Vermont Agency of Human Services

Transition Book

Table of Contents

Executive Summary

About the Agency of Human Services

The Agency of Human Services was created by the Vermont Legislature in 1969 to serve as the umbrella organization for all human service activities within state government. The Secretary's Office strategically leads the Agency and its departments in establishing and implementing Agency-wide and government-wide policies and practices.

The scope of AHS is expansive. As a single entity, AHS builds a continuum of care that protects and supports vulnerable Vermonters; addresses individual, family and regional crises as they arise; develops and promotes whole population approaches to physical and behavioral health; works to build economic self-sufficiency; and keeps communities safe.

AHS delivers human service programs within the state through six departments, twelve district offices, and a network of community partners and providers. Each department has a distinct area of focus and responsibility that contributes to the creation and sustenance of an entire system of human service supports. DMH, DAIL, and DVHA operate almost exclusively within a community partner framework, relying on private entities for service delivery to their constituent populations. Conversely, DCF, VDH, and DOC are primarily responsible for the delivery of their services, although they may intersect at times with the private provider system.

The Secretary of the Agency of Human Services serves in a broad position with multiple dimensions. The Secretary works directly with the Deputy Secretary and with Agency Commissioners towards solving policy and implementation challenges across portfolios. She/he also facilitates the coordination of policy initiatives across the public sector, including cross-Agency and State issues, and promotes leadership and information exchange across the Executive Branch.

The Secretary provides high quality policy advice to the Administration and ensures the delivery of outcomes that contribute to the achievement of Administration priorities. As such, the Secretary is accountable for the delivery of publicly-funded services, for adapting programs and activities in accordance with the direction of the Administration, and ensuring the Agency responds to the ways in which the Administration seeks to develop and implement its policies and programs.

The Deputy Secretary supports Agency and Administration priorities, helps promote cross-agency coordination, and works closely with Deputy Commissioners and departmental leadership on issues related to the execution of Agency programs and the Agency Strategic Plan. The Deputy Secretary fulfills the duties and responsibilities of the Secretary in the Secretary's absence.

Department	Employees	Budget (in millions)	Vermonters Served
Disabilities, Aging and Independent Living (DAIL)	286	$ 453	89,574
Children and Families (DCF)	1,078	$ 389	185,000
Corrections (DOC)	1,055	$ 157	1,755
Health (VDH)	530	$153	626,562
Health Access (DVHA)	208	$1,200	230,602
Mental Health (DMH)	267	$ 217	34,074

The AHS mission is "to improve the health and well-being of Vermonters today and tomorrow, and to protect those among us who are unable to protect themselves.

I. Major and Evolving Issues

Below is a non-exhaustive list of major, legislative and evolving issues to be aware of. These issues are also discussed at length throughout this memo and we would be happy to provide briefings on any of the topics.

Budget

All-Payer Waiver

Vermont is currently negotiating an All Payer Waiver with CMS. The Department of Vermont Health Access has been the lead in negotiating the contract with the ACO and will provide more information.

Reliance on Federal Funds – Medicaid

Over the past decade, AHS has been very successful in obtaining waivers allowing Medicaid reimbursement of previously non-covered services. Title XIX (Medicaid) funds now cover 68% of AHS expenditures (excluding Department of Corrections, which is almost exclusively general funds – including DOC, Medicaid covers 64% of expenditures). The downside to this success in maximizing federal revenue is there are very few AHS programs that rely solely on State funds. Any reduction to Medicaid programs generates only a fractional portion of state savings and in most instances invokes federal rules and restrictions regarding reductions. Current waiver renewal negotiations underway, with a January 1, 2017 start date, include major changes to the current Global Commitment Waiver. These changes have significant financial implications over the next 5 years and beyond. Changes include impacts on MCO investments, administrative claiming and budget neutrality.

Reliance on Federal Funds – Non-Medicaid

Even AHS programs outside of Medicaid may have significant federal matching participation, and hence become less attractive for reduction. Setting aside Medicaid, 42% of AHS expenditures are supported by federal funds (51 % federal funds if remove Corrections). Much of the remaining non-Corrections general funds are tied as mandatory matching for federal funds and/or maintenance of effort (MOE) with federal funds.

Capital Funding Needs

Over the next five years, AHS has several priority projects that will require capital appropriations to support. These include:

1) Health & Human Services Enterprise
   a) Vermont Health Connect (VHC)
   b) Integrated Eligibility (IE)
   c) Medicaid Management Information System (MMIS)
   d) Health Information Technology/Exchange (HIT/HIE)
2) Replacement of the Middlesex Community Therapeutic Residence
3) Additional Vermont Psychiatric Care Hospital (VPCH)-like facility
4) Additional Correctional Facility

5) Replacement of the Woodside Youth Residence
6) Additional AHS Office Space in Waterbury and district offices
7) Implementing safety and security across the state as well as fulfilling the obligations set forth in Act 109.

Tobacco Fund Revenue Decline

The Agency of Human Services relies on $31 million of funding from the Tobacco Fund. These funds are used to support the Medicaid program and tobacco cessation programs at VDH. The fund receives revenue through the Master Settlement Agreement (MSA) which settled claims between states and the tobacco industry. As part of the MSA, the Strategic Contribution Fund (SCF) allowed for 10 years of extra payments to recognize states for their tobacco control efforts. For Vermont, these payments have been approximately $12 million annually. **Vermont will receive its final SCF payment in 2017 and thereby, create a significant funding shortfall in developing the FY18 budget.**

State Innovation Model Sustainability

Vermont received a 4-year, $45-million federal State Innovation Model (SIM) grant that is set to expire on November 30, 2017. This SIM grant funded important innovations in health care delivery, health information technology and payment models. Though the grant is ending, the important work related to SIM must continue. The FY18 budget includes proposals to allow for health care delivery reform to continue.

Department of Labor Rule

In May 2016, the federal Department of Labor finalized the rule updating overtime regulations, which extends overtime pay protections for full-time salaried executive, administrative and professional employees. This will have a financial impact on the Designate Agency (DA) system. The DAs have indicated it could cost them an additional $5 million to implement. AHS is in the process of reviewing the DA analysis.

Integrating Family Services

A priority of the Agency of Human Services is to create an Agency of One; a system in which Vermonters who need services can receive them with a complete and coordinated plan that works for the entire family. Integrating Family Services (IFS) is how we describe the set of strategies being employed to achieve this goal. Working alongside ***Medicaid Pathways***, IFS is focused on promoting and sustaining collaborative leadership and decision making, among other areas of focus.

Resources to Support Central Medicaid Operations

The AHS Central Office is the Vermont Medicaid "Single State Agency" and has responsibility for integrated planning, policy development, regulatory compliance and funding in Medicaid. These responsibilities require cross-departmental (and intra-governmental) operations for successful implementation and outcomes. Staffing at the Central Office is currently augmented by multiple short-term contracts and positions through VHCIP. AHS expects multiple continuing and new needs for staff and contractor resources over the next biennium due to pressures of compliance with new Waiver expectations and sustaining health reform initiatives of the Agency.

Department of Disabilities, Aging & Independent Living

DAIL's primary role in Vermont is to fulfill the commitment that we have made to individuals with disabilities and to seniors, enabling them receive supports and services in their homes and in their communities, living independently and fully included as participating and contributing members of those communities. This commitment is underlined by state and federal mandates like the Olmstead Decision, which require states to provide services to people in the least restrictive environments possible. Vermont remains a leader in the nation in terms of our work in closing institutions, supporting choice and community-based settings, and the development of robust supported employment and mature worker options for all.

DAIL's work across all five divisions is most directly related to the seventh outcome in Act 186: Vermont's elders and

people with disabilities and people with mental conditions live with dignity and independence in settings they prefer. At a population level, this outcome embodies the concept of choice, a cornerstone for our role in state government and across Vermont. Along with a robust provider system, DAIL strives to ensure that individuals not only choose the settings in which they live but choose how they live their lives, focusing on independence, inclusion in their own communities and contributions to the Vermont community. For this outcome, we measure where people live, employment rates and rates of abuse and neglect.

Major issues include:

- Long term services and support workforce crisis that must be addressed to fulfill commitment to caring for those in need.
- Vermont's aging population: changing the cultural narrative that consistently paints this population as frail, needy and a drain on resources vs. celebrating the opportunities to age well.
- Rising rates of disability among the population based on early diagnosis particularly in relation to increasing rates of diagnoses on the Autism spectrum
- Rising rates of diagnosis of Alzheimer's and dementia and the significant economic impact of the costs of care, loss of pay for caregivers and the devastating impact on families
- Medicaid budget pressures: consistently increasing caseload based on aging and disability and care needs

Department for Children & Families

DCF's mission is to foster the healthy development, safety, well-being, and self-sufficiency of Vermonters. We envision Vermont as a place where people prosper; children and families are safe and have strong, loving connections; and individuals have the opportunity to fully develop their potential.

DCF is comprised of three support units: Commissioner's Office, Business Office and Information Technology and six programmatic Divisions:

- Child Development Division
- Economic Services Division
- Family Services Division
- Office of Child Support
- Office of Disability Determination Services
- Office of Economic Opportunity

Major and evolving Issues:

- Caseload Pressures. Since 2008, there has been a 100% increase in the number of accepted reports. In 2015, over 5600 reports were assigned for a child safety intervention (investigations or assessments). Custody numbers have also risen. Since 2011, there has been a 43% increase in the number of children and youth in custody, with current number totaling approximately 1,400. These increases are due in large part to the state's current opioid/substance abuse crisis.
- Safety and Security. DCF has been addressing the safety and security needs of its employees and clients on many different levels: policy and practice, building security and emergency planning and preparedness. During the last year, the Family Services Division (FSD) has created a Staff Safety Coordinator position to provide multi-level consultation and support to division staff before, during, and after critical incidents. In collaboration with the UVM Child Welfare Training Partnership, FSD has provided staff safety training specific to social work practice to every district office.
- Child Care Financial Assistance Program. Despite a $1 million-dollar increase in FY 17, child care subsidies continue to be a critical need for Vermont families which impacts their ability to enter the workforce.
- Child Care Licensing. In 2012, CDD embarked on a major revision of all child care licensing regulations which has recently been completed. New updated regulations took effect in September of 2016. Some providers have found it challenging to meet the new regulations.
- Early Learning Challenge Grant. The Child Development Division (CDD) is one of four key partners in Vermont's

$39.7 million Early Learning Challenge grant. CDD manages the grant and division staff are responsible for 12 of the 24 projects funded under the initiative. The purpose of the grant is to improve and expand high quality early childhood services for high needs children and has allowed CDD to improve, expand and evaluate it programs and services.

- 3SquaresVT. Also known as Supplemental Nutrition Assistance Program (SNAP), is a federal USDA Food and Nutrition Services (FNS) program administered by EDS that provides healthy food to needy households. Challenges within this program include compliance with federal regulations of an extremely complex federal entitlement program with ever-changing policies.
- General Assistance (GA). Since 2015, due to increased use and expense of GA emergency housing, the DCF housing team has worked to foster community-based alternatives to the GA motel program. Results of the first year are encouraging; spending came in on-budget, and we are making strides towards a better service model that includes buy-in from community partners and critical supports for clients.
- Reach Up. While the Reach Up caseload has dropped, the families remaining face significant barriers to employment including mental and physical health issues, substance use, legal issues, homelessness, lack of childcare, and lack of transportation.

Department of Corrections

The mission of the Department of Corrections (DOC) is to support community safety by ensuring offenders serve their sentence, take responsibility for their crimes and have the opportunity to make amends to their victims. The department partners with Vermont communities to manage offender risk and assure accountability. It provides disciplined preparation of offenders to become productive citizens.

DOC operates an integrated system of incarceration and field supervision services to meet the sanctioned requirements placed on offenders. The DOC operates 7 correctional facilities and 11 field supervision offices. On a daily basis, the DOC directly serves approximately 10,000 people. It also provides indirect services to law enforcement organizations, victims, and the public. Page | 60

The delivery of Correctional services is a blend of local actions and department-wide guidelines and direction. Unlike many States, Vermont operates as a unified department to manage offenders throughout their terms of custody, across incarceration and field supervision. Even while incarcerated, a sentenced inmate has both an onsite caseworker and an assigned field officer to coordinate the planning of the individual's case.

Major and Evolving Issues:

- Position turnover and training. Correctional Officers are required to attend the Correctional Academy and to shadow staff at correctional facilities, at a cost of 8 paid weeks, and a significant training cost. Position turnover remains a challenge, and the inability to retain staff has tremendous costs, both in the vacancies and the overtime resulting from this, as well as the recruitment and training of new staff.
- Increasing population. The sentenced inmate population had been steadily declining for the past couple years, but has more recently seen an uptick, particularly with the detention numbers. As the population rises, this places stress upon the facilities which become increasingly crowded. It also adds pressure to the budget, as the Department may need to transport more inmates to the OOS facility, which has not been factored into the OOS appropriation.
- Facility Planning. The Department was tasked with assembling a committee and providing a report with recommendations to the House and Senate Institutions Committees. VT DOC is challenged both operationally and fiscally by having several small facilities (by corrections standards). The Department is not able to benefit from economy of scale; for example, larger facilities would not need to utilize space for several medical areas, and the staff required to maintain the basic needs of inmates. In comparison, multiple smaller facilities require multiple medical areas and staff at each site, effectively creating higher costs for the same services.
- Out of State (OOS). Currently there are 251 inmates housed in an OOS facility located in Michigan. DOC contracts for these services. The per capita cost, while less costly than an in-state bed, results in higher costs

overall to the Department. The in-state facilities have relatively fixed costs with regard to staff and operational expenses, but the lack of capacity for the incarcerated population necessitates additional space to house sentenced inmates.

- Aging Population. Planning for the appropriate setting to address the needs of **inmates who are aging,** have mental health and/or substance abuse needs, and people with disabilities. The Department has engaged in conversation with AHS sister departments, advocates and other stakeholders in an effort to find a solution to the challenges of incarcerating this population. A report is due to the Legislature in February 2017 that will outline the scope of the problem and deliver recommendations.

Department of Mental Health

It is the mission of the Vermont Department of Mental Health to promote and improve the mental health of Vermonters. Mental health will be a cornerstone of health in Vermont. People will live in caring communities with compassion for and a determination to respond effectively and respectfully to, the mental health needs of all citizens. Vermonters will have access to effective prevention, early intervention and mental health treatment and supports as needed to live, work, learn and participate fully in their communities As restored by Act 15 in 2007 and updated by Act 79 in 2012, the Department of Mental Health (DMH) has a broader legislative mandate than it had when it was the Department of Developmental and Mental Health Services. As Vermont's Mental Health Authority, DMH's responsibilities include:

- Maintain and improve a system of care for children and youth experiencing a severe emotional disturbance and their families and for adults with severe mental illness
- Centralize and more efficiently establish the general policy and execute the programs and services of the state concerning mental health, and integrate and coordinate those programs and services with the programs and services of other departments of the state, its political subdivisions, and private agencies, so as to provide a flexible comprehensive service to all citizens of the state in mental health and related problems
- Offer a continuum of community and peer services, as well as a range of acute inpatient beds throughout the state
- Operate the Vermont Psychiatric Care Hospital (VPCH) and the Middlesex Therapeutic Community Residence
- Coordinate services for mental health, physical health, and substance abuse across both public and private health-care delivery systems in Vermont
- Provide leadership and direction for the public mental-health system
- Conduct program and service monitoring and assessment to:
    - assure adherence to state and federal regulations
    - manage the quality of mental-health services and supports delivered by the state's designated agencies (DAs), also known as community mental health centers, and the single Specialized Service Agency (SSA) for children and adolescents and their families.

