (VHCIP) came to a close. During the quarter we continued to monitor the activities of the VHCIP Core Team and attended one Core Team meeting as an interested party.

Affordable Care Act Tax-related Activities

This quarter saw the end of the third tax season since ACA implementation. In general, VHC handled its tax reporting obligations smoothly. However, the HCA did get a significant number of calls related to the tax season. The HCA helped consumers who had trouble obtaining Form 1095-A, trouble understanding what the form meant, or who had disputes about the form. Although for most VHC consumers the tax reconciliation process has greatly improved, some consumers still had problems getting a Form 1095-A that accurately reflected their coverage for the year. Some consumers also had to delay filing their taxes while they waited to a get a revised Form 1095-A.

The HCA continued to employ a half-time tax attorney, who also staffs the Low-Income Taxpayer Clinic at VLA. This arrangement has allowed the HCA to stay up to date on tax law developments, and enables our staff to effectively field calls related to the ACA and VHC.

As in prior quarters, the HCA's tax attorney consulted with HCA advocates when particularly difficult IRS-related issues arose in HCA cases. During this quarter, the tax attorney advised the HCA on 18 technical assistance questions. She also responded to 43 technical assistance questions from nonprofit tax assisters, Vermont tax preparers, and legal services attorneys in other states. Question topics included IRS audits, appeals, and amended returns, shared responsibility exemptions, reconciliation of advance premium tax credits, and Modified Adjusted Gross Income.

The HCA continued its outreach to Vermont tax professionals this quarter, attending the Vermont Tax Practitioners Association annual tax season wrap-up meeting. The HCA offered information about when and how to refer consumers to the HCA for help with Form 1095-A and other health insurance issues. Further information is below in the **Outreach and Education** section.

Other Activities

Administrative Advocacy

✧ Access to Screening Mammography

During the last quarter the HCA became aware that Act 25 of 2013, which requires first dollar coverage of screening mammography including additional views, has largely not been implemented. We believe that hundreds of women have been and continue to be charged cost-sharing and deductibles for call-back mammograms that should be fully covered under Vermont law. This quarter, the HCA met and communicated with representatives from the American Cancer Society, Central Vermont Medical Center, the University of Vermont Medical Center, Blue Cross Blue Shield of Vermont, and the Department of Financial Regulation to try to identify where problems are occurring and rectify them. This law had an implementation date of over three and a half years ago, and yet it continues to not be followed. We are actively pursuing full implementation, which would save many Vermont women hundreds of dollars each year.

✧ Access to Treatment for Hepatitis C Virus

This quarter the HCA continued to monitor access to treatment for hepatitis C. The HCA had one meeting this quarter with the Vermont Department of Health's Hepatitis Coordinator.

✧ Controlled Substance and Pain Management Advisory Council

Act 173 of 2016 created this council to advise the Commissioner of Health on matters related to the Vermont Prescription Monitoring System, the appropriate use of controlled substances in treating pain, and preventing prescription drug abuse, misuse, and diversion. This quarter the HCA attended one Legislative Committee on Administrative Rules (LCAR) hearing for the Department of Health's proposed Rule for Medication-Assisted Treatment for Opioid Dependence. The rule expands capacity for the treatment of opioid dependence by allowing advanced practice registered nurses and physician's assistants to prescribe buprenorphine to individuals requiring and seeking treatment for opioid dependence. The rule also increases the number of patients a provider may treat.

✧ Health Care Administrative Rules (HCAR)

The Department of Vermont Health Access (DVHA) has begun a multi-year revision of Medicaid rules. Eventually all Medicaid rules will be amended and adopted under the title of Health Care Administrative Rules (HCAR). In January, the HCA submitted formal comments on three proposed HCAR Rules describing coverage for dental and orthodontic services. We asked for changes to the proposed rules

that would clarify providers' responsibility to explain the patient's financial responsibility for non-covered services, and would use the existing definition of the clinical criteria for coverage of orthodontic services. During the previous quarter, DVHA made changes to address our concerns in the final proposed version of the regulations. These rules were approved by the Legislative Committee on Administrative Rules (LCAR) during the quarter.