Major and Evolving Issues:

- Budget Pressures. One-time to designated agency Medicaid rate, overtime rule change, loss of HUD funding, etc.
- Development of a Secure Residential Program. DMH currently operates a 7-bed secure residential program in Middlesex (Middlesex Therapeutic Community Residence – MTCR) that was developed following Tropical Storm Irene. A long-term permanent structure is needed.
- Level I (VSH replacement) Inpatient Bed Capacity. At this time, demand for inpatient access still exceeds current capacity with some frequency, as evidenced by the number of people in emergency rooms waiting for placement in an inpatient bed. This is disruptive to the emergency care setting and not a standard that the Department regards as adequate for individuals requiring inpatient care.
- Suicide Prevention. Vermont has the seventh-highest rate of deaths by suicide in the country and by far the highest in New England. DMH leads an AHS-wide workgroup with representation from every department in the agency to work on reducing that. Additionally, we work closely with non-state organizations interested in suicide prevention. This includes the Center for Health and Learning, Vermont Suicide Prevention Center (VTSPC), Veterans Administration, local schools and universities as well as providers such as the designated agencies.

- Vermont Psychiatric Care Hospital. The operations of VPCH carry all the intrinsic risks of any hospital setting. These expectations are complicated by its existing composition of civil and forensic admissions within the regulatory environment and a legal system whose timeline does not follow an acute care and treatment timeline for disposition. Staffing issues persist.

Department of Vermont Health Access

DVHA's responsibilities and prominence within the state's priorities and budget have increased substantially since it was first created as a separate 'Office' in the AHS reorganization of 2004.

The Vermont Medicaid program is the largest health insurer in Vermont, providing comprehensive coverage for over 190,000 citizens; commercial insurance premium assistance for over 17,000 Vermonters; and pharmacy only benefits assistance for over 11,000 Vermonters.

With the Centers for Medicare and Medicaid (CMS) approval of Vermont's Global Commitment to Health (GC) 1115 demonstration waiver in 2005 (and subsequent renewals), OVHA also became a statewide Public Managed Care Entity, with oversight responsibility for all statewide Medicaid programs and expenditures. In this role, DVHA also must comply with federal regulations related to Managed Care Organizations.

As of December 2008, OVHA added the organizational responsibilities of coordinating Vermont's comprehensive health care reform efforts, statewide health information technology (HIT) planning and oversight, and implementation of federal health care reforms.

As of July 2010, in recognition of the expanded scope of its mission and focus, the Office became the Department of Vermont Health Access. DVHA also became the home of the Blueprint for Heath, a program for integrating a system of health care for patients for improving health outcomes and controlling health care costs.

As of July 2016 the Health Access Eligibility and Enrollment Unit (HAEEU) and Long Term Care (LTC) Unit have merged with DVHA adding approximately 160 positions to DVHA, bringing the position total to 386 positions.

With a budget of over $1.2 billion, DVHA ranks first in the State of Vermont's programmatic expenditures. The following five highest programmatic expenditures account for more than 50% of the annual expenditures:

1. Pharmacy (gross; after rebates, it is 5th highest expenditure)
2. Hospital Inpatient
3. Hospital Outpatient
4. Physician Services
5. Nursing Homes

Major and Ongoing Issues:

- Medicaid Pathways. The Vermont Medicaid Pathway (VMP) advances payment and delivery system reform for services not included in the initial implementation of Vermont's All Payer Model. The ultimate goal of this multi-year planning effort is the alignment of payment and delivery system principles through both the All Payer Model and VMP to support a more integrated system of care, including integrated physical health, long-term services and support, mental health, substance abuse treatment, developmental disability services, and children's service providers.
- Vermont Health Connect Reconciliation. VHC solidified its reconciliation team structure in the VHC Enrollment unit to address the reconciliation inventory on a monthly basis. 2016 also saw the remediation of multiple defects affecting integration and causing system discrepancies, as well as the implementation of additional tools to review and fix discrepancies.
- Blueprint for Health. Successfully implemented the program statewide. Analytic capability links claims and

clinical data for all payers. Independent evaluations by CMS and peer reviewed publications show the program has reduced the growth in health care costs.

Vermont Department of Health

Public health is the system that works to protect and promote the health of all citizens. It is the science and art of preventing disease, prolonging healthy life and promoting physical and mental health.

On June 18, 2014, the Public Health Accreditation Board (PHAB) conferred accreditation to the Vermont Dept. of Health. PHAB standards and measures provide a means for the Department to continually assess its effectiveness in delivering the 10 essential public health services. Performance management is a core element in Departmental operations.

Mission: Protect and promote optimal health for all Vermonters
Vision: Healthy Vermonters living in healthy communities
Health Dept. Strategic Plan sets the strategic direction and priorities, based on Healthy Vermonters 2020 data, to guide the Health Department's work, quality and system improvements.
Six major goals:

1. Effective and integrated public health programs
2. Communities with the capacity to respond to public health needs
3. Internal systems that provide consistent and responsive support
4. A competent and valued workforce that is supported in promoting and protecting the public's health
5. A public health system that is understood and valued by Vermonters
6. Health equity for all Vermonters

Major and Ongoing Issues:

- Integrate Substance Abuse Treatment into the Larger Health Care System. Primary focus for the past two years has been: public education and social marketing campaigns, prevention and community action, Screening, Brief Intervention and Referral to Treatment (SBIRT) Initiative with primary care and hospital providers; increased access to treatment (Hub & Spoke Initiative), recovery supports, distribution of naloxone rescue kits to reverse opioid overdoses, and the Vermont Prescription Monitoring System (VPMS).
- Eliminating health disparities and creating health equity. Vermont is consistently ranked as one of the healthiest states in the nation, however, health is not equally shared among all. Too many Vermonters, especially younger, less educated, minority and lower income citizens, experience real differences in years of healthy life when compared to the general population. Our goal is to eliminate health disparities for vulnerable populations.
- Health in All Policies Task Force. Key initiatives include: Healthy Food Procurement Guidelines for all State Agencies, Worksite Wellness; a catalogue of best practices here and elsewhere to be amplified; and guidance on assessing health impacts of policies, budgets and programs throughout state government.

High Level Commissions and Initiatives

Financial Commission

The Director of Policy and Integration works with the Vermont Financial Literacy Commission so the Commission and AHS initiatives can be aligned. The commission was created by the State Legislature in 2015. The 12- member commission was established to measurably improve the financial literacy and financial capability of Vermont's citizens. Current initiatives include support for Children's Educational Savings Accounts and raising the asset limit for public programs. Click here for Enabling legislation.

Blue Ribbon Commission

The Director of Policy and Program Integration for AHS is a Commissioner on the Blue Ribbon Commission (BRC). The BRC is charged with recommendations regarding financing "equal access to high quality child care" in the state. After a series of data collection, research presentation from subject matter experts and discussions, the BRC seeks to begin discussion regarding financing with the total cost of funding high quality child care system in the state for all children

birth to five. The BRC Report is due in November 2016.

Governor's Council on Pathways from Poverty

The Secretary or her/his representative sits on this Council. The Council is the advisory to the Governor and its responsibilities include, determining the nature and primary causes of poverty in Vermont; reviewing the extent to which public and private agencies are addressing poverty in Vermont; and making recommendations on action that should be taken to respond to poverty in Vermont, including actions taken by: federal government, state government, local government, private non-profit agencies and programs, charities, business and industry.

Vermont Child Poverty Council

The Secretary or her/his representative sits on this Council. The Vermont Child Poverty Council was established in 2007 to address child poverty in Vermont. The Council helps advance the poverty-reduction recommendations outlined in the Council's 2009 report, Improving the Odds for Kids. View the Council's Annual Progress Report (January 2015) here.

Ending Family Homelessness 2020

In early 2015, AHS launched a comprehensive strategy to rapidly reduce homelessness in Vermont, particularly among families with children. AHS is coordinating multiple cross-department and cross-agency activities under this initiative all of which focus on better coordination of services, rental subsidies and access to housing among people in housing crises.

15% Goal for Housing the Homeless

A year into the Ending Family Homelessness initiative, Governor Shumlin established a goal that publicly-funded housing organizations make 15% of their rental units available to people coming from homelessness. While initially controversial, most housing partners are now on board and we have strong support from federal partners including HUD, USDA-RD and the US Interagency Council on Homelessness. AHS is working closely with ACCD-DHCD to implement this goal and refine reporting.

Medicaid Expansion of Family Supportive Housing

After seeing strong outcomes in five pilot communities, AHS is expanding its Family Supportive Housing (FSH) program to additional regions in SFY '17 through drawing down federal Medicaid funds for eligible case management services. The FSH program provides intensive support services to families with multiple challenges as they transition from homelessness to stable housing. FSH staff assist in finding housing and then stay with a family, providing customized services on-site for an average of 24 months.

Governor's Commission on Alzheimer's, Dementia and Other Related Disorders (ADRD)

DAIL, VDH, DMH all participate to address the Commission's charge related to education, outreach, awareness and state planning in relation to the rising rate of diagnosis and the significant economic and emotional impact of this illness.

Medicaid for Working People with Disabilities Workgroup

DAIL and DVHA continue to partner to move forward a State Plan Amendment (SPA) to enact the legislation related to raising the asset limits to get more people on Medicaid into the workforce

Governor's Committee on the Employment of People with Disabilities

Division of Vocational Rehabilitation and Division for the Blind and Visually Impaired in conjunction with the Department of Human Resources and the Department of Labor participate on the Governor's Committee on the Employment of People with Disabilities with a subcommittee focused on the hiring of individuals with disabilities into the state workforce.

About the Agency of Human Services

The Agency of Human Services was created by the Vermont Legislature in 1969 to serve as the umbrella organization for all human service activities within state government. The Secretary's Office strategically leads the Agency and its departments in establishing and implementing Agency-wide and government-wide policies and practices.

The scope of AHS is expansive. As a single entity, AHS builds a continuum of care that protects and supports vulnerable Vermonters; addresses individual, family and regional crises as they arise; develops and promotes whole population approaches to physical and behavioral health; works to build economic self-sufficiency; and keeps communities safe.

AHS delivers human service programs within the state through six departments, twelve district offices, and a network of community partners and providers. Each department has a distinct area of focus and responsibility that contributes to the creation and sustenance of an entire system of human service supports. DMH, DAIL, and DVHA operate almost exclusively within a community partner framework, relying on private entities for service delivery to their constituent populations. Conversely, DCF, VDH, and DOC are primarily responsible for the delivery of their services, although they may intersect at times with the private provider system.

The Secretary of the Agency of Human Services serves in a broad position with multiple dimensions. The Secretary works directly with the Deputy Secretary and with Agency Commissioners towards solving policy and implementation challenges across portfolios. She/he also facilitates the coordination of policy initiatives across the public sector, including cross-Agency and State issues, and promotes leadership and information exchange across the Executive Branch.

The Secretary provides high quality policy advice to the Administration and ensures the delivery of outcomes that contribute to the achievement of Administration priorities. As such, the Secretary is accountable for the delivery of publicly-funded services, for adapting programs and activities in accordance with the direction of the Administration, and ensuring the Agency responds to the ways in which the Administration seeks to develop and implement its policies and programs.

The Deputy Secretary supports Agency and Administration priorities, helps promote cross-agency coordination, and works closely with Deputy Commissioners and departmental leadership on issues related to the execution of Agency programs and the Agency Strategic Plan. The Deputy Secretary fulfills the duties and responsibilities of the Secretary in the Secretary's absence.

Department	Employees	Budget (in millions)	Vermonters Served
Disabilities, Aging and Independent Living (DAIL)	286	$ 453	89,574
Children and Families (DCF)	1,078	$ 389	185,000
Corrections (DOC)	1,055	$ 157	1,755
Health (VDH)	530	$153	626,562
Health Access (DVHA)	208	$1,200	230,602
Mental Health (DMH)	267	$ 217	34,074

The AHS mission is "to improve the health and well-being of Vermonters today and tomorrow, and to protect those among us who are unable to protect themselves.

Fiscal Operations Unit

The Fiscal Operations Unit manages the development, implementation, coordination and monitoring of the Agency's $2.5 Billion budget to ensure that departmental programs reflect the Governor's priorities and are in compliance with legislative requirements. Specifically, the unit:

1) Develops financial status reports and monitors key financial program performance indicators for each Agency department and office
2) Coordinates all federal block grant and statewide single audit functions
3) Updates federal cost allocation plans
4) Updates the State plan for federal assurances and documentation
5) The Rate Setting Unit, audits and establishes Medicaid payment rates for nursing facilities for the Department of Vermont Health Access (DVHA), intermediate care facilities for people with developmental disabilities for the Department of Disabilities, Aging and Independent Living (DAIL) and private non-medical institutions for the Department for Children and Family (DCF)
6) Oversees and manages the fiscal operations of the Global Commitment waiver to ensure compliance with the federal managed care fiscal requirements and the Single State Medicaid Agency
7) Coordinates and supports the audit process through the Internal Audit Group (IAG)
8) Supports the financial needs of the Health and Human Services Enterprise. The HSE includes the following programs: Vermont Health Connect (VHC), Integrated Eligibility (IE), Medicaid Management Information System (MMIS) and Health Information Exchange/Technology (HIE/HIT)

Budget

Reliance on Federal Funds – Medicaid

Over the past decade, AHS has been very successful in obtaining waivers allowing Medicaid reimbursement of previously non-covered services. Title XIX (Medicaid) funds now cover 68% of AHS expenditures (excluding Department of Corrections, which is almost exclusively general funds – including DOC, Medicaid covers 64% of expenditures). Medicaid expenditures earn federal reimbursement for 54.32% of costs in FY 2017 and 54.39% in FY 2018. (Some Medicaid reimbursements, including technology projects, are reimbursed at different rates). Through its Medicaid waiver, AHS has been able to expand coverage and services at a fraction of the cost versus using State funds alone.

In particular, as it relates to Medicaid and the Affordable Care Act (ACA), Vermont has leveraged even more federal funds through enhance match opportunities provided for New Adults.

The downside to this success in maximizing federal revenue is there are very few AHS programs that rely solely on State funds. Any reduction to Medicaid programs generates only a fractional portion of state savings and in most instances invokes federal rules and restrictions regarding reductions.

Current waiver renewal negotiations underway, with a January 1, 2017 start date, include major changes to the current Global Commitment Waiver. These changes have significant financial implications over the next 5 years and beyond. Changes include impacts on MCO investments, administrative claiming and budget neutrality. Vermont has negotiated a transition schedule to mitigate the financial challenges with CMS. The transition plan will be highlighted later in the document.

GC Waiver – Budget Neutrality

The Vermont Section 1115 Global Commitment to Health Demonstration has operated under an aggregate budget neutrality ceiling since its inception in 2006. The aggregate budget neutrality ceiling for the initial five-year Demonstration period was derived from the sum of the following:

- A continuation of the "without waiver" expenditure projections from Vermont's previous Section 1115 Demonstration, the Vermont Health Access Plan (VHAP)
- Actual State Fiscal Year 2004 Medicaid expenditures for all services and populations that were not previously included under the VHAP Demonstration[1]
    - The "without waiver" expenditure projections from the initial five-year period have been extended under various Demonstration renewals and amendments. The budget neutrality model also was adjusted to accommodate the Affordable Care Act's changes to Medicaid eligibility as well as the consolidation of Vermont's two Section 1115 Demonstrations, Global Commitment to Health and Choices for Care (Vermont's long-term care Demonstration)
    - However, as part of the current waiver negotiations, CMS has requested the following adjustments:
        - Conversion from an aggregate budget neutrality ceiling to per capita limits;
        - Limitation on the amounts of savings carry-forward from previous Demonstration periods;
        - Limitation on annually accrued savings for Demonstration Years 12 through 16.
    - These adjustments will result in a reduction of accumulated savings by approximately $1.44 Billion. The table below presents a summary of estimated, accumulated Demonstration savings and permissible savings, pursuant to CMS policies.[2]

Demonstration Year	Accumulated Savings without Phase Down	Accumulated Savings with Phase Down	Impact of Phase Down Policies
12	$ 2,070,369,249	$ 1,374,402,610	$ (695,966,638)
13	$ 2,345,240,100	$ 1,443,120,323	$ (902,119,777)
14	$ 2,604,344,147	$ 1,507,896,335	$ (1,096,447,812)
15	$ 2,844,106,197	$ 1,567,836,847	$ (1,276,269,350)
16	$ 3,060,509,932	$ 1,621,937,781	$ (1,438,572,151)

Reliance on Federal Funds – Non-Medicaid

[1] In order to ensure that Medicaid expenditures were not omitted or duplicated, CMS and Vermont fiscal staff performed a reconciliation of expenditures by eligibility group and service category.