DVHA also proposed new HCAR rules covering augmentative communication devices. The Disability Law Project (DLP) of Vermont Legal Aid and other advocates commented extensively on these regulations because they made substantive changes in coverage criteria for the devices. The HCA endorsed the DLP comments. As a result of the large number of public comments, DVHA rewrote the rule and held a new public comment period. The DLP and HCA agreed with the new version of the rule which was adopted by LCAR during the quarter.

- **Vermont Health Connect Escalation Path**

The HCA and VHC continued to collaborate on improving the State's escalation path for HCA cases involving complex VHC issues. We communicate with VHC multiple times a day and meet as needed to discuss the most difficult cases.

- **Comments on Vermont Health Connect Notices**

At VHC's request, the HCA commented on 7 notices, in an effort to make them more readable and consumer-friendly. See **Promoting Plain Language in Health Communications** below.

- **Medicaid and Exchange Advisory Board**

This quarter, the Chief Health Care Advocate remained actively involved in Vermont's Medicaid and Exchange Advisory Board (MEAB) and was appointed to co-chair the MEAB. The Chief attended 3 meetings of the MEAB during the quarter, chairing his first meeting in June.

- **Proposed Rule CMS-1677-P**

This quarter, the HCA and Vermont Legal Aid submitted comments on proposed rule CMS-1677-P, in particular on proposed regulations related to the Measure of Quality of Informed Consent Documents for Hospital-Performed Elective Procedures. We supported strong informed consent requirements, quality measurement related to informed consent, and shared decision-making.

Legislative Activities

This quarter included the end of the 2017 session of the Vermont Legislature, which was extended by a disagreement related to school employee health care issues. The HCA responded to a number of legislator requests for education about the complex relationships between premiums, out of pocket costs, and potentials for behavior change. The HCA also advocated for legislation that would benefit health care consumers and monitored the activity of legislative committees that took up issues related to health care. We worked on legislation to improve Accountable Care Organization transparency to the public as well as reporting on ACO activities to the Legislature. The HCA also responded to legislative requests for comment on a number of additional issues.

Our Chief Health Care Advocate testified twice before legislative committees this quarter, including the Senate Committee on Health and Welfare and the House Committee on Health Care.

Collaboration with Other Organizations

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

- American Cancer Society
- American Civil Liberties Union of Vermont
- Bi-State Primary Care Association
- Blue Cross Blue Shield of Vermont
- Central Vermont Medical Center
- Department of Financial Regulation
- MVP Health Care
- OneCare Vermont
- Planned Parenthood of Northern New England
- Southeastern Vermont Community Action
- South Royalton Legal Clinic
- University of Vermont Medical Center
- Vermont Association of Hospitals and Health Systems
- Vermont CARES
- VT Coalition of Clinics for the Uninsured
- Vermont Health Connect
- Vermont Medical Society
- Voices for Vermont's Children

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 225 pages of consumer-focused health information maintained by the HCA. We work diligently to keep the site updated in order to provide the latest and most accurate information to Vermont consumers.

Google Analytics Statistics

- The total number of health pageviews increased by 27% in the reporting quarter ending June 30, 2017 (10,406 pageviews), compared with the same quarter in 2016 (8,176 pageviews). This is noteworthy because the total number of pageviews for the entire Vermont Law Help website increased by only about 5%.
- The number of people who visited our ***Resource Limits - Medicaid*** page increased by 234% this quarter, with 367 pageviews compared with 110 during the same quarter in 2016.
- Views for our ***Services Covered by Medicaid*** page increased by 92% this quarter, with 248 pageviews compared to last year's 129.
- ***Medicaid Income Limits*** continues to be our most popular page, with 2,748 pageviews – up 1% over last year.
- The ***Health home page*** again had the second largest number of pageviews (1,151), up 29% over last year's 895. The home page tells consumers how we can help them and provides our contact information, including an online form that can be filled out and submitted 24/7.