[2] Savings are equal to the projected annual waiver limit minus projected expenditures; projected expenditures do not reflect provider rate increases for purposes of addressing cost shift

Even AHS programs outside of Medicaid may have significant federal matching participation, and hence become less attractive for reduction. Setting aside Medicaid, 42% of AHS expenditures are supported by federal funds (51 % federal funds if remove Corrections). Much of the remaining non-Corrections general funds are tied as mandatory matching for federal funds and/or maintenance of effort (MOE) with federal funds.

Capital Funding Needs

Over the next five years, AHS has several priority projects that will require capital appropriations to support. These include:

1) Health & Human Services Enterprise (additional information below)
2) Replacement of the Middlesex Community Therapeutic Residence
3) Additional VPCH-like facility
4) Additional Correctional Facility
5) Replacement of the Woodside Youth Residence
6) Additional AHS Office Space in Waterbury and district offices

Health & Human Services Enterprise (HSE)

Within the HSE, the following projects exist:

1) Vermont Health Connect (VHC)
2) Integrated Eligibility (IE)
3) Medicaid Management Information System (MMIS)
4) Health Information Technology/Exchange (HIT/HIE)

AHS has worked and will continue to work with the federal partners to arrive at mutually acceptable plans and this will continue to be prominent in order to fund IT investments. Several Implementation Advance Planning Documents (IAPDs) with CMS (Centers for Medicare and Medicaid) exist to cover a considerable part of the costs of the enterprise projects listed above.

In addition, AHS has had to rely on the capital bill extensively for funding for these very important projects. Since 2009, AHS has received over $15 million in funding via various capital bills and general fund appropriations.

Tobacco Fund Revenue Decline

The Agency of Human Services relies on $31 million of funding from the Tobacco Fund. These funds are used to support the Medicaid program and tobacco cessation programs at VDH. The fund receives revenue through the Master Settlement Agreement (MSA) which settled claims between states and the tobacco industry. As part of the MSA, the Strategic Contribution Fund (SCF) allowed for 10 years of extra payments to recognize states for their tobacco control efforts. For Vermont, these payments have been approximately $12 million annually. **Vermont will receive its final SCF payment in 2017 and thereby, create a significant funding shortfall in developing the FY18 budget.**

Vocational Rehabilitation Re-Allotment Funds

VR and DBVI – DAIL was recently notified of the loss of $4.5 million in federal re-allotment funds for the first time since 2008; although this is not built as part of base budget it is a significant loss to those programs and will require significant reductions in programming.

All-Payer Waiver

Vermont is currently negotiating an All Payer Waiver with CMS. The Department of Vermont Health Access has been the lead in negotiating the contract with the ACO and will provide more information.

State Innovation Model Sustainability

Vermont received a 4-year, $45-million federal State Innovation Model (SIM) grant that is set to expire on November 30, 2017. This SIM grant funded important innovations in health care delivery, health information technology and payment

models. Though the grant is ending, the important work related to SIM must continue. The FY18 budget includes proposals to allow for health care delivery reform to continue.

Department of Labor Rule

In May 2016, the federal Department of Labor finalized the rule updating overtime regulations, which extends overtime pay protections for full-time salaried executive, administrative and professional employees. This will have a financial impact on the Designate Agency (DA) system. The DAs have indicated it could cost them an additional $5 million to implement. AHS is in the process of reviewing the DA analysis.

Offender and Inmate Records Rule

DOC was required to create a rule concerning offender and inmate records. Unless changed or delayed, effective in May 2017, DOC will be required to provide complete files annually, albeit redacted, to each inmate and offender who chooses to request his or her file. A copy can also be requested annually, which would include only items that have been added/changed since the time of the full file request in the same calendar year. There are some significant challenges related to this, including the need to scan potentially millions of documents, upload them to the Offender Management system or at least the network drive, and then review/redact these files before being able to print them upon request.

The estimated time and cost of this could be as much as $25 million if every offender and inmate requests a file within the first year. If staff need to complete some of this work by May, the potential exists that several staff (administrative and casework staff have been identified) at each DOC site will be offline until this project is complete. There will be significant overtime costs as well as additional costs for scanners and specialty software for redacting.

Audit Issues

AHS continues to work to improve its auditing process and results. However, there continues to be challenges to resolve some audit findings. The FY16 audit is underway. In FY15, AHS had 29 findings in the single audit, which was 4 less than the FY14 audit (33 findings). Of the 29 findings in FY15, 14 were repeat findings.

Procurement Grants

Due to resource constraints, AHS has utilized procurement grants over the past decade as a legitimate contracting vehicle. In FY17, this amounts to approximately $351 million in procurement grants – this primarily reflects the Master Grant Agreements with the Designated Agencies. It is critical for AHS that procurement grants continue as a contracting tool. If not, there will be a resource need at AHS.

Information Technology

The Agency of Human Services Information Technology Unit (AHS IT) oversees and manages the design, implementation, procurement, project management, operation, and maintenance of the hundreds of information systems of the Agency of Human Services (AHS). AHS IT is a dedicated group of over one hundred professionals who work under the direction of the Agency of Human Services Chief Information Officer (CIO). AHS staff are located within both AHS Central Office and AHS departments. Some staff work directly for the Agency, some staff work directly for AHS departments, and some staff work as liaisons between the Agency and its departments.

AHS IT fulfills its mission by providing varied IT-related services to all departments within AHS. Services include project management, business analysis, content/document management, database administration, application development, and business process/architecture development assistance.

In order to best serve AHS needs, AHS IT works to ensure that its systems are operationally capable, secure, and compliant. AHS IT strives to develop and/or acquire systems that are designed for modularity; such systems are easier to maintain and integrate. At all levels, AHS IT works transparently to achieve its desired results efficiently and sustainably.

Structure

Four substructures comprise the overall structure of AHS IT. The organizational and reporting substructures are shaped by prior consolidations and reorganizations. These substructures are straightforward to explain and document. In contrast, the financial and functional substructures are by-products of public sector dynamics. They are more difficult to depict, as they often do not align with the first two substructures.

Organizational Substructure

The organizational substructure describes the organizational location of AHS IT units within the Agency.

Prior to 2006, all IT staff resided within individual AHS departments. Starting in 2006, department IT staff that performed duties related to infrastructure were consolidated into AHS IT. In 2011, senior IT leadership positions within AHS departments were moved to AHS IT. Around this time, AHS IT infrastructure positions were reassigned to DII, removing most hardware- and network-related positions from AHS IT.

Today, most IT staff with AHS work for AHS IT. DCF and VDH retain substantive subsidiary IT units. The IT staff of DCF work for the DCF Information Services Division (ISD or DCF-ISD). The IT staff of VDH work in the VDH Information Technology Unit (VDH IT).

The general organizational substructure of AHS IT is depicted in Figure 1 below. The specific organizational charts of AHS IT, DCF-ISD, and VDH IT contain details of positions within these organizational units.

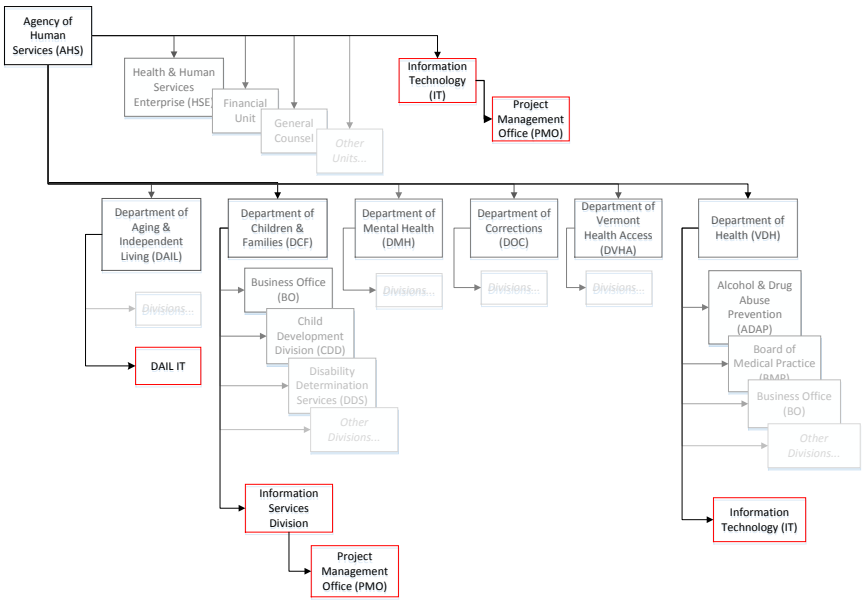


Figure 1. AHS IT organizational substructure.

Reporting Substructure

The reporting substructure describes the reporting relationships among staff within AHS IT. Despite the physical and structural fragmentation of the AHS IT organization, all AHS IT components ultimately report to the AHS CIO.

The general reporting substructure of AHS IT is shown in Figure 2 below. The specific organizational charts of AHS IT, DCF-ISD, and VDH IT contain details of reporting hierarchy within these organizational units.

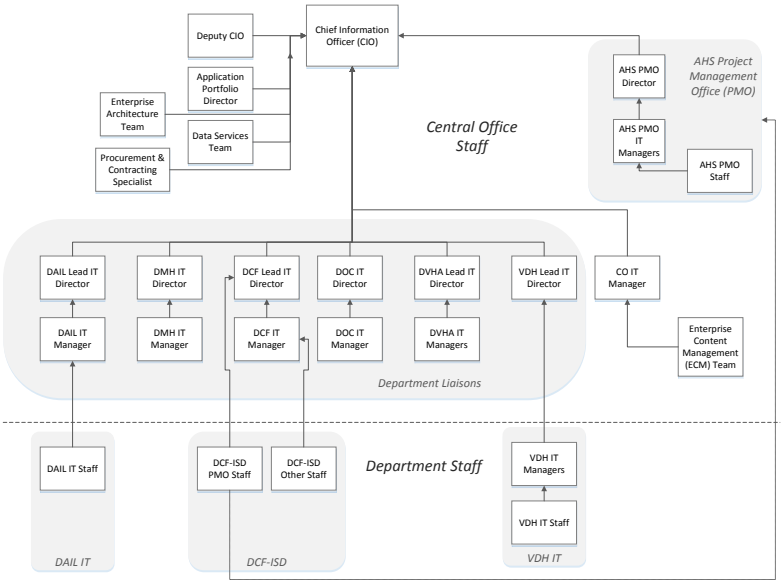


Figure 2. AHS IT reporting substructure.

Financial Substructure

The financial substructure depicts which funding sources support specific positions within AHS IT. The financial substructure is extremely complex. As a support unit of AHS, AHS IT receives the majority of its financial support by charging its work to the Agency, AHS departments, and specific projects. Consequently, AHS IT receives operating funds from dozens of funding streams, which in turn originate from several sources.

The AHS Fiscal Operations Unit will work with AHS IT to create an IT budget for the Agency and its departments for fiscal year 2017.

Services

AHS IT provides information technology services to all departments within AHS. Department staff work through their IT Managers to request these services.

Data Services

The AHS Data Services group leads the Agency in data systems and governance. This includes data and database administration, security, warehousing, analytics, architecture, design, and disaster recovery planning. The group works with AHS and its partners to provide and support cost-effective data services and solutions. The group also formulates and maintains both policies and supporting governance for the AHS data environment.

Department IT Management and Procurement Services

AHS IT provides each department one or more dedicated IT Management which supports the respective individual departments that comprise the Agency. These managers adhere to common Agency vision and IT principles while managing the IT needs within their support domains. The tasks of this unit include planning, procurement, implementation, maintenance, and support of information technology systems. In addition, AHS has one IT-specific procurement specialist who offers expert consultation for RFI, RFP, contract, vendor management, and software licensing.

Development Services

AHS IT provides software development services to support several applications, which are written in many diverse languages and hosted in many different types of environments. The team supports all the departments and Central Office in varying degrees of development, analysis, and solution administration.

Architecture and Planning Services

The Enterprise Architecture team reviews and tracks business, information, and application connections among AHS systems. The group collects and manages a knowledge base in order to both assess new initiatives for impact to existing systems and discover opportunities for business process improvements.

The Application Portfolio group provides application data to the Agency, its departments, and its divisions. The group provides consultation about proactive decision-making about applications and the business processes that those applications support.

Enterprise Content Management Services

The AHS Enterprise Content Management (ECM) team provides and supports ECM best practices, guidance, and solutions within the Agency. ECM covers solutions and processes related to imaging, records management, document management, collaboration, web content management, search, and digital asset management.

Project Management Services

The AHS Project Management Office (PMO) provides guidance on business analysis and project management, including process definition, mentorship, and document templates. The AHS PMO has a pool of highly skilled business analysts and project managers available for allocation to information technology projects.

Software Applications

As of January 2016, AHS uses 334 software applications that directly support business programs. This count does not include enterprise productivity applications, development and maintenance software used by development staff, general reporting software, and survey tools. This count does include Microsoft Access databases, Microsoft Excel workbooks, and Microsoft Word documents which act as the primary source of business program data.

Of the 334 applications which AHS currently uses, 79 applications were developed and/or are maintained by in-house development staff. The technical characteristics of these “in-house applications” are diverse. Most in-house applications are client-server based or data-centric, but some are monolithic. In-house applications are hosted on local computers, on Windows servers, on Linux servers, and on a mainframe. In-house applications are written in a variety of languages. Ages of in-house applications vary from a few years to several decades.

In addition to the 79 applications above, AHS IT also provides support to enterprise productivity applications at the department IT management level. This support usually encompasses user-level support. However, during implementations of changes or upgrades, AHS IT also provides coordination, testing, and training support to the Agency and its departments. AHS IT primarily supports the software components of applications. Hardware components of locally hosted applications are primarily supported by DII, except for applications that are cloud-based.

Relationship with DII

AHS IT is not a unit of the Department for Information and Innovation (DII). DII provides general oversight of the above IT functionality, but primarily with a focus on alignment to similar State initiatives. DII predominantly provides basic infrastructure support, including the areas of desktop support, networking, cloud services, information security, and risk management (Vermont Department of Information and Innovation, 2016).