- Five of the top 20 health pages with the largest number of pageviews focused on ***Long-Term Care Medicaid (Choices for Care)***. All of these pages saw increases when compared with the same quarter in 2016.
- The number of people viewing our ***Dental Services*** page decreased (21%) compared with the previous year. However, this page continues to be one of our most-viewed health pages. (434 pageviews this quarter, compared with 552 in the same period last year.)
- We saw a 63% increase in pageviews for our ***Medicare Savings / Buy-In Programs*** page (157 pageviews versus 96 last year).
- Our page on ***Prescription Assistance State Pharmacy Programs*** saw an increase in pageviews of 1033% - with 68 pageviews compared to 6 in the same period last year.
- There were spikes in interest in our pages on ***How the Public Can Participate in Insurance Rate Reviews*** (up from 0 last year to 60 pageviews this year); the ***Ladies First Health Program*** (up from 0 to 59 pageviews); ***Immigrants, Health Coverage and Penalties*** (up from 2 to 45 pageviews); and ***Medicaid Transportation*** (up from 16 to 81 pageviews).
- The top-12 health pages on our website this quarter with change over last year:
    - Income Limits – Medicaid – 2,748 pageviews (1% ↑)
    - Health section home page – 1,151 (29% ↑)
    - Vermont Choices for Care – 608 (167% ↑)
    - Dental Services – 434 (21% ↓)
    - Resource Limits – Medicaid – 367 (233% ↑)
    - Services Covered by Medicaid – 248 (92% ↑)
    - Health Insurance, Taxes and You – 230 (16% ↓)
    - Choices for Care Resource Limits – 221 (99% ↑)
    - Medical Marijuana Registry Patient Form – 204 (14% ↓)
    - Choices for Care Income Limits – 197 (86% ↑)
    - Medicare Savings / Buy-In Programs – 157 (63% ↑)
    - Federally Qualified Health Centers – 157 (7% ↑)

PDF Downloads

- 37 out of 119 or **31% of the unique PDFs downloaded** from the Vermont Law Help website were on health care topics. Of those unique health-related PDF titles:
- 26 were created for consumers. The top five consumer-focused PDF downloads were:
    - *Vermont Dental Clinics Chart* (108 downloads)
    - *Advance Directive, short form* (86 downloads)
    - *Advance Directive, long form* (45 downloads)
    - *Moving from Catamount/VHAP to Medicaid* (19 downloads)
    - *Vermont Medicaid Coverage Exception Request - 10 Standards and Provider Request Form* (18 downloads)
    - The advance directive forms were accessed more often this year as compared to the same period last year (131 downloads versus 76 last year).
- 5 were prepared for lawyers, advocates and assisters who help consumers with tax issues related to the Affordable Care Act. The top advocate-focused downloads were:
    - *PTC Rule Allocation Summary* (6 downloads)
    - *Low-Income Taxpayers and the Affordable Care Act – November 2014* (3 downloads)
    - *Getting MAGI Right presentation* (2 downloads)
- 6 covered topics related to health policy. The top policy-focused download was:
    - *Vermont ACO Shared Savings Program Quality Measures* (3 downloads)

Our *Vermont Dental Clinics Chart* is the **fifth most downloaded of all PDFs** downloaded from the Vermont Law Help website.

The *Advance Directive, short form* is the **sixth most downloaded of all PDFs** downloaded from the Vermont Law Help website.

B. Education/Outreach

The HCA increased its advertising this quarter in an effort to make more consumers aware of our services. It ran the following advertisements:

- Front Page Forum in Washington and Lamoille Counties, May 21 to May 28, 2017. (33,000 ads and 50 unique clicks)
- Seven Days, May 31, 2017. (print circulation of 36,000 copies)
- Facebook, June 20, 2017. (reached 5,200 people)

In addition to increased advertising of the HCA's services, we engaged in several in-person outreach and educational events during the quarter.

Bristol Health Activists (April 12, 2017)

The Chief Advocate gave a presentation to a group of activists on how consumers and advocates can engage in health policy issues. He also gave information about HCA services.

Rights and Democracy (April 20, 2017)

The HCA conducted outreach at a "Rights and Democracy" public event at Montpelier High School. Approximately 50 individuals attended.

Vermont Tax Practitioners Association (May 16, 2017)

The HCA distributed brochures and hotline cards at the annual tax season wrap-up meeting of the Vermont Tax Practitioners Association. Several tax preparers requested HCA materials to provide to their clients.

Here to Help Clinic (May 20, 2017)

The HCA attended this event targeted at helping homeless individuals access services, and distributed brochures and hotline cards.