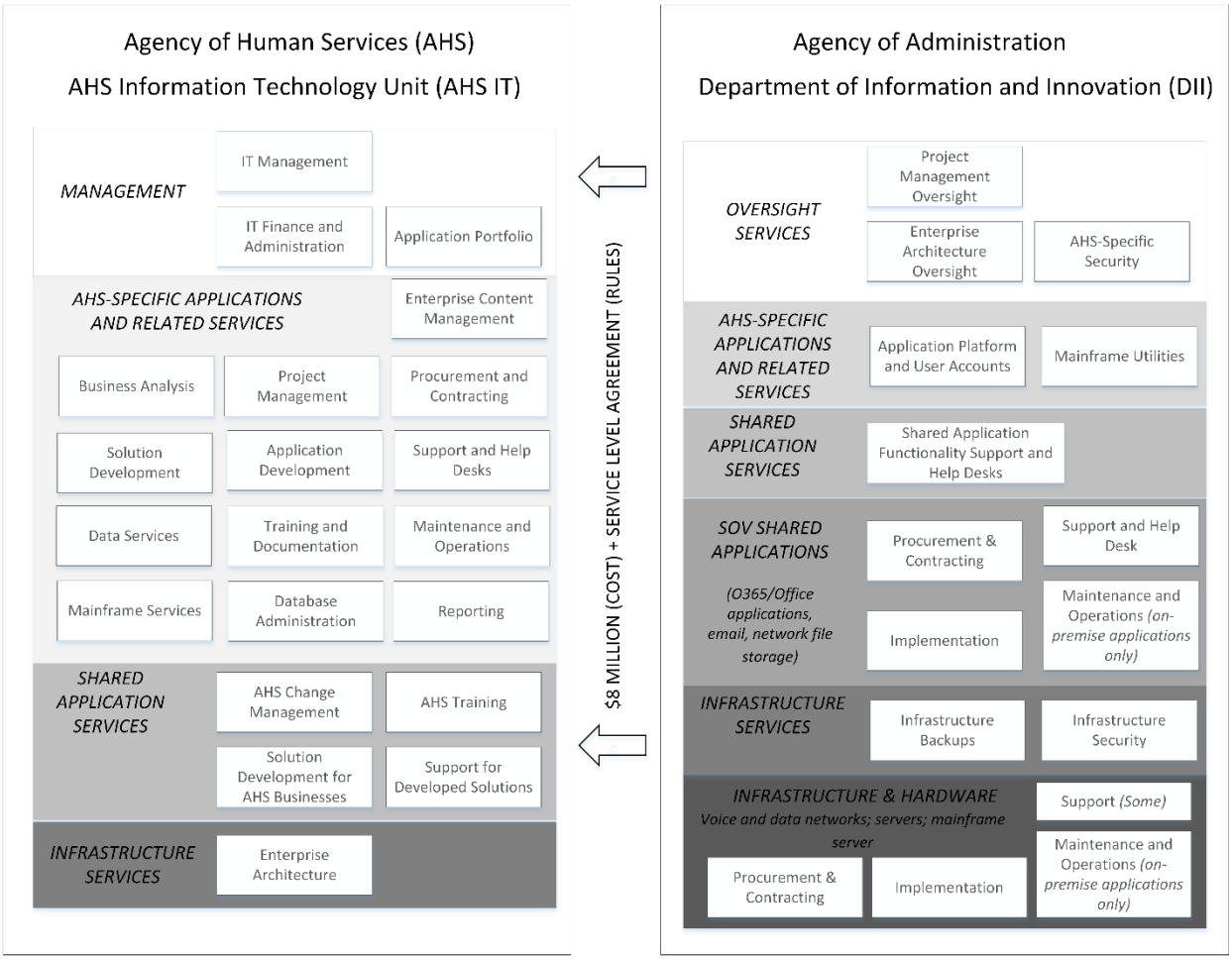


Figure 3. Comparison of AHS IT and DII roles and responsibilities.

Current Resources

AHS IT resources primarily consist of its staff. As of May 2016, AHS IT has 123 positions as defined by its reporting substructure. Sixty of these positions are located directly in the AHS IT unit. DCF-ISD has 38 positions. VDH IT has 23 positions. DAIL IT has two positions.

Primary Service	Total	*AHS IT*	*DCF-ISD*	*VDH IT*	*DAIL IT*	Vacant	Limited[3]	On Loan
Development	47	*4*	*24*	*18*	*1*	6	3	5
Project Management	38	*24*	*8*	*5*	*1*	5	16	1
IT Management	13	*13*	*0*	*0*	*0*	0	1	0
Technical Lead	6	*4*	*2*	*0*	*0*	0	2	2
Architecture	4	*4*	*0*	*0*	*0*	0	3	0
Data Services	4	*0*	*0*	*0*	*0*	0	0	0
ECM	3	*3*	*0*	*0*	*0*	0	0	0
Support	3	*2*	*1*	*0*	*0*	1	2	0
Leadership	2	*2*	*0*	*0*	*0*	0	0	1
Totals	**123**	***60***	***38***	***23***	***2***	**12**	**26**	**9**

Table 1. Position distribution across AHS IT.

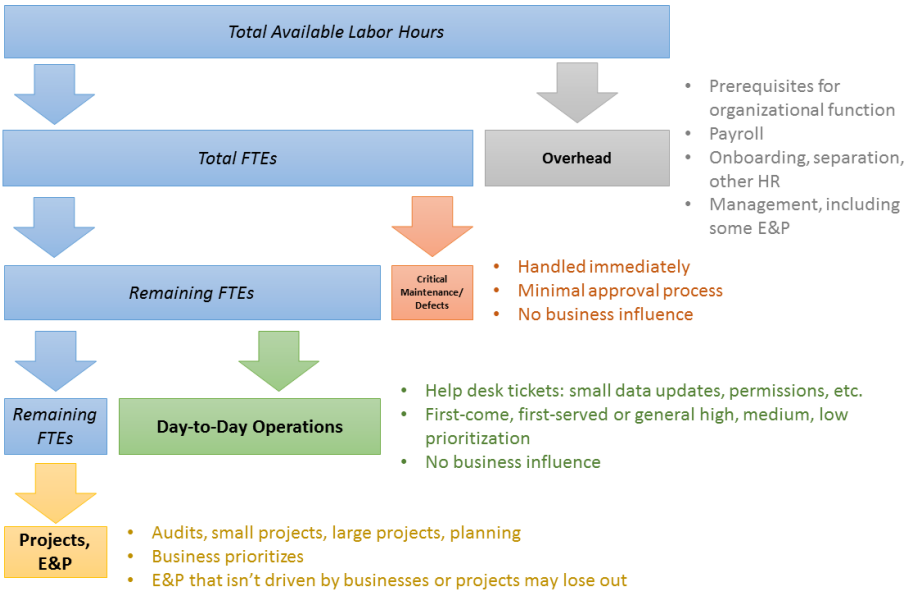
[3] Limited positions include both limited service and temporary positions.

There are some positions within AHS departments that are labeled as IT positions but are not part of the AHS IT organizational or reporting substructures.

Decision-Making about Resource Allocation

Who makes the decisions about the work that AHS IT performs day to day?

There is a division of responsibility. AHS IT prioritizes and executes critical maintenance (fixing defects and other issues of system functionality) as well as daily maintenance and operations work. But the businesses AHS IT serves make the decisions about which projects to execute moving forward.



Drivers of Resource Needs

AHS IT resource needs arise from a nexus of three different drivers: maintenance and operations (M&O), projects, and exploration and planning (E&P). Each of these drivers is essential to fulfilling the basic mission of AHS IT. While each driver consumes resources, each driver also has the capability to reduce resource use.

Figure 4. The three drivers of AHS IT resource needs.

M&O activities ensure that existing tools and services run smoothly and receive necessary support to stay current. M&O also includes the activity of fixing what is currently broken. The trio of better documentation, process improvement, and reinvestment in existing technology reduce future M&O resource costs by increasing efficiency, reducing likelihood of defects, and decreasing the difficulty of fixes.

Projects are conducted to support new requests from AHS businesses, often to comply with state or federal mandates. Examples of projects include requests for new systems, more integrations among existing systems, or reports of metrics from existing systems. Projects sometimes have independent resource streams which would not appear to impact AHS IT workload. However, even independently-resourced projects can increase M&O needs, because every new IT tool and service requires resources for M&O. Not all projects yield a corresponding increase of M&O needs. A project can lessen M&O needs by retiring, transitioning, or improving existing solutions.

E&P activities are key to making efficient use of AHS IT resources, ultimately supporting both project and M&O demands. E&P controls the pipeline of work feeding the other two areas. In this realm, strategic and tactical plans are developed both to create a road map for the future and to avoid a reactive "firefighting" approach to workload management. Plans may include retirement of outdated services, consolidation of systems, or replacement of less effective or costlier services. E&P can also include better leverage of financial structures to optimize funding.

If AHS IT resources, including staffing, remain at a fixed level while the needs of one area expand, then resources across AHS IT will be insufficient to meet all of the needs of AHS. This occurs most often when an unfunded state or federal mandate requires output from AHS IT; this situation is described in the Threats section below. However, smaller initiatives, such as rule changes or more stringent audit requirements, may have a similar impact. These initiatives require more output without an increase in funding. Each addition to assigned work without an increase in resources results in a greater likelihood of inefficiency.

AHS IT Overall Current State

Information technology is the source of, and subject to, disruptive and dynamic forces in our culture at large. It is unsurprising that some of these forces are reflected in the microcosm of AHS IT. However, as a unit of a much larger agency, AHS IT is subject to significant external forces as well.

AHS IT can evaluate its current state by considering those forces, which are reflected in opportunities, strengths, threats, and weaknesses. Opportunities describe beneficial forces that drive from outside AHS IT. Strengths describe positive forces that are internal within AHS IT and helpful to achieving its goals. Threats describe external forces that are harmful to AHS IT's goals. Weaknesses are also internally generated, but weaknesses are harmful to achieving AHS IT goals.

Opportunities

The information technology sector continues to expand, disrupt, and reshape itself, creating opportunities that allow entities like AHS IT to revise their core businesses. For example, cloud services offer significant opportunities to dramatically reshape development, maintenance, and operations burdens by outsourcing work in exchange for a subscription fee.

In parallel, local resources that expand the tech labor force and enhance tech sector innovation continue to grow. Nearby academic resources include information security programs at Norwich University, IT development and management curricula at Champlain College, and IT development and management programs at Vermont Technical College. Job and innovation fairs, like the Seven Days-sponsored Tech Jam, draw tech workers to the area and provide recruiting opportunities. BTV Ignite is a federally-funded tech initiative aimed at expanding the Burlington-area technology ecosystem.

As a State employer, AHS IT can offer quality-of-life benefits that compare well to benefits at other organizations. AHS IT staff generally enjoy a set schedule, a good work/life balance, and job stability. They receive high-quality health

insurance, pension benefits, and other extras. This helps to entice certain categories of workers that the private sector cannot attract.

AHS IT also experiences opportunities due to its positioning in State government, particularly within the health and human services sector. Significant federal funding is available to support health and human services initiatives.

Strengths

AHS IT draws great strength from an engaged and caring workforce. Its colleagues support one another with the same commitment that they bring to customer service. AHS IT serves both internal and external customers equally with dedication to quality and transparency.

AHS IT staff are highly skilled. The unit has parlayed their talents into centers of excellence in data services, enterprise content management, and project management, among other disciplines. In addition to solving development and operations challenges, AHS IT staff also demonstrate their skills by taking an advisory role with AHS businesses regarding best practices in governance and process improvement.

AHS businesses are subject to numerous information security and privacy regulations and standards, including HIPAA, FERPA, and IRS 1075. In its efforts to stay compliant with these regulations, AHS IT has become a leader in information security practice at the State of Vermont.

Though there are significant pressures to improve and modernize, AHS IT currently operates and maintains a portfolio of tools and services that successfully function to support mission-critical Agency functions. AHS IT continues to broaden its solution portfolio to meet emerging business needs.

Challenges

One of the greatest challenges of AHS IT is its siloed nature. Departments, Central Office, and the Health and Human Services Enterprise (HSE) all have IT services and personnel that often do not share resources or coordinate as efficiently as could be possible.

AHS IT, like many other public sector organizations, owns archaic applications that are difficult to maintain and much more challenging to replace, and these represent a major weakness in resource consumption and opportunity cost. At the other end of the scale, the unit is now responsible for hundreds of Microsoft Access databases and other similar applications. These silo important data, have inadequate security controls/auditing, subject AHS to risk of information loss, and consume undue IT resource time. Broadly speaking, only a small percentage of AHS IT applications, across the board, have fully documented sustainability and retirement plans.

More information on Department Specific IT Status is available from the AHS CIO

Threats

AHS IT inherits some threats as a natural consequence of the Agency of Human Services' challenging mission, as well as from the general nature of the public sector.

The Agency serves the most vulnerable parts of Vermont's population. This group of people often has complicated needs; in turn, these needs often do not have a simple resolution. The needs of this populace are the subject of many legal mandates. Each additional mandate makes AHS more dependent upon AHS IT for successful development, integration, and functionality of IT applications, services, and tools.

These mandates are enacted by several sources, including federal partners, the Vermont Legislature, and the Agency of Administration. Thus, the roles and responsibilities of supporting those mandates are often shared among multiple entities. This creates challenges related to governance, decision-making, and execution.

Many of these mandates are not delivered with additional funding. Without additional funding, AHS is typically under-resourced to meet those mandates. By extension, AHS IT also is under-resourced to meet those mandates. A

Department of Human Resources survey showed that over seventy percent of State of Vermont employees disagree that their agency or department has enough staff to achieve its mission. All AHS department responses to the same question landed within ten percent of the State average (Vermont Department of Human Resources, 2016).

The State of Vermont is under consistent pressure to reduce labor costs. Salaries and incentives offered to its staff are highly constrained by factors outside AHS IT's control. A report commissioned by DII found that State of Vermont IT salaries, including AHS IT salaries, trail those seen in the private sector by more than ten percent (Gadway & Sadowski, 2012). This salary discrepancy impedes AHS IT's ability to compete for qualified staff, particularly in the database administration realm. Once personnel arrive, they are difficult to retain for the same reasons. This leads to turnover, wasted training funds, and loss of institutional knowledge.

Retirement also takes its toll on available staff. For example, a 2015 incentive package successfully induced retirements. However, these retirements also generated a significant loss of institutional knowledge and experience as veteran staff left the workforce.

Aside from pressure on the labor market, other uncertainties and challenges arising in the larger information technology sector also influence AHS IT. Vendors and advisory bodies continue to recommend cloud-based services to replace traditional on-premises applications and hardware. While cloud-based software might cost far less time and money to implement, this software incurs significant subscription costs that are not always less expensive than in-house maintenance and operations. Transitioning existing data to cloud systems can be very challenging. Moving data from one cloud system to another cloud system can be equally difficult. In some circumstances, it might be impossible to fully extract existing information from a cloud service; subscribers can experience service lock-in, leaving them subject to price increases and service decreases. Software as a service can be inflexible in design, lack transparency, and change without time to plan, test, or mitigate dependencies.

Although AHS IT evidences an organizational strength in information security, the corresponding challenges in maintaining information security and privacy are growing at a pace that outweighs State resources to react proactively. The complexity of IT systems grows at an exponential rate and the sophistication of attackers is increasing so fast that most government institutions cannot match defense-wise. Information security continues to be a major threat to all IT resources across the state; this includes AHS IT as well.

Health and Human Services Enterprise

The Health & Human Services Enterprise Portfolio Management Office (HSE-PMO) is comprised of 25 direct staff supported by 260 strategically-placed staff throughout the State who are charged with securing, directing, and managing a significant technology investment. The investment is funded mainly by our federal partners, with support from the State, in an effort to benefit all Vermonters by enhancing service delivery, improving health outcomes, and controlling costs. To this end, the HSE-PMO sits at the nexus of people, process, and technology driving best practice development of enterprise systems that allow AHS to take a cost-conscious approach to helping residents establish themselves as productive, contributory members of the Vermont community.

HSE at a Glance

- The HSE exists to support the Agency in achieving its strategic goals of improving outcomes and reducing per capita costs through integrated service delivery and improved program administration.
- Over 200,000 Vermonters (1/3) are touched directly by the HSE portfolio of projects. The entire state feels the financial benefits of Vermont's relationship with the US Center for Medicare & Medicaid Services (CMS).

- The HSE Portfolio Management Office (HSE-PMO) manages a $200M+ portfolio for FY2016-FY2018.
- The HSE Portfolio Director reports to the Agency Secretary. A formal Agency-wide and Inter-Agency governance structure supports the strategic direction of the HSE.
- HSE-PMO staff represent disciplines essential to supporting the successful execution of HSE projects. Disciplines include, Budgeting/Financial Management, Procurement, Project Management, Organizational Change Management, Business Architecture & Design, Privacy & Consent Management, Vendor Management, and Enterprise System Implementation.
- The HSE has yielded millions of dollars of savings for Vermont.

Key Initiatives

Through the HSE initiative, Vermont along with our federal investment partner, CMS, has been driving innovative changes for over seven years, spanning three administrations and representing over $350M invested in the State to date. CMS not only acts as our funder, but as our partner, allowing us to join other innovators in staging the national path forward. The path that leads to a healthy population empowered by social services, not encumbered by the system that provides them.

Today, the main systems that Vermont uses to administer the Medicaid program and enroll Vermonters in health and human service programs are close to 40 years old. The antiquity and inadequacy of these systems causes a number of costly challenges. However, the opportunity to update these systems, and the federal support and funding behind us, has opened a number of doors for the State.

The HSE initiative is aimed at transforming the Agency from a siloed program-centric organization to an agile person-centric organization. The range of operations under the HSE umbrella include the following:

Human Services Enterprise Platform (HSEP)

A shared suite of modern technology tools positioned to satisfy a significant portion of AHS' software needs including transactions, analysis, and infrastructure. Today these needs are supported by over 200 different, detached, disconnected software packages. CMS is funding 90% of the costs of designing and developing the HSEP and 75% of the cost of Maintenance & Operations (M&O). Leveraging one system, over many, represents material savings for the State, and allows for rapid response to ever-changing regulatory, policy, and programmatic demands.

DVHA – Department of Vermont Health Access
DCF – Department for Children and Families
HIE/HIT – Health Information Exchange/Health Information Technology
IE – Integrated Eligibility & Enrollment
MMIS – Medicaid Management Information System

Vermont Health Connect (VHC)

VHC uses the HSEP's basic Exchange and Eligibility & Enrollment services and capabilities. Some see VHC as our insurance marketplace with a poor and very public track record, but despite a tough start, the marketplace drove uninsured rates to their lowest levels ever and they are now the 2nd lowest in the nation. The State estimates annual savings resulting from the increase in Vermonters with health coverage at ~$50M.

Through VHC, the State was able to leverage $200M in federal financing to establish the HSEP which supports numerous AHS initiatives including Integrated Eligibility and Enrollment, MMIS, HIE/HIT, among others (see below for details on some of these efforts).

Integrated Eligibility and Enrollment

This project will provide additional capabilities that will be added to the HSEP allowing for automation and standardization of the health & human services case management and program administration systems (screening, application, eligibility determination and enrollment). This represents the integration of the Agency's remaining health programs and economic services into one system. This means that our staff, and the Vermonters we serve, will use one system -one door- to manage services. The State can enjoy future savings of close to $20 million a year in technology costs alone by using a single system for eligibility and enrollment.

Health Information Exchange/Health Information Technology (HIE/HIT)

HIE/HIT is a secure digital enterprise network that connects Vermont's electronic health records, enabling the sharing of clinical and demographic data for patients across the State. Tightly interwoven with the Blueprint for Health and VITL, this forward-looking set of projects has created and advanced a State-wide environment for digital sharing of patient health records, connecting the vast majority of medical providers in the State.

Medicaid Management Information System (MMIS)

A claims processing and provider payment system that allows Vermont to maintain compliance with Federal and State regulations for administering Medicaid. The State processes over $1Billion in Medicaid claims annually and the claims information itself (e.g., the services an individual receives) provides care and case managers with the information they need do their jobs effectively.

In 2016 AHS "reset" the strategy for the MMIS Core Project - an initiative to replace the core MMIS system. Proposals for a modular, iterative approach to replacing the MMIS are forthcoming in the 2017 legislative session once CMS Funding Approval is received.

There are two key projects under the MMIS umbrella that are currently underway:

Pharmacy Benefit Management (PBM)

Represents clinical, operational, and business services that allow Vermont to meet the challenge of increasing pharmaceutical costs for consumers with a real solution. Vermont's PBM program is aimed at both reducing and controlling costs of drugs and providing the State with high quality, local pharmaceutical expertise. In FY2016, the PBM generated $15.3 million in savings thanks to improved operational efficiency.

Care Management

A set of activities intended to improve clinical patient care and reduce the need for services by helping patients and caregivers more effectively manage health conditions and issues impacting health and well-being.

The Enterprise Care Management System supports not only AHS care management staff but also hundreds of Vermont provider organizations engaged in direct care services. The Enterprise Care Management system offers some of the highest levels of sophistication in forecasting & analytics, and vastly improves Vermont's ability to utilize data to improve population-wide outcomes. The system will unite and integrate the Agency's related care management programs in a way that was never possible before.

Challenge & Opportunities

Outdated Technology

Challenge: It has been close to 40 years since the State has updated its Medicaid claims system (MMIS) and the system used to manage eligibility/enrollment and member's cases for many State programs (ACCESS).
Opportunity**:** The federal government assumes 90% of the cost of designing, developing and implementing new eligibility/enrollment and Medicaid management systems. CMS knows the value of updating these systems and they offer Vermont this opportunity because they realize that integrating health and human services using technology that actually meets today's needs will allow the State to control costs and achieve better outcomes.

Project Oversight

Challenge: The HSE projects are overseen by three external groups that employ three distinct oversight methods. These groups are: Internal Validation and Verification (IV&V), a federally mandated contracted vendor; the Department of Information and Innovation (DII), oversight of projects exceeding a certain dollar value as mandated by State law; and the Vermont Legislature's Independent Technology Consultant, who influences

many aspects of the Agency's work including the 10% funding required to obtain the 90% federal match for the HSE projects.
Opportunity**:** The HSE and Agency leadership is committed to helping the State use its resources effectively, including streamlining oversight activities between the legislature and DII.

Staying in Step with CMS
Challenge: The federal government continues to evolve its approach to Medicaid. In order to maintain or enhance the annual revenue generated by Medicaid, the State must continue to evolve its approach to administering all aspects of the Medicaid-funded programs.
Opportunity: The HSE PMO continues to develop an agile workforce who understands that our strategic direction must position us to ensure our systems meet evolving needs.

Budget
Although it is complex and nuanced, essentially we receive 90% of our funding from the federal government provided we supply a 10% match. This is known as the 90/10 match. Without this funding, Vermont would not be able to develop systems that meet regulatory, policy, and programmatic requirements, and our residents would be without the quality health and human services that state law and policy dictate.

In addition to the 90/10 match for new systems, the State also benefits from a 75/25 match rate for Maintenance & Operations (M&O) of new systems. This funding is only available if the State implements new systems. Legacy systems (many of the systems used today) receive a much lower match rate, and are subject to match rate discontinuation if they do not meet regulatory hurdles.

Finally, Vermont has a short time left to benefit from the federal "A-87 Exception" funding mechanism which allows a State to use 90/10 match funding for the improvement of non-Medicaid programs.

Key Dates & Decision Points
The HSE is building innovative solutions that will support the Agency for decades. The HSE has and will continue to span administrations. Each respective administration will represent many of the HSE's far-reaching successes, but none will represent the full life of these innovation projects. The HSE can only be successful if AHS has the opportunity to strategically execute projects without encumbrances related to political timelines.

As noted in the Budget section, the State is required to provide a portion of funding to "match" federal funding. The federal government distributes funding in two-year commitments. The State's portion of the funding is contingent on the discretion of the legislature and the direction of the Governor.

Legislation
HSE is not directly involved in supporting the creation of legislation. All work done by the HSE is directed by the "business areas" or State Agencies and Departments involved in each HSE project. However, due to the nature of the HSE projects, and the funding required to maintain them, HSE leadership is often asked to testify. In 2016, the HSE received formal approval from Senate & House Institutions for $5.4M in capital bill reservation for investment in the Integrated Eligibility & Enrollment program.

Operations Unit

This Unit is the overall operational arm for the Agency of Human Services. The Unit is comprised of individual entities that support the Secretary's Office and the Agency's departments and offices including facilities, emergency

management, personnel investigations, workforce and organizational development, performance improvement, security and the support for five boards. Operations is responsible for cross agency committees including merit, classification, policy, operations and safety.

Chief Operations Officer

The AHS COO oversees and supports five boards, the Workforce and Professional Development Director, the Performance Improvement Manager, the Emergency Management Director, the Administrative Services Director (space, leases, building issues), and the AHS Investigations Unit; facilitates cross-agency work groups such as merit, classification, policy, and safety, and oversees Agency personnel issues and safety and security issues. This position supports the Secretary and Deputy Secretary and provides coverage in their absence.

Since the death of a DCF social worker, the work of the AHS Safety Committee and the collaboration with BGS has been strengthened. Working together, AHS and BGS have prioritized improving safety and security across the state as well as fulfilling the obligations set forth in Act 109 (An act relating to safety policies for employees delivering direct social or mental health services). As a result of the opiate crisis and other factors, threats against AHS employees have increased dramatically, resulting in a high incidence of vicarious trauma in the workforce. It will be extremely important that AHS/BGS implement the proposed security plan in a timely manner.

Administrative Support for Five Boards

SerVermont

The Vermont Commission on National and Community Service, was established by Executive Order 05-98 on 11/30/93 by Governor Dean. SerVermont promotes, supports, and recognizes volunteerism and community service throughout Vermont. Vermont has held the #4 ranking for producing AmeriCorps members per capita for the past two years.

Vermont Developmental Disabilities Council

VTDDC is part of a network of state councils created by federal law. The Council partners with Vermont disability-related groups to move key legislation and policy initiatives forward and supports self-advocates and families to develop leadership and advocate for change.

Vermont Tobacco Evaluation and Review Board

VTERB is dedicated to a statewide comprehensive tobacco control program that continually and effectively reduces tobacco use prevalence to improve the health and well-being of Vermonters. VTERB ensures fiscal responsibility for the state appropriation dedicated to tobacco control, develops funding and programmatic recommendations and works with partner agencies to ensure the overall program meets long-term goals. The tobacco fund will sunset in 2018 and the tobacco control program will be maintained by the VT Department of Health.

Parole Board

The Vermont Parole Board is an independent entity that considers eligible offenders for parole, rendering just decisions by balancing victim needs, the risk to public safety, while promoting offender accountability success.

Human Services Board

The HSB is a citizen's panel consisting of seven members created by the legislature pursuant to 3 V.S.A., 3090. Its duties are to act as a fair hearing board for appeals brought by individuals who are aggrieved by decisions or policies of departments and programs within the Agency of Human Services.

Workforce and Professional Development

The director of organizational and human resource development fosters the development of an organizational culture of integration, performance accountability and continuous improvement through the design and development of programs

that support the Agency's strategic direction. The development and administration of integrated models of professional development align with the core vision, values and desired culture of the Agency.

This is a single incumbent working to meet the professional development needs of the largest Agency in state government. There are numerous unmet training needs for the Agency. AHS works with the Center for Achievement in Public Service but they do not have the resources to meet all of our needs. The lack of training resources presents an ongoing challenge.

Director of Emergency Management

The Director of Emergency Management is the primary AHS representative to the State Emergency Operations Center for State Support Functions including mass care, emergency assistance, housing and human services. The Director works closely with the American Red Cross (ARC) and coordinates with all AHS Departments, and the mental health designated agencies, to meet our responsibilities for all-hazards emergency response. The Director serves as the Vermont Individual Assistance (IA) Program Officer, coordinating all assistance to individuals and families impacted by local and statewide emergencies or disasters. During federally declared disasters, the IA Program Officer is the primary liaison with FEMA and local and state agencies, coordinating activities from preliminary damage assessments through recovery assistance. During disaster recovery, the Director of Emergency Management chairs the Individual and Family Needs Recovery Task Force, which includes state agencies and private relief organizations, such as the ARC and VOAD (Voluntary Organizations Active in Disasters).

The Director of Emergency Management position in AHS has been instrumental in developing closer relationships with FEMA, DEMHS, ARC and VOAD to put AHS in a better position to provide needed comprehensive social services during all-hazard emergency events. As the Vermont State Coordinator for the U.S. Repatriation Program, the Emergency Management Director also coordinates the AHS response for citizens being repatriated to Vermont by arranging temporary financial assistance, medical care, counseling, temporary shelter, transportation, and other goods and services necessary for the health or welfare of the returning individuals.

Administrative Services Director

AHS occupies over 1.2 million sf in State owned space as well as 45 leases statewide. This position includes space planning, design, fit-ups, moves, coordination of renovations and alterations; working collaboratively with BGS, telecommunications and landlords.

AHS Investigations Unit

The three person investigations unit ensures the timely completion of misconduct investigations, child abuse and neglect conflict investigations, adult protective services conflict investigations, HRC complaint investigations and critical incident reviews.

Performance Improvement Manager

The PIM works to develop, administer, coordinate and monitor a performance improvement system in coordination with the AHS strategic plan, the Governor's strategic plan and Act 186. This position manages a monitoring system to evaluate performance across the Agency, identifies areas for performance improvement, strengthens performance measures, maintains a public dashboard for population data/information and performance data/information, and serves as liaison and representative of RBA and performance accountability to internal work groups, external organizations, the Vermont Legislature, and the state Chief Performance Officer.

Policy & Program Integration

Director of Policy and Program Integration

Direction of policy and planning efforts across the Agency of Human Services and its six departments. This work involves a wide range of complex policy initiatives across the spectrum of health and human services. The Director ensures a coordinated and integrated approach to policy development, vetting and implementation across the six distinct departments and within the AHS Secretary's Office. The Director oversees Field Services, the Housing Program and the Refugee Program.

Field Services

Field Service Directors represent the AHS Secretary in the field and lead AHS strategic initiatives in the district. Field Services Directors blend the AHS mission into the unique needs and cultures of Vermont's communities to inform local and systems level change. The work of the Field Services Directors has been focused on implementing the AHS Strategic Plan at the district level, facilitation of the Integrating Family Services model in the Districts, assisting to develop warming shelters and other General Assistance alternatives and supporting complex clients in the district through Local Interagency team meetings (LIT) and Housing Review Teams (HRT). . They provide leadership, support and direction to address gaps in systems, resources and services and facilitate problem solving strategies to ensure people have access to services and systems.

Field Service Directors also contribute to the creation of positive climates in AHS districts so staff members feel safe and supported. Field Service Directors have recently entered into an agreement with AmeriCorps and are supervising VISTA volunteers. Field Service Directors have been reduced from 12 to seven over the years and now cover more than one district. In addition, Field Service flexible funding was reduced by half last year. This funding goes to the neediest people and families who don't have another source of funding. Field Service Directors are supervised by the Director of Policy and Program Integration Some examples of current work include:

Trauma

Trauma work has continued in the Agency through the Child and Family Trauma Work Group (CFTWG), a collection of staff from across the Agency along with partners that meets monthly to address the trauma services provided to AHS staff and customer. AHS hopes to revive the Trauma Coordinator position that existed in 2009 or at least resource, focus, build upon the previous work and the current work of CFTWG. This work would include finalizing and implementing the new AHS trauma policy across departments, coordinate trauma-related work such as domestic and sexual violence, human trafficking and create a trauma-informed Agency through staff wellness, training, supervision, and support.

Workforce Development Team

A group of stakeholders from VDOL, the Agency of Commerce and Community Development (ACCD) and AHS have been meeting monthly to respond to the projects outlined by the Governor's Retreat in August 2015 aimed at addressing workforce development and financial capability for people in poverty. Efforts are underway to connect post-secondary education to Reach up and Corrections clients through collaboration with the Community College of Vermont (CCV) and Vermont State College. The plan is to expand this work to include other Vermont colleges and universities. Other projects include creation of the Vermont Employment Opportunity Program and using behavioral economics to create employment incentives. This group is also looking to initiate an AHS wide-employment policy that is endorsed by each department. The policy will create uniform practices to ensure that AHS is doing its part to get people with low-incomes back to work.

Seriously Functionally Impaired (SFI)

Serious functional impairment means:

(A) a disorder of thought, mood, perception, orientation, or memory, as diagnosed by a qualified mental health professional, which substantially impairs judgment, behavior, capacity to recognize reality, or ability to meet the ordinary demands of life and **which substantially impairs the ability to function within the correctional setting**; or

(B) a developmental disability, traumatic brain injury or other organic brain disorder, or various forms of dementia or other neurological disorders, as diagnosed by a qualified mental health professional, **which substantially impairs the ability to function in the correctional setting**."

The Charge to AHS from Act 87

"For the purpose of identifying and assessing the needs of individuals with a serious functional impairment…..who are incarcerated in a correctional facility, the secretary of human services shall establish….a work group…. The work group shall:

(1) **determine whether individuals with SFI are receiving appropriate programs and services** while incarcerated…..;
(2) **consult with members of the criminal justice community on ways to prevent initial incarceration and on ways to limit the length of incarceration** for an individual with a serious functional impairment, as appropriate;
(3) **work toward the successful reintegration into the community** of an individual with serious functional impairment who has been incarcerated in a correctional facility:
(4) **work towards reducing the recidivism rate** among individuals with a serious functional impairment; and
(5) **make long-term, systemic policy recommendations** to the secretary of human services to create or improve mechanisms, programs, and services that benefit individuals with a serious functional impairment incarcerated in a correctional facility."