Community in Action (May 25, 2017)

The HCA attended an outreach and community mobilization event hosted by Southeastern Vermont Community Action in Brattleboro. The HCA staffed a table and distributed brochures, hotline cards, and other materials to consumers and to other organizations in attendance. Approximately 20 nonprofit organizations and nearly 100 individuals attended.

Vermont Legal Services Staff College (June 2, 2017)

The HCA co-presented on a panel on immigrant legal issues, including health care issues and ACA complications for non-citizens. The presentation was a collaboration with the South Royalton Legal Clinic. Approximately 70 lawyers, paralegal advocates and other staff members who serve people across the state attended.

UVM Pediatric Community Resource Fair (June 23, 2017)

The HCA attended and handed out 94 HCA brochures and 56 hotline cards and answered questions about the HCA.

C. Promoting Plain Language in Health Communications

- During this quarter, the HCA provided feedback and revisions to promote the use of plain language and increase consumers' accessibility to and understanding of important communications from the state and other health organizations regulated by the state. The HCA made extensive plain language edits and edits/comments to improve comprehension of message and ability to resolve the problem being addressed in the following notices/letters:
    - EEE200-MNT QHP APTC Redetermination Notice
    - ADM600-MM Direct Enrollment Notice
    - EMP717
    - EMP 718
    - Medicare Equitable Relief notice
    - Macro Rewrites for Access Notices
    - Direct Enrollment Script

Office of the Health Care Advocate

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264 North Winooski Avenue
Burlington, Vermont 05401
800.917.7787