The SFI State Team meets monthly working to align itself with Act 87 and to support the local district Interagency Teams in planning for transition back to the community for Corrections clients with the(SFI) designation.

Successes

People with Disabilities Employment Program

This AHS Workforce Development Group successfully designed an initiative to make the State of Vermont a leader in employing people with disabilities. The Governor signed an Executive Order leading to a process and work plan that will increase over time the number of state employees with disabilities

AHS Trauma Policy

This policy has been drafted to recognize the role trauma plays both in the lives of the clients served by AHS staff, as well in the lives of staff. It also outlines the importance of creating a trauma-informed Agency that responds to the needs of clients and the organization itself.

Community Profiles

The Agency has developed a sustainable way to develop and utilize Community Profiles. Community Profiles are a district level data- driven portrait and "one stop shop" for key indicators in communities. They will help communities collaborate to improve outcomes and help AHS leaders and policymakers communicate and make decisions based on geographic disparities in well-being.

Challenges

Funding

Although there is no funding for new initiatives we continue to find ways to improve our services through existing avenues.

Staff Resources in the Central Office

Staff resources are stretched very thin and it is difficult to initiate and implement new initiatives.

Opportunities

Policy and Planning Group at AHS Central Office

Organizing existing staff and resources into AHS Policy & Planning Group (PPG) will provide a tool of governance to recognize opportunities, manage risks, & develop options that: Support "One Agency" approach; Align policy, outcome, and performance; Set goals and strategy based on needs, strengths, and resources; Manage risk and budgets; Manage and improve performance transparently; Design agency program and process.

Pay for Success – Social Impact Bonds

In the fall of 2015, staff from across departments within AHS and from the Office of the Secretary met with the Harvard Kennedy School Government Performance Lab (GPL) to consider if GPL technical assistance could support the expansion or improvement of a key area of AHS service delivery, potentially through a Pay for Success project[i]. AHS decided to move forward with GPL technical assistance and use the late fall and early winter to vet ideas for projects from leaders within the agency while also learning more about the PFS approach and its fit for the agency's priorities. AHS has chosen nurse home visiting as a project to analyze for feasibility and is working with VDH and CDD on this potential model.

Emergency Response to Homelessness

Coordinating within AHS and with external like the Red Cross to set up emergency beds in extreme cold weather. Staffing will include AmeriCorps volunteers through SerVermont and the Department of Mental Health's Medical Reserve Corps.

Working Landscapes Initiative

Federal Reserve Initiative in New England states to boost employment activities through funding. AHS is representative on the New England Federal Reserve Advisory Committee.

Intra-Agency or Interdepartmental Items

Duplication of Services

Ensure that we are not funding the similar services in each of the departments. See 2015 and 2016 Legislative Reports on Duplication of Services.

Teaming and Coordination

Ensure that individuals and families get coordinated care from multiple programs and departments in the Agency.

Release of Information

Ensure there is a process for sharing information among multiple AHS departments and partner organizations.

Key Dates and Decision Points

The Director of Policy and Integration is the legislative liaison for the agency. Activities and dates on the State of Vermont Legislative Website should be followed. In addition, there is a spreadsheet posted on SharePoint with duedates for the legislative reports and the legislation enabling those reports. Each year we prepare for the legislative session beginning in the Summer when departments build legislative initiatives and begin to prepare reports. The draft legislative initiatives are due in September to the Director Policy and Program Integration and final initiatives are presented to the Secretary in October. Also, in October legislative initiatives are presented to the Governor's Office and in November - legislative initiatives are presented to key legislators. Please refer to SharePoint site with the Agencies legislative initiatives and reports.

External Groups and organizations

The Director of Policy and Integration works with the range of groups and organizations across the Agency including, at times, the boards that AHS oversees. In particular, the Director regularly attends the meetings at the Child Poverty Council, Governor's Poverty Council, Early Learning Challenge Team, Building Bright Futures, the Blue Ribbon Commission and the Community Development Advisory Council for the New England Federal Reserve.

Financial Commission

The Director of Policy and Integration works with the Vermont Financial Literacy Commission so the Commission and AHS initiatives can be aligned. The commission was created by the State Legislature in 2015. The 12-member commission was established to measurably improve the financial literacy and financial capability of Vermont's citizens. Current initiatives include support for Children's Educational Savings Accounts and raising the asset limit for public programs. Click here for Enabling legislation.

Blue Ribbon Commission

The Director of Policy and Program Integration for AHS is a Commissioner on the Blue Ribbon Commission (BRC). The BRC is charged with recommendations regarding financing "equal access to high quality child care" in the state. After a series of data collection, research presentation from subject matter experts and discussions, the BRC seeks to begin discussion regarding financing with the total cost of funding high quality child care system in the state for all children birth to five. The BRC Report is due in November 2016.

Governor's Council on Pathways from Poverty

The Secretary or her/his representative sits on this Council. The Council is the advisory to the Governor and its responsibilities include, determining the nature and primary causes of poverty in Vermont; reviewing the extent to which public and private agencies are addressing poverty in Vermont; and making recommendations on action that should be taken to respond to poverty in Vermont, including actions taken by: federal government, state government, local government, private non-profit agencies and programs, charities, business and industry.

Vermont Child Poverty Council

The Secretary or her/his representative sits on this Council. The Vermont Child Poverty Council was established in 2007 to address child poverty in Vermont. The Council helps advance the poverty-reduction recommendations outlined in the Council's 2009 report, Improving the Odds for Kids. View the Council's Annual Progress Report (January 2015) here.

Federal Reserve Community Development Advisory Committee

The Director of Policy and Integration is the Vermont representative. Provides Vermont economic information to the Reserve particularly as in regards to low income communities in Vermont. Meets every other month in Boston.

Housing

AHS Director of Housing: Angus Chaney

Key Initiatives

Ending Family Homelessness 2020

In early 2015, AHS launched a comprehensive strategy to rapidly reduce homelessness in Vermont, particularly among families with children. AHS is coordinating multiple cross-department and cross-agency activities under this initiative all of which focus on better coordination of services, rental subsidies and access to housing among people in housing crises.

15% Goal for Housing the Homeless

A year into the Ending Family Homelessness initiative, Governor Shumlin established a goal that publicly-funded housing organizations make 15% of their rental units available to people coming from homelessness. While initially controversial, most housing partners are now on board and we have strong support from federal partners including HUD, USDA-RD and the US Interagency Council on Homelessness. AHS is working closely with ACCD-DHCD to implement this goal and refine reporting.

Medicaid Expansion of Family Supportive Housing

After seeing strong outcomes in five pilot communities, AHS is expanding its Family Supportive Housing (FSH) program to additional regions in SFY '17 through drawing down federal Medicaid funds for eligible case management services. The FSH program provides intensive support services to families with multiple challenges as they transition from homelessness to stable housing. FSH staff assist in finding housing and then stay with a family, providing customized services on-site for an average of 24 months.

Successes

Decline of homelessness in Vermont

For the second year in a row, the rate of homelessness has declined in Vermont. Data from the annual point in time count indicated a 28% decline in the number of homeless Vermont children in 2016, and a 22% decline in the number of homeless families with at least one child. These data reflect the lowest statewide rate of homelessness in our state for the past five years.

New incentives to increase housing access

Working with our external housing partners, AHS has spurred and strengthened incentives to serve and house people experiencing homelessness as well as other vulnerable populations. This was done through Vermont's Qualified Allocation Plan (QAP), set-asides for supportive housing, and new subsidy preferences with the Vermont State Housing Authority.

New partnerships involving housing and health care

UVM Medical Center has formed an active partnership with the Champlain Housing Trust to develop transitional and permanent housing for people who are chronically homeless and were often frequent users of emergency resources. Models such as Harbor Place and Beacon Apartments are being looked at by other communities and health care organizations as possibilities for replication.

Greater coordination of departmental housing programs

The Secretary's office has improved coordination of AHS housing efforts through an AHS Housing Task Force, an AHS Housing Policy, and adoption of common outcome measures across depts.

Vermont Rental Subsidy Program

Vermont launched and continues to manage a successful state-funded rental subsidy program which has demonstrated effectiveness at moving people from shelter and emergency motels to stable, affordable housing. The program provides affordable housing for one year at a cost comparable to the traditional 84 days in a motel.

Collaboration between DCF and DV Programs

DCF is working closely with local domestic violence agencies in three districts to coordinate access to shelter & services for people made homeless by domestic violence. It is hoped such collaborations – which also reduce expenditures - can grow to additional districts.

Challenges

- Inadequate supply of rental housing affordable and accessible to AHS clients.
- Inadequate emergency shelter bed capacity and some fragile NP organizations.
- Onerous reporting requirements – particularly HUD - which increase cost each year.
- Strong local opposition in some communities to siting of affordable housing, transitional housing or emergency shelter capacity.

Opportunities

- Medicaid guidance. Shifting some portion of eligible housing case management costs from state GF to federal Medicaid.

- Coordinated Entry and Assessment: Common assessments and provider agreements to better coordinate how homeless Vermonters access services and programs.
- National Housing Trust Fund - $3M for Vermont.
- Likelihood that new federal resources and programming will align with our state goal of ending family homelessness by 2020.

Intra-Agency or Inter-Departmental Items

1) Ending Family Homelessness 2020
2) AHS Housing Task Force: coordinates housing programs, policies & special projects across AHS
3) AHS Common Housing Outcomes
4) Exploring collaboration between DOC, DMH and VFH/ADAP to identify and target supportive housing to users of institutions who have experienced multiple episodes of homelessness.

Inter-Agency Items

1) Ending Family Homelessness 2020 (*outlined above*)
2) ACCD/DHCD funding a rental repair pilot as part of the Ending Family Homelessness initiative.
3) AHS is working closely with Agency of Education's McKinney Vento Homeless Coordinator to offer shared training for schools and local organizations around homelessness.
4) 15% Housing for the Homeless Goal (*outlined above*)

Key Dates and Decision Points

Vermont has set 2020 as a target to have ended homelessness among children and families. AHS' strategic plan identifies additional benchmarks over the next three years.

Legislation

Homeless Bill of Rights

Legislators may re-introduce legislation this session creating new protections for people experiencing homelessness. This builds on existing federal and state fair housing protections. AHS is not averse to the concept but neither feels we should lead on it.

General Assistance

DCF desires technical/housekeeping edits to the General Assistance statute to reduce interpretation issues and codify what has become effective practice through pilots, waiver authority and session law. No substantive changes to practice are envisioned.

External Group and Organizations

AHS Housing works closely with external partners who finance, develop and manage affordable housing, including the Vermont Housing Finance Agency and Vermont State Housing Authority. The Housing Director represents the AHS Secretary on the Vermont Housing and Conservation Board, is appointed to Vermont's Joint Committee on Tax Credits (which governs allocation of tax credits for affordable housing development), and is a member of the Vermont Community Development Board and Consolidated Plan Advisory Group. He chairs the Governor's Interagency Council on Homelessness.

Other Topics

Global Commitment (GC)

Multiple AHS housing programs are supported with some portion of GC funding through Vermont's 1115 waiver. Successful re-negotiation of the waiver is key to sustainability of these activities which keep vulnerable Vermonters housed in the community.

SASH Sustainability

Continued federal support for the Support and Services at Home (SASH) program is likely to remain an area of interest. Evaluation shows some promising initial outcomes but the initiative requires a costly infrastructure to maintain.

Refugee Office

Director, Refugee Office and State Refugee Coordinator: Denise Lamoureux

Key initiatives

Develop and maintain a program that leads to economic self-sufficiency and integration of newly arrived refugees in Vermont through:

- Producing and updating the Vermont State Plan for Refugee Resettlement
- Coordination of refugee resources
- Managing federal grants and sub-grants to local providers for refugee services
- Chairing the Refugee and Immigrant Service Providers Network

Successes

- Comprehensive network of Chittenden County service providers, who provide a wide range of culturally appropriate services to new refugee arrivals
- Supportive community who views refugee resettlement as an asset and a good humanitarian program

Challenges

- Pressure of increasing number of arrivals vs diminishing funding and capacity of communities.
- New proposed site to absorb increase in numbers. Rutland has been proposed by the Voluntary Agency (Volag) and opinions run strong on both sides, leading to high profile media coverage
- If a discretionary grant is not approved and Rutland goes forward, it will be a challenge to provide essential services needed for successful resettlement

Opportunities

- If Rutland happens and discretionary grant is successful, the new site could bring positive developments to Rutland.
- Physical distance of new site and limited staff capacity at the State and Volag level could make implementation more difficult.

Intra-Agency or Inter-Departmental Items

Coordination of services and public benefits to new arrivals (Health, TANF/Reach Up, SNAP/3SquaresVT, WIC, Mental Health, employment, elders, etc.).

State government serving a diverse population in a culturally appropriate fashion

Key Dates and Decision Points

Because it is entirely federally funded, the program and budget run on the federal fiscal year. Department of State decision on the new site is expected in September for a start in October.

External Group and Organizations

Localities, school districts, non-profit social agencies, employers, the community in general and the media

General Information

In general, Vermonters are very supportive of the refugee program and have high expectations for the services provided to them, sometimes higher than what the federal program provides. This is a small program but the administrative structure is very complex and often, the decisions not at the state level.

Integrating Family Services

Integrating Family Services is overseen by the Deputy Secretary of AHS

IFS Vision

Vermonters work together to ensure all children, youth and families have the resources they need to reach their fullest potential.

Overview and Approach

IFS propels individuals, organizations and systems to work together more collaboratively, use resources more flexibly, and make supports and services more family-friendly so children, youth and families are better off as a result of their interaction with AHS and its community partners.

A priority of the Agency of Human Services is to create an Agency of One; a system in which Vermonters who need services can receive them with a complete and coordinated plan that works for the entire family. Integrating Family Services (IFS) is how we describe the set of strategies being employed to achieve this goal. Working alongside ***Medicaid Pathways***, IFS is focused on promoting and sustaining collaborative leadership and decision making, among other areas of focus. These efforts are taking place both internally and in our AHS regions, and tie together AHS providers focused on the social determinants of health. Medicaid Pathways is the larger Administration and Agency initiative to create integrated, accountable, and value-based payments for Medicaid services.

The initial IFS implementation site in Addison County is in its fifth fiscal year, and the second pilot region in Franklin/ Grand Isle counties celebrated its second anniversary on April 1, 2016. The initial pilot included consolidation of over 30 state and federal funding streams through one master grant agreement. The second pilot also includes consolidation of multiple state and federal funding streams. This has created a seamless system of care to help ensure there is no duplication of services for children and families.

Key Role Within AHS

The ***IFS Management Team is a team of three individuals*** in central office that is working closely with existing and "pre-IFS" regions, AHS Field Service staff and AHS leadership to build a state and regional collaborative leadership and decision making infrastructure. Translating the IFS model into practice provides leaders within AHS and in IFS communities an unprecedented opportunity to "connect the dots" in terms of more efficient and effective delivery of state and federally funded human services.

The IFS model requires high levels of communication and collaboration. Several internal teams meet regularly with the IFS Management Team to help assure the various Divisions within the Agency work together to move the Agency's integration agenda forward as it relates to children and families. These IFS teams are integral to the change process, as they represent the Agency's diverse perspectives, and assure proposed integration efforts make sense, and take into consideration resource constraints, internal priorities, federal and state mandates, and other practicalities.

IFS Initiatives

As the diagram below depicts, IFS is leading discussions and decision making regarding a number of AHS priorities. These areas of focus include:

- Establishing inclusive and robust regional collaborative leadership and decision making processes
- Growing the awareness of and focus on the Strengthening Families™ Framework
- Articulating and embedding two-generational approaches
- Implementing trauma-informed policies and practices
- Enhancing service coordination through improved teaming
- Building a stronger partnership between AHS and youth and families
- Developing a conflict-resilient agency so conflict leads to positive outcomes rather than setbacks in policy development or inter-personal relationships

Focus Going Forward: Expansion and Related Goals

Five additional AHS regions are actively working toward becoming "IFS-ready" in FY17: Bennington, Brattleboro, St. Johnsbury, Springfield, and Washington. These regions are creating formal collaborative relationships and decision making processes. Becoming an IFS region means that as a group of state and community providers, the region:

- Has an operating agreement that includes details such as who has a seat at the table, and how youth and family voice will be included in its decision making;
- Commits its combined and collective resources through an annual work plan intended to bend the curve on the IFS population indicators, and reports annually to the state on its impact on those indicators;
- Responds to state surveys on the functioning of the leadership team;
- Creates a supportive and respectful environment for each member of the regional team to share performance level data on an annual basis; and
- Demonstrates how resources are consolidated and shared to improve services for children and families.