http://www.vtlegalaid.org/health

Attachment 6 - Investment Expenditures

CY 2017 Investment Expenditures

Department	Criteria	STC #	Final Receiver	Final Receiver Suffix	Investment Description	QE 0317	QE 0617	CY 2017 Total
AHSCO	4	41	99999	9091	Investments (STC-79) - 2-1-1 Grant (41)	113,250	113,250	**226,500**
AHSCO	2	54	99999	9090	Investments (STC-79) - Designated Agency Underinsured Services (54)	1,289,600	1,250,906	**2,540,506**
AOE		11	n/a	n/a	Non-state plan Related Education Fund Investments	-	-	-
DCF	2	1	99999	9403	Investments (STC-79) - Residential Care for Youth/Substitute Care (1)	2,302,666	3,750,502	**6,053,168**
DCF	2	2	99999	9412	Investments (STC-79) - Lund Home (2)	563,548	1,205,069	**1,768,617**
DCF	2	9	99999	9415	Investments (STC-79) - Challenges for Change: DCF (9)	64,031	15,000	**79,031**
DCF	2	26	99999	9416	Investments (STC-79) - Strengthening Families (26)	140,360	124,483	**264,843**
DCF	2	33	99999	9413	Investments (STC-79) - Prevent Child Abuse Vermont: Shaken Baby (33)	-	-	-
DCF	2	34	99999	9414	Investments (STC-79) - Prevent Child Abuse Vermont: Nurturing Parent (34)	28,742	27,605	**56,347**
DCF	2	35	99999	9418	Investments (STC-79) - Building Bright Futures (35)	215,963	153,681	**369,644**
DCF	2	55	99999	9402	Investments (STC-79) - Medical Services (55)	18,232	34,104	**52,336**
DCF	2	56	99999	9405	Investments (STC-79) - Aid to the Aged, Blind and Disabled CCL Level III (56)	-	198,036	**198,036**
DCF	2	57	99999	9406	Investments (STC-79) - Aid to the Aged, Blind and Disabled Res Care Level III (57)	-	-	-
DCF	2	58	99999	9407	Investments (STC-79) - Aid to the Aged, Blind and Disabled Res Care Level IV (58)	-	-	-
DCF	2	59	99999	9408	Investments (STC-79) - Essential Person Program (59)	247,955	245,989	**493,944**
DCF	2	60	99999	9409	Investments (STC-79) - GA Medical Expenses (60)	57,275	61,464	**118,739**
DCF	2	61	99999	9411	Investments (STC-79) - Therapeutic Child Care (61)	183,832	171,688	**355,520**
DCF	1	62	99999	9417	Investments (STC-79) - Lamoille Valley Community Justice Project (62)	54,000	54,000	**108,000**
DDAIL	2	27	99999	9604	Investments (STC-79) - Flexible Family/Respite Funding (27)	668,431	231,127	**899,558**
DDAIL	2	42	99999	9605	Investments (STC-79) - Quality Review of Home Health Agencies (42)	1,768	-	**1,768**
DDAIL	4	43	99999	9606	Investments (STC-79) - Support and Services at Home (SASH) (43)	320,709	337,902	**658,611**
DDAIL	2	63	99999	9602	Investments (STC-79) - Mobility Training/Other Svcs.-Elderly Visually Impaired (63)	-	141,010	**141,010**
DDAIL	2	64	99999	9603	Investments (STC-79) - DS Special Payments for Medical Services (64)	143,988	620,425	**764,413**
DDAIL	4	65	99999	9609	Investments (STC-79) - Seriously Functionally Impaired: DAIL (65)	16,943	22,350	**39,293**
DDAIL	4	77	99999	9607	Investments (STC-79) - HomeSharing (77)	162,018	-	**162,018**
DDAIL	4	78	99999	9608	Investments (STC-79) - Self-Neglect Initiative (78)	138,499	-	**138,499**
DMH	2	3	99999	9511	Investments (STC-79) - Institution for Mental Disease Servcies: DMH (3) - VPCH	5,771,260	4,901,581	**10,672,841**
DMH	2	3	99999	9512	Investments (STC-79) - Institution for Mental Disease Servcies: DMH (3) - BR	613,029	1,935,511	**2,548,540**
DMH	2	12	99999	9506	Investments (STC-79) - Mental Health Children's Community Services (12)	1,097,702	1,110,338	**2,208,040**
DMH	2	13	99999	9516	Investments (STC-79) - Acute Psychiatric Inpatient Services (13)	501,066	1,009,161	**1,510,227**
DMH	4	16	99999	9505	Investments (STC-79) - Mental Health CRT Community Support Services (16)	(2,462,689)	72,606	**(2,390,083)**
DMH	2	22	99999	9510	Investments (STC-79) - Emergency Support Fund (22)	253,299	168,692	**421,991**
DMH	2	28	99999	9501	Investments (STC-79) - Special Payments for Treatment Plan Services (28)	30,423	37,281	**67,704**
DMH	2	29	99999	9507	Investments (STC-79) - Emergency Mental Health for Children and Adults (29)	6,052,211	421,086	**6,473,297**
DMH	2	66	99999	9502	Investments (STC-79) - MH Outpatient Services for Adults (66)	758,456	487,738	**1,246,194**
DMH	2	67	99999	9508	Investments (STC-79) - Respite Services for Youth with SED and their Families (67	302,241	201,030	**503,271**
DMH	2	68	99999	9514	Investments (STC-79) - Seriously Functionally Impaired: DMH (68)	77,578	(57,791)	**19,787**
DMH	2	79	99999	9504	Investments (STC-79) - Mental Health Consumer Support Programs (79)	141,257	111,938	**253,195**
DOC	2	4	n/a	n/a	Return House	108,512	130,579	**239,091**
DOC	2	5	n/a	n/a	Northern Lights	97,223	96,231	**193,454**
DOC	2	6	n/a	n/a	Pathways to Housing	-	-	-
DOC		14	n/a	n/a	St. Albans and United Counseling Service Transitional Housing (Challenges for Cha	458,426	386,589	**845,015**
DOC	4	15	n/a	n/a	Northeast Kingdom Community Action	46,405	48,975	**95,380**
DOC	2	69	n/a	n/a	Intensive Substance Abuse Program (ISAP)	-	-	-
DOC	2	70	n/a	n/a	Intensive Domestic Violence Program	-	-	-
DOC	2	71	n/a	n/a	Community Rehabilitative Care	-	1,365,476	**1,365,476**
DOC	2	80	n/a	n/a	Intensive Sexual Abuse Program	2,130	2,835	**4,965**
DVHA	1	7	99999	9107	Investments (STC-79) - Institution for Mental Disease Services: DVHA (7)	1,763,069	2,251,854	**4,014,923**
DVHA	4	8	99999	9101	Investments (STC-79) - Vermont Information Technology Leaders/HIT/HIE/HCR (8)	968,032	1,758,683	**2,726,715**
DVHA	1	18	99999	9106	Investments (STC-79) - Patient Safety Net Services (18)	206,199	171,891	**378,090**
DVHA	4	51	99999	9102	Investments (STC-79) - Vermont Blueprint for Health (51)	507,608	971,586	**1,479,194**
DVHA	1	52	99999	9103	Investments (STC-79) - Buy-In (52)	5,762	10,720	**16,482**
DVHA	1	53	99999	9104	Investments (STC-79) - HIV Drug Coverage (53)	1,422	1,607	**3,029**
DVHA	1	72	99999	9108	Investments (STC-79) - Family Supports (72)	-	-	-
GMCB	4	45	n/a	n/a	Green Mountain Care Board	609,467	796,535	**1,406,002**
UVM	4	10	n/a	n/a	Vermont Physician Training	1,011,555	1,011,552	**2,023,107**
VAAFM	3	36	n/a	n/a	Agriculture Public Health Initiatives	5,335	46,167	**51,502**
VDH	3	17	99999	9220	Investments (STC-79) - Recovery Centers (17)	430,500	380,500	**811,000**
VDH	2	19	99999	9201	Investments (STC-79) - Emergency Medical Services (19)	157,292	127,062	**284,354**
VDH	3	21	99999	9214	Investments (STC-79) - Area Health Education Centers (AHEC) (21)	266,000	-	**266,000**
VDH	4	23	99999	9223	Investments (STC-79) - Public Inebriate Services, C for C (23)	594,748	353,986	**948,734**
VDH	4	24	99999	9225	Investments (STC-79) - Medicaid Vaccines (24)	-	-	-
VDH	3	25	99999	9210	Investments (STC-79) - Physician/Dentist Loan Repayment Program (25)	432,000	68,111	**500,111**

Department	Criteria	STC #	Final Receiver	Final Receiver Suffix	Investment Description	QE 0317	QE 0617	CY 2017 Total
VDH	3	30	99999	9219	Investments (STC-79) - Substance Use Disorder Treatment (30)	1,918,079	1,408,748	**3,326,827**
VDH	2	31	99999	9206	Investments (STC-79) - Health Laboratory (31)	854,053	743,581	**1,597,634**
VDH	2	37	99999	9213	Investments (STC-79) - WIC Coverage (37)	478,297	409,352	**887,649**
VDH	4	38	99999	9224	Investments (STC-79) - Fluoride Treatment (38)	21,715	14,661	**36,376**
VDH	2	39	99999	9205	Investments (STC-79) - Health Research and Statistics (39)	341,202	317,081	**658,283**
VDH	2	40	99999	9204	Investments (STC-79) - Epidemiology (40)	214,776	198,470	**413,246**
VDH	4	44	99999	9228	Investments (STC-79) - VT Blueprint for Health (44)	372,571	176,411	**548,982**
VDH	4	46	99999	9221	Investments (STC-79) - Enhanced Immunization (46)	47,498	80,762	**128,260**
VDH	3	47	99999	9217	Investments (STC-79) - Patient Safety - Adverse Events (47)	1,221	20,893	**22,114**
VDH	4	48	99999	9222	Investments (STC-79) - Poison Control (48)	26,873	80,618	**107,491**
VDH	4	49	99999	9226	Investments (STC-79) - Healthy Homes and Lead Poisoning Prevention Program (4	68,973	70,509	**139,482**
VDH	4	50	99999	9207	Investments (STC-79) - Tobacco Cessation: Community Coalitions (50)	-	-	**-**
VDH	2	73	99999	9211	Investments (STC-79) - Renal Disease (73)	-	6,750	**6,750**
VDH	2	74	99999	9203	Investments (STC-79) - TB Medical Services (74)	40,705	40,557	**81,262**
VDH	2	75	99999	9209	Investments (STC-79) - Family Planning (75)	378,879	378,576	**757,455**
VDH	2	76	99999	9208	Investments (STC-79) - Statewide Tobacco Cessation (76)	158,405	99,102	**257,507**
VSC	2	32	n/a	n/a	Health Professional Training	204,730	-	**204,730**
VVH	2	20	n/a	n/a	Vermont Veterans Home	110,986	-	**110,986**
						32,778,291	**33,184,769**	**65,963,060**