Successes

IFS pilot regions are showing promising results in its pilot regions; due in large part to the payment and service delivery system reforms enabled by IFS. The early successes of these two pilots include:

- Increased service hours overall, increased number of people served, and simultaneous reduction in requests for children's mental health crisis services.
- Stable trend line for children entering the state's custody in the Addison pilot region (while at the same time the state overall has experienced a 30% increase in children coming into DCF custody).
- Increased ability to provide the right services to children and their families more immediately.
- Increased ability to provide services in a child's natural setting.
- Increased ability to work with a variety of providers and bring resources together to support families.
- Reduction in separate and conflicting paperwork for the Designated Agencies, having a positive impact on the number of hours clinicians can spend on direct services.
- 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.
- Increased staff morale at the two Designated Agencies that are IFS grantees.

Opportunities

IFS continues to work on statewide health care and human services reform by aligning approaches to achieve an integrated behavioral and physical health system and payment systems that focus on quality and outcomes.

Some examples of how IFS is working to align approaches include:

Reducing reliance on residential care

IFS is engaged in a statewide effort to look more effectively at how Vermont can increase the number of children and youth in family settings as opposed to residential treatment.

Reinvigorating Act 264

The IFS Director is the facilitator of the State Interagency Team and supporting the coordination of services to children and youth with complex needs as mandated in Act 264.

Initiating Teaming Pilots

IFS is spearheading a teaming pilot in two regions in Vermont to support departments to better support families who have complex needs and that are accessing services through a number of providers (e.g., child welfare, economic services, corrections, substance abuse, early childhood).

Coordinating Autism Services

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

Healthcare Operations, Policy & Compliance

The AHS Health Care Operations, Policy and Compliance Unit oversees activities pertaining to Medicaid and associated healthcare operations. It is responsible for integrated planning, policy development, regulatory compliance and funding. These initiatives require cross-departmental (and intra-governmental) operations for successful implementation and outcomes.

Activities include but are not limited to:

- Federal negotiations relative to changes in the AHS Medicaid structure
- Oversight of the AHS Department policy and operations of the Vermont Global Commitment to Health Medicaid Waiver and Medicaid State Plan
- Quality assurance, improvement and performance measurement of program activities and providing technical assistance to departments
- The Medicaid Pathway, including Integrating Family Services, is a major initiative of the Secretary's Office to address the fragmented and overlapping programming across departments administering healthcare programming

Key Initiatives

Global Commitment to Health Section 1115 Medicaid Demonstration Waiver

The Global Commitment (GC) is a Section 1115 Demonstration Waiver approved by CMS as an alternative service delivery model in the Medicaid Program. This is a very unique Demonstration that includes the Choices for Care program (a former standalone 1115 consolidated with the GC in 2015) and has received national attention and accolades. The GC utilizes a Managed Care-like approach to deliver both traditional and expanded services to our Medicaid populations. Choices for Care allows home and community based services to share an equal Medicaid entitlement as nursing home care and seeks to offer older Vermonters and persons with disabilities a choice about where they receive their long term care.

Fundamental Goals of the GC Waiver:

1) Increase access to health care coverage
2) Cost containment (HCBS often less costly then Nursing Home)

3) Quality services
4) Consumer Choice
5) Quality

The Waiver is expected to be renewed for 5 years: 1/1/2017 through 12/31/2021. The 2017 renewal is still under negotiation as of the drafting of this document. Areas of expected impact will be detailed further below in this section and in the Budget section II above.

Under the Special Terms and Conditions (STC) of the Waiver, AHS operates the Vermont Medicaid program using a Managed Care-like approach. This requires that the AHS Central Office (the Medicaid "Single State Agency") retain oversight and direction of the waiver operations while "contracting" with AHS departments through Inter-Governmental Agreements (IGA) for service delivery. AHS, using a per member per month approach, provides a monthly capitation payment to DVHA and AHS oversees the annual, CMS approved, IGA terms with DVHA. DVHA in turn maintains IGA's with DAIL, DCF, DMH, VDH, DOC and AOE relative to their Medicaid operations under the Managed Care-like model.

Investments

Through the GC STCs, CMS provides AHS with expenditure authority to fund investments in overall health care system. Historically, this category was limited by the extent of excess capitation revenue from the AHS to DVHA PMPM payment (after all traditional Medicaid obligations are paid for). The 2017 STCs propose to de-couple the limit on total funds available for Investments from the annual PMPM calculation and sets a hard annual limit in the amount of $140,496,966. Investment funding appears in all AHS programs and across state government.

CMS has approved four categories of investments:

1) Reduced rate of uninsured or underinsured
2) Increase access to quality health care for Medicaid beneficiaries
3) Use public health approaches to improve outcomes for Medicaid beneficiaries
4) Promote public private partnerships in health care

Special Terms and Conditions of the 2017 Renewal

Multiple items are still under negotiation as of the drafting of this document. Categories currently under negotiation include:

- CMS proposal to cap investments at $140,496,966.
- Establishing guardrails for <u>new</u> MCO Investments to ensure that these dollars are not spent on unallowable items, such as room and board, school based services, bricks and mortar, HIT/HIE, and IMDs.
- Phasing out <u>current investments</u> on items that will be unallowable in the new waiver. This is estimated to be $64 million over the next 10 years. We are actively negotiating the timing of the phase out.
- Alternative funding sources for "in lieu of services" which are services that are provided in a private managed care contract in lieu of state plan services. There are $13.7M in these types of expenditures. It's not yet clear how much can be moved to an alternative source
- Using Administrative match rates for administrative expenditures (see Budget section II) instead of managed care match rates. This has a fiscal impact of $3.6M GF in FY17 and $7.2 M GF in FY18. CMS just indicated that admin rates will also apply to Investments.
- Increased oversight and approvals. These changes need to be analyzed to determine staffing and contractor needs for the new compliance tasks and could have a fiscal impact.
    - Examples of approvals include:
        - Submitting annual PMPM rates for CMS approval.
        - Submitting annual AHS/IGA terms for CMS approval.

- Calculation/submission of an Medical Loss Ration (MLR (not to include Investments).
- Annual submission of alternative payment models (Value Based Purchasing and certain bundled rates) for approval to the managed care group at CMCS – this requires a minimum 90-day time period and prior approval before implementation. Details of this requirement still in negotiation. Could impact long standing payment arrangements.
- Notice prior to implementation for new investments with some investments requiring prior approval. The details are in clearance, so we do not have the information yet.

- Other operational modifications to meet the new Medicaid managed care rule requirements.

  See section c. for perceived challenges of operationalizing CMS required Waiver changes.

Medicaid Pathway and the All-Payer Model

Vermont is actively negotiating an "All Payer Model" agreement between the State and the federal government to target a sustainable rate of growth for health care spending in Vermont across Medicaid, Medicare, and commercial payers. The All Payer Model is based on an ACO delivery system using Medicare's Next Generation Accountable Care Organization (ACO) model.

If implemented, this model will focus on a set of health care services roughly equivalent to Medicare Parts A and B (hospital and physician services) that are currently delivery through the Department of Vermont Health Access; it would also include strict quality and performance measurement.

Medicaid Pathway

The ACO-focused delivery reform must begin to integrate over time with community based providers in Vermont and address the social determinates of health in order to realize a fully organized and accountable system of care.

The Vermont Medicaid Pathway (VMP) advances payment and delivery system reform for services not included in the initial implementation of Vermont's All Payer Model, including Disability and Long-Term Services and Supports (DLTSS), mental health, and substance abuse treatment.

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

The Medicaid Pathway Work is currently supported out of Vermont Health Care Innovation Project (VHCIP) by three contractors at about $2M annually and several VHCIP staff and has a funding expiration date of 7/1/17. Work on the VMP is slated to continue over the next 5 years in tandem with the All Payer Model Agreement. Departments currently involved in VMP efforts primarily include DMH, VDH-ADAP and DAIL. DVHA and DCF will have greater involvement in future phases of planning.

AHS has identified goals for care delivery, payment model and quality framework, and administration. These goals mirror the stated goals of Vermont's Designated and Specialized Service Agencies, which include payments that allow for flexible service delivery and are rational and predictable that support provider financial health, as well as administrative simplification.

Care Delivery Goals

1) Support primary and secondary prevention, including early intervention to reduce risk factors.
2) Support flexibility to allow individuals and providers to decide on necessary services based on a person's unique treatment and/or support plan needs and social determinants of health, including use of home- and community-based services.
3) Foster integrated service delivery for Medicaid beneficiaries across the care continuum.

Payment Model and Quality Framework Goals

1) Expressly move from fee-for-service payments to population-based payments, increasing accountability and risk to impacted providers.
2) Incentivize high quality, efficient services and reduce incentive for high service volume.
3) Increase flexibility in payment to support more efficient delivery of services.
4) Reduce payment silos and fragmentation across provider and service types.
5) Connect payments with quality in service delivery and health of Medicaid beneficiaries.
6) Align measurement and reporting with values, principles and goals.
7) Provide data and feedback to providers delivering care to support accountability for quality and cost.

Administrative Goals

1) Create a foundation for program oversight, provider monitoring, provider reporting, corrective action and quality improvement planning that assesses accountability for delivering contracted services; appropriateness of care based on best practice and State standards; and outcomes.
2) Reduce administrative burden to providers and the AHS.
3) Standardize payment structure and quality measurement for similar services across AHS.
4) Allow for seamless oversight and monitoring across AHS.
5) Improve data collection to support future policymaking.
6) Transition payments in a manner that is operationally feasible for both the State and providers.

See section c. on challenges associated with VMP continued implementation efforts.

Successes

Global Commitment to Health Section 1115 Medicaid Demonstration Waiver

With the flexibility granted under the public managed care model, Vermont has demonstrated success and will continue to use innovative approaches to improve the health care delivery system and enhance positive health outcomes. Demonstration successes are summarized below.

Access to Health Care

The Demonstration extends coverage to approximately thirty percent of Vermont's population and Vermont's uninsured rate is among the lowest in the country and has declined from 11.4 percent in 2005 to approximately 5 percent in 2014. The program has experienced positive trends in access-to-care measures, such as well-child visits and adult access to preventive care.

In 2014, Vermont implemented the "Hub and Spoke" Initiative to enhance access to medication-assisted treatment for opioid dependence. The initiative includes regional treatment centers (i.e., Hubs) along with community support (i.e., Spokes) integrated with the Blueprint for Health model (described below) and office-based practices statewide.

In 2011, Tropical Storm Irene caused the abrupt closure of Vermont's only state-run psychiatric hospital. In addition to development of new inpatient hospital capacity, the State made significant investments in the community mental health system. Vermont has continued to enhance the mental health system to reduce its reliance on institutional care. Small-scale psychiatric centers, enhanced mobile crisis teams, peer-run recovery options, and hospital diversion programs have been supported as the State continues to promote a more person- centered, flexible, and community-based system of care.

Enhanced Quality of Care and Improved Health Care Delivery for Individuals with Chronic Care Needs

Under the managed care model, Vermont monitors its compliance with the managed care quality-of-care standards. Vermont has consistently improved compliance, scoring one-hundred percent compliant with all

CMS measurement and improvement standards in 2014. Vermont also has undertaken performance improvement projects and has received a score of one-hundred percent for applicable evaluation elements.

Under the Demonstration, Vermont implemented the Vermont Chronic Care Initiative (VCCI) to improve health outcomes for Medicaid beneficiaries by addressing the increasing prevalence of chronic illness. VCCI has made improvements in health outcomes for Vermont's highest-risk Medicaid beneficiaries.

Medicaid is an active partner in Vermont's Blueprint for Health, described in Vermont statute as "a program for integrating a system of health care for patients, improving the health of the overall population, and improving control over health care costs by promoting health maintenance, prevention, and care coordination and management" (18 VSA Chapter 13). In 2014 Blueprint participants had lower hospitalization rates and lower expenditures on pharmacy and specialty care. Vermont has worked to integrate its children's and family services programs. The Integrating Family Services (IFS) Program employs an innovative payment approach and performance standards to unify several, disparate Medicaid programs into a single payment and delivery system. In FFY14, a district with a fully implemented IFS program showed positive outcomes for clients and more efficient service delivery with the same level of funding providers received in previous years. Through promotion of early intervention and prevention, the district reduced crisis intervention services by nearly fifty percent.

Containment of Program Costs

The Demonstration has contained spending while adding significant quality and value to the health care system. Demonstration expenditures are well below the anticipated expenditures as expressed by the Demonstration's aggregate budget neutrality limit. In State Fiscal Year (SFY) 2013, the Vermont Chronic Care Initiative (VCCI) documented net savings of $23.5 million over anticipated expense among the top 5% of eligible Medicaid members (high utilizers). Vermont's Blueprint for Health has reduced the annual growth rate in health care expenditures for Blueprint participants. In addition, Vermont's multi-payer, shared savings program has demonstrated savings under the Demonstration.

Choice in Long-Term Services and Supports

The Demonstration has enabled Vermont to address and eliminate the bias toward institutional care and offer cost-effective, community based services. The proportion of Choices for Care participants served in the community has passed fifty percent and continues to increase. In addition, Vermont no longer has a waiting list for individuals seeking long term services and supports.

Challenges

Resources to Support Central Medicaid Operations

The AHS Central Office is the Vermont Medicaid "Single State Agency" and has responsibility for integrated planning, policy development, regulatory compliance and funding in Medicaid. These responsibilities require cross-departmental (and intra-governmental) operations for successful implementation and outcomes. Staffing at the Central Office is currently augmented by multiple short-term contracts and positions through VHCIP. AHS expects multiple continuing and new needs for staff and contractor resources over the next biennium due to pressures of compliance with new Waiver expectations and sustaining health reform initiatives of the Agency.

Health reform initiatives are currently supported through the leadership of the Health Care Ops & Policy Director, 3 contracts and several limited service staff. Existing staff. Activities through Medicaid Pathway are expected to be implemented throughout the term of the 5 year APM Waiver. Current contracts and staffing should see the state through initial planning and development needs of 2016 and early 2017, however, current state staffing will not be adequate to support ongoing development and implementation requirements. Current estimates are that 4 FTE at roughly $500K will be required. Given the phased in approach of Medicaid Pathway reforms, some development costs will continue through the second and third years of the initiative. Staffing estimates focus on supports for Quality, Payment, Policy and Data Analytics.

Global Commitment Waiver Operations and Policy are supported through 1 contract ($500K through DVHA) and a team of 10 FTE (1 Compliance/Quality, 8 Policy and 1 Overall Director also responsible for federal negotiations and healthcare reform initiatives above). Current estimates are that at least 2 FTE are necessary to additionally satisfy CMS compliance and policy oversight processes.

Health reform internal politics

Health reform initiatives require that participants think critically regarding necessary changes to get from the current state to future, desired state operations. Impacts to staffing, work flow, work products and overall business architecture are often anxiety producing and can result in resistance, entrenchment and fear. Alternatively, others will see these initiatives as promising opportunities to redesign and do our work better.

The new administration should expect near term conversations regarding departmental participation in reforms including timing and design. Additionally, the secretary's office will be required to consider best staffing and structure to support the changes desired (see section 2, above).

Opportunities

Substance Use Disorder (SUD) Demonstration Authority

Global Commitment Waiver Amendment. One positive outcome of GC Waiver negotiations is that CMS and Vermont are aligned on desired improvements for the SUD continuum of care. Vermont has committed to seeking a GC Waiver Amendment that would add formal approval for Vermont to move forward on continuum planning in its Substance Abuse Treatment Services (SATS).