Companion Aide Pilot Summary

June 2017

Summary

In March 2015, Vermont implemented a Companion Aide Pilot Project to provide assistance to nursing facilities in advancing culture change with a focus on person-centered dementia care through July 1, 2017. The intent of the pilot was to provide an enhanced Medicaid rate to five interested and eligible facilities that were committed to person-centered dementia care through dedicated "Companion Aide" staff. The Companion Aide is a trained licensed nursing assistant (LNA) who champions person-centered dementia care with the goal of improving the lives of people with dementia, as evidenced by positive changes such as a reduction of the use of psychotropic drugs, incidence of resident to resident altercations, and improved staff satisfaction. Standards for choosing pilot facilities and payment methodology can be found in section 17.1 of the Methods, Standards and Principles for Establishing Medicaid Payment Rates for Long-Term Care Facilities.

Five pilot facilities were chosen and four participated in the pilot: Derby Green, Helen Porter, Mayo, and Mountain View Each facility submitted quarterly progress reports and annual data reports. One facility was unable to adequately staff the project and decided to withdraw from the pilot.

Data included:

- # of resident to resident incidents
- # of residents with a positive response for use of antipsychotic medications
- # of involuntary discharges
- LNA turnover rate
- # of Companion Aide staff & hours worked
- List of specialized training provided for Companion Aide staff
- Resident and employee satisfaction survey results
- Artifacts of Culture Change: Care Practice
- Artifacts of Culture Change: Family & Community

The following targets were established before the start of the pilot:

Target #1: Reduction in resident to resident incidences by ten percent in the first year; additional 25 percent in second year for a total of 35 percent by end of year two.
Target #2: Reduction in antipsychotic use to at least five percent below the state average by the end of the pilot.
Target #3: Ten percent reduction in LNA turnover each year.
Target #4: Reduce involuntary discharges based on behavioral issues to zero by the end of the pilot.
Target #5: Maintain or improve overall satisfaction of residents and employees by the end of the pilot.
Target #6: Increase Care Practice Artifact score by the end of the pilot.
Target #7: Increase Family & Community Artifact score by the end of the pilot.

Accomplishments

Companion Aide staff consistently reported a sense of satisfaction with regards to improving the lives of people living with dementia. Though the data collected was small and directly related to the small number of participating facilities, some positive changes were reported in five of the seven target areas.

Baseline to November 2016:

1. 35% average reduction in use of anti-psychotics
2. 25% average reduction in involuntary discharges
3. Maintained high levels of resident satisfaction
4. 16% average increase in Care Artifacts Score
5. 13% average increase in Family & Community Artifacts Score

November 2015 to November 2016:

1. 12% decrease in resident to resident incidents

In addition to some positive changes in data reported, many individual "successes" and positive outcomes were reported by Companion Aide staff in the following "Success Stories".

Success Story #1: One facility was able to accept a female resident from our local hospital. She had a diagnosis of dementia with both anxiety and behaviors. She had been transferred to the hospital from her a residential care home due to overall decline including her cognitive status/behaviors. The residential care home was unable to accept her back. Both in the home and hospital, this resident had behaviors ranging from refusals of care to verbal/physical altercations. At the time of transfer, the hospital was unwilling to let the family transport in private car due to her behaviors as it was felt it was unsafe. As a result, she had to be transferred by ambulance. Since admission, the Companion Aide has been working with this resident. At first, just to build a relationship then she took over her care. As of this time, her physical and verbal behaviors have almost completely resolved. Her psychotropic medications have been decreased twice, she is accepting more care, and her family has been able to take her out of the facility without incident.

Success Story #2: A Companion Aide started a reading program for two residents with end stage dementia. Both of these residents were non-verbal except for a rare word a few times a month. Since she has been reading to these residents, both are more alert and talking almost daily. As a result of the Companion Aide reading to the above two residents, another resident has started reading herself. Her primary care physician stated she could not believe the change in her.

Success Story #3: One Companion Aide has been completing life stories and starting the Music and Memory program with residents. When meeting with one family along with the resident, the family expressed how elated they were with their loved one's response to the music.

Success Story #4: One facility noticed a decrease in all resident-resident incidents in their "Memory Care Neighborhood" for the time period since they started using companion aides. They have also experienced great family satisfaction with the individualized attention for residents involved.