This represents a great opportunity for Vermont to integrate and improve often siloed SATS programming and fits well within current health care reform initiatives and planning. AHS Secretary's Office and VDH- ADAP are partnering and will need to find a bill sponsor to authorize the amendment to the Waiver early in the 2017 session.

Department of Disabilities, Aging & Independent Living

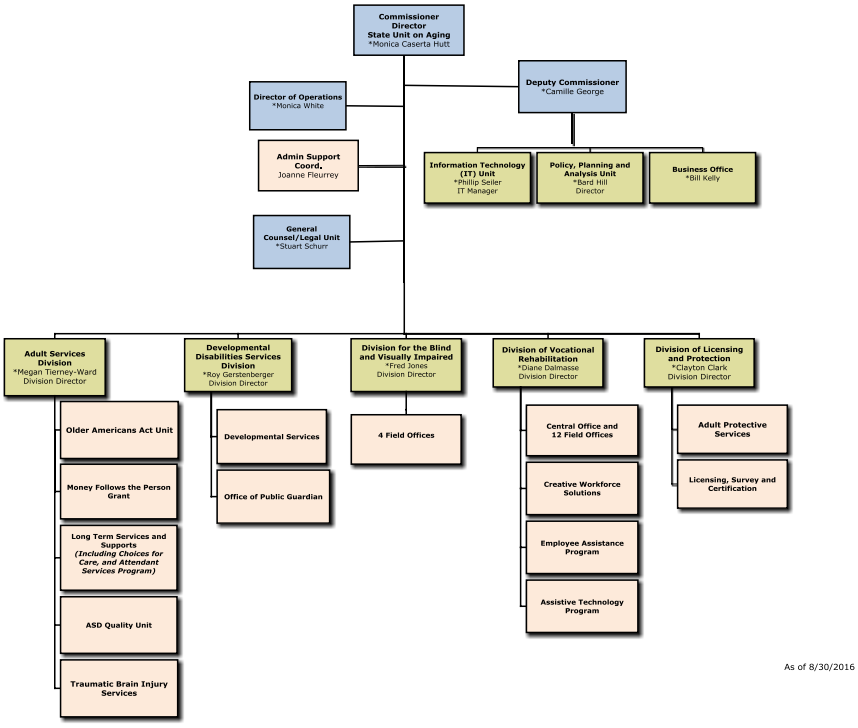
DAIL's primary role in Vermont is to fulfill the commitment that we have made to individuals with disabilities and to seniors, enabling them receive supports and services in their homes and in their communities, living independently and fully included as participating and contributing members of those communities. This commitment is underlined by state and federal mandates like the Olmstead Decision, which require states to provide services to people in the least restrictive environments possible. Vermont remains a leader in the nation in terms of our work in closing institutions, supporting choice and community-based settings, and the development of robust supported employment and mature worker options for all.

As we embrace the intent and spirit behind the federal Home and Community Based Services (HCBS) rules, we ensure that Vermonters value the inclusion and contributions of individuals with disabilities and seniors, and strive to enhance and promote those contributions. We see this as a value both to those individuals receiving supports and services and to the larger Vermont community.

DAIL's work across all five divisions is most directly related to the seventh outcome in Act 186: Vermont's elders and people with disabilities and people with mental conditions live with dignity and independence in settings they prefer. At

a population level, this outcome embodies the concept of choice, a cornerstone for our role in state government and across Vermont. Along with a robust provider system, DAIL strives to ensure that individuals not only choose the settings in which they live but choose how they live their lives, focusing on independence, inclusion in their own communities and contributions to the Vermont community. For this outcome, we measure where people live, employment rates and rates of abuse and neglect.

Department of Disabilities, Aging, and Independent Living (DAIL) Organizational Chart
State Unit on Aging (SUA)



Budget

DAIL's total budget for SFY 17 is $453,019,736. That budget is funded through the state general fund, global commitment and federal funds. The budget funds split is roughly as follows:

- General Fund: 4.88%
- Global Commitment: 87.91%
- Federal Funds: 5.94%
- Special and Interdepartmental Funds: 1.27%

Caseload, utilization and policy issues drive the DAIL budget. With two major programs, Developmental Services and Choices for Care in the Adult Services Division, our budget needs are primarily driven by caseload need in those two programs; we consistently see increasing diagnosis of developmental disability, particularly autism, and Vermont's demographic represents an aging population, both of which drive DAIL budget expenditures. Conversely, our ability to address budget reductions is severely limited without resorting to significant service reductions in those two arenas.

Both Vocational Rehabilitation and the Division for the Blind and Visually Impaired are primarily federally funded through Section 110 (80% federal) which has a Maintenance of Effort (MOE) requirement. The penalty for not meeting the MOE requirement is one federal dollar lost for each dollar below meeting MOE.

The Division of Licensing and Protection Survey and Certification is also federally funded. Adult Protective Services and our Public Guardianship Program are completely funded through the State General Fund (gf).

Choices for Care (CFC) and Developmental Services (DS) in addition to the Traumatic Brain Injury Program (TBI) all fall under our Global Commitment 1115 Waiver which is a combination of Medicaid and GF (with the exception of the Money Follows the Person grant). They are listed as special populations and receive services that are outside of the normal medical supports in order to provide long term services and supports that contribute to health, wellbeing and quality of life.

Upcoming Budget Challenges:

1) Loss of Money Follows the Person federal funding of approximately $1.7M Gross CFC service costs for SFY '18
2) Caseload Pressures
    a. Developmental Services - $8.1M
    b. Choices for Care (including Nursing Homes) - $8M estimate at this time.
3) Administrative Pressures - $150K GC and $550K GF estimate only at this time.
4) Annualizing 2% increases for both the Designated Agencies and for the Choices for Care Providers
5) DOL overtime rules – the Designated Agencies, based on recommended methodology from the Federal DOL, have estimated that this will be a challenge of $4.9 million annually, DAIL's portion is approximately $1.7 million
6) VR and DBVI – We were recently notified of the loss of $4.5 million in federal re-allotment funds for the first time since 2008; although this is not built as part of base budget it is a significant loss to those programs and will require significant reductions in programming
7) Sustainability of the Aging and Disabilities Resource Connection Grant (ADRC) as the federal funding decreases
8) VT Sick Leave- Addressing the impact of the Vermont legislation in relation to guaranteed sick leave for all employees who work over 18 hours per week will have an impact on our two primary programs, DS and CFC due to the significant number of workers employed by self-advocates or families; current estimates have not yet been established

Division for the Blind and Visually Impaired (DBVI)

The Vermont Division for the Blind and Visually Impaired (DBVI) provides and oversees specialized services for individuals who are blind or visually impaired using a rehabilitation model that starts when the individual experiences vision loss. DBVI offers an array of services specifically designed for people who have lost visual function and independence.

Vocational Rehabilitation Services

The goal of vocational rehabilitation services for the blind and visually impaired is to help the individual retain, return to or enter employment.

Transition Services

DBVI collaborates with several partners including the Division of Vocational Rehabilitation, Vermont Association for the Blind and Visually Impaired (VABVI), Vermont Youth Conservation Corps, ReSource, the Gibney Family Foundation and Linking Learning to Life. Several of these partnerships come together in the LEAP Program to support transition skills, employment skills and experiences and leadership development for students who are blind or visually impaired. See more information here: http://www.retrainvt.org/retrain/LEAP

Homemaker Services

Although the primary objective is to enable people to work in competitive employment, including self-employment, occupations such as extended employment, homemaking, or unpaid family work may be a person's most appropriate and acceptable choice. The Homemaker Services have been eliminated through the most recent adoption of the Workforce Innovation and Opportunity Act (WIOA) and must wind down by July of 2017. We will need to work with the Vermont Association for the Blind to address this loss across the state.

Independent Living Services

For those individuals for whom employment is not a feasible goal, but whose independence is threatened by vision loss, DBVI provides assistance in maintaining independence.

Randolph/Sheppard Program

This is a vending program which supports small business and vending opportunities in state and federal buildings.

DBVI's mission is to support the efforts of Vermonters who are blind or visually impaired to achieve or sustain their economic independence, self-reliance, and social integration at a level consistent with their interests, abilities and informed choices. Those who participate in DBVI services learn or re-learn skills and become successful and active members of their communities. Given appropriate adaptive skills training, and assistive technology instruction, many limitations due to blindness can be overcome. Quality of life, dignity, and full integration are the focus of DBVI.

The goal of DBVI's vocational vision rehabilitation services is to help people with vision loss to retain, return, or secure employment. DBVI transition services provide youth with opportunities for learning independent living, job skills, or support for higher education. When employment is not a feasible goal, DBVI provides assistance in maintaining independence.

DBVI continues to provide services to consumers needing Independent Living services. The Vermont Association for the Blind and Visually Impaired (VABVI) continues to receive both federal and state funds from DAIL to provide services to adults over the age of 55 with impaired vision.

Developmental Disabilities Services Division (DDSD)

The DDSD is responsible for services to people with developmental disabilities, and for guardianship services to adults with developmental disabilities and older Vermonters. The DDSD works with private non-profit organizations to provide a broad array of long term services and supports, including: service coordination, family supports, community supports, employment supports, residential support, crisis support, clinical interventions and respite.

Developmental Disabilities Services (DDS) are provided by Designated Agencies and Specialized Services Agencies with the goal of cost- effective, integrated community living. In SFY 15, 2,917 Vermonters received home and community-based services. Other services include Flexible Family Funding, Family Managed Respite, Bridge Program: Care Coordination, Targeted Case Management, Vocational Grants and one 6-person Intermediate Care Facility. In SFY 15, 1,213 people with developmental disabilities received supported employment to work, an 8% increase over the previous year.

Office of Public Guardian

The Office of Public Guardian (OPG) provides guardianship and other court-ordered supervision to people age 18 and older with developmental disabilities and to Vermonters age 60 and older.

- In SFY 15, 747 adults received guardianship
- This included 650 people with developmental disabilities and 97 adults over age 60. The program also provides case management (4 people served) and representative payee services (368 people served).

Developmental Disabilities Services

Utilizing Home and Community Based Services (HCBS) Medicaid funding, Developmental Disabilities services connects individuals to their communities and supports them to increase their independence. These services provide support to prevent or end institutionalization, abuse and neglect; prevent imminent risk to people's health and safety; respond to adults who are or may become homeless; help with employment; help parents with developmental disabilities keep their children; & prevent adults posing a risk to public safety from endangering others.

Public Safety

DDSD coordinates statewide supports for people with developmental disabilities who present a risk to public safety through a variety of activities. The focus of offender services is to keep the community and past victims safe while providing treatment and supervision to offenders.

Act 248 authorizes a State Criminal Court to commit a person with intellectual disabilities who is dangerous to others to the custody of the Commissioner of the Department of Disabilities, Aging, and Independent Living (DAIL). Annual reviews are completed by the Public Safety Specialist and reviewed and approved by the Commissioner. Currently there are 28 individuals in the Commissioner's custody under Act 248.

Flexible Family Funding

The Flexible Family Funding (FFF) program for children and many adults with developmental disabilities, allows families to provide care by avoiding more intensive and costly out-of-home services. The stipend is given annually with a maximum available amount of $1,000 per person, per year. The funding can be used for purchasing assistive technology, household purchases to support and enhance the lives of individuals with disabilities and respite.

Family Managed Respite

FMR funding is allocated to Designated Agencies to provide families with a break from caring for their child with a disability, up to age 22. This includes children with mental health or developmental disabilities who do not receive home and community-based services funding. Respite can be used as needed, either planned or in response to a crisis. It may be used to allow the caregiver to attend to his or her own needs or the needs of other family members. Respite may also be used to create a break from the normal routine for the child with a disability. It is intended to promote the health and well-being of a family by providing a temporary break, not child care to enable employment. Eligibility for FMR, determined through a needs assessment with a Designated Agency, is defined in the FMR guidelines. Families are given an allocation of respite funds that they will manage. Families are responsible for recruiting, hiring, training and supervising their respite workers. Agencies may provide assistance with these responsibilities. The workers are paid through the Fiscal/Employer Agent ARIS who processes the payroll and conducts background checks for these employees.

The Bridge Program

The Bridge Program is an Early Periodic Screening, Diagnosis and Treatment (EPSDT) service that provides support to families in need of Care Coordination to help them access and/or coordinate medical, educational, social or other services for their children with developmental disabilities under the age of 22. On an annual basis, the Division will negotiate and approve funding allocations for Designated Agencies for the Bridge Program. Designated Agencies will determine clinical and financial eligibility and approve individuals to receive this service. The Bridge Program Guidelines provide details regarding eligibility, scope of service provision and overall management of services. The Bridge Program is available in non-pilot IFS regions.

Targeted Case Management

Targeted Case Management is a Medicaid State Plan service that provides assessment, care planning, referral and monitoring. Services are provided by the DA/SSA and designed to assist adults and children to gain access to needed services.

Intermediate Care Facility for Developmentally Disabled Individuals (ICF/DD)

The ICF/DD is a highly structured residential setting for up to six people which provides needed intensive medical and therapeutic services. Vermont has only one ICF/DD in the Rutland area.

Division of Licensing and Protection (DLP)

The mission of the Division of Licensing and Protection (DLP) is to ensure quality of care and quality of life to individuals receiving health care services from licensed or certified health care facilities, through the Survey and Certification

program and to protect vulnerable adults from abuse, neglect and exploitation, through the Adult Protective Services program (APS).

Survey and Certification Program (S&C)

The S&C Program is the State Survey Agency, working on behalf of CMS, for the State of Vermont. S&C provides regulatory oversight of licensed or certified health care facilities and agencies under state and federal regulations through regular and unannounced onsite visits both routinely and as a result of complaints received. Providers receiving regulatory oversight and/or periodic review include: Nursing Facilities (NF), Residential Care Homes (RCH) Therapeutic Care Residences (TCR), Home Health Agencies, Hospice Programs, Renal Dialysis Units, Ambulatory Surgical Centers, Rural Health Clinics, Acute Care Hospitals, Critical Access Hospitals, Portable X-ray Units, Clinical Laboratories and Rehabilitation or Psychiatric Units.

Adult Protective Services (APS)

Adult Protective Services is the state unit responsible for investigating allegations of abuse, neglect and/or exploitation of vulnerable adults. The investigative and protection activities of APS are governed by Chapter 69 of Title 33 of the Vermont Statutes Annotated. APS maintain the Adult Abuse Registry which is a list of those individuals who have been substantiated for abuse, neglect or exploitation of vulnerable adults. The Commissioners Office is responsible to conduct hearings to finalize recommendations for substantiation and to enact the expungement of a name from the Registry.

Division of Vocational Rehabilitation (DVR)

DVR is the public rehabilitation agency for Vermont designated to serve the general population of individual with disabilities who experience barriers to employment. DVR assists Vermonters with a disability to enter or re-enter the work force through a wide variety of programs and individual support services. The core program (VR Section 110) enables Vermonters with a disability to assess their skills and abilities, identify a vocational goal, develop an Individualized Plan for Employment (IPE) and receive services leading to meaningful employment. VR invests heavily in services for people with the most significant disabilities through supported employment programs. The U.S. Congress reauthorized the Rehabilitation Act via the Workforce Innovation and Opportunity Act in 2014 and required VR to substantially expand services to high school students with IEPs or eligible for 504 plans. The Division operates a statewide Benefits Counseling Program to support Social Security beneficiaries to find work; and the Assistive Technology (AT) Project which provides Vermonters with information and training on AT devices and services.
Our continued success at helping Vermonters with employment is a direct result of a sustained, integrated effort across AHS, state government and private partners.

DVR leads Creative Workforce Solutions (CWS), an Agency of Human Services (AHS) initiative that has filled gaps in employment services by eliminating the barriers between service providers and partnering actively with employers. CWS created local employment teams that span four AHS departments and seven divisions within these departments. The coordination and teamwork ensures that employers have an easier time interacting with AHS, which in turn leads to a greater willingness to support our customers and better outcomes for all. In FFY 2015, VR was able to get 1,922 Vermonters to work.

School to Work Program for Youth in Transition

With the new WIOA