Success Story #5: One facility described the entire atmosphere on their Dementia Care Unit as "quite remarkable". This facility said: "It's difficult to pin point exactly what it is other than the added attention and support provided by the companion aides. Being a secured unit the companion aides provide the ability to assist residents off the unit more frequently to other activities, walks, visits etc. The 1:1 attention continues to enrich the lives of those living on the Dementia Care unit as well as throughout the Center. Each neighborhood will frequently call and request a companion aid throughout the day for residents around the building with dementia who would benefit from some extra support."

Success Story #6: One facility reported that they have a long-term resident who often presents with challenging behaviors. With the support of the Companion Aides, this resident has had a decrease in her antidepressant medication and her behaviors have also decreased despite the reduction in medication. This person is described as "remarkably more pleasant and engaging with others". Though she has a history of only liking to sit in the recliner by the nurse's cart, she has recently participated in activities and stayed at the dining room table for lunch positively interacting with the other resident's. Prior to the companion aid project and med changes, this person was agitated every day primarily in the late afternoon and evening. Each day there would be a nurse's note in regard to her behaviors. Now the nurse's notes reflect a decrease in behaviors with the occasional agitation. Social Services, her primary care physician and nursing recently met with family. Family commented on how much of a change they've seen in their mother and how happy they are to see their mom doing so well.

Success Story #7: One gentleman has a history of increased anxiety and weeping. Since the Companion Aide program started, the facility has reported that his anxiety has decreased a great deal and he has begun to enjoy activities such as checkers.

Success Story #8: One Companion Aide employee has started to experience "buy-in" from her LNA peers who are now witnessing the positive changes in residents. Family, visitors and other residents have commented on the positive changes as well. She did this by providing the Centers for Medicare and Medicaid Services (CMS) "Hand in Hand" training to staff, updating care plans to add "What works well for…" instead of "What does not work well for….", providing education to staff around using labels with residents and participating in all care plan meetings.

Challenges

Though the successes clearly outnumbered the challenges, the pilot identified some concerns.

Baseline to 2016:

1. 59% average increase in resident to resident incidents reported
2. LNA turnover increased an average of 18 percentage points
3. Lack of consistent employee satisfaction survey implementation

Though the average number of resident to resident incidents increased overall, the number reported and overall sample size were relatively low making any increase result in a large percentage change. It is also important to note that the increase in incidents occurred during

the first half of the first pilot year, **while the second year (2015 to 2016) showed a 12% decrease in incidents**.

Facilities reported that staffing continues to be one of the top challenges in the delivery of consistent care practices for people with dementia. Not only is high LNA turnover a challenge in training new staff, the inconsistencies between shifts can be a challenge. Staff reported how important it is to maintain a consistent and personal family-like relationship with a person with dementia, as it helps prevent behavioral changes related to memory-related fear and anxiety.

Unfortunately, facilities had not established a consistent employee survey amongst all four facilities. Therefore, this measure could not be used in the pilot.

Finally, Companion Aide staff reported difficulty championing "culture change" throughout their facilities. In some cases, Companion Aide staff did not feel supported or felt isolated in their role, making it hard to effectively teach and support culture change to their non-companion aide peers and facility management. Staff also expressed a desire to have more support from the State in advancing their role as Companion Aide staff.

Continued Funding

As reflected in section 17.1 of the regulations, the rate adjustment for the Companion Aide Pilot ends July 1, 2017. At that time, nursing care costs will be rebased to 2015 and the costs of the Companion Aides will then be captured in the facility's base year costs. For facilities with years ending earlier than December 31, the Division of Rate Setting will annualize the cost of the Companion Aides so that a full year of these costs will be included in the selected facilities' 2015 base year cost. The Companion Aide costs at the selected facilities will be exempt from the cap on nursing costs in the July 1, 2017 rebase. In rebases after that time, the extant cap on Nursing Care Costs will apply.

Continued Practices

The Department of Disabilities, Aging and Independent Living (DAIL) is committed to the continued support of culture change and quality dementia care for Vermonters who chose to receive their care in a nursing facility. Therefore, DAIL will continue work with facilities to implement the best practices discovered during the Companion Aide pilot and to continue to focus on person-centered dementia care beyond July 1, 2017. These best practices will be used as a resource for other facilities who are interested in furthering culture change using Companion Aide staff. Recommendations will be posted online and made available to all facilities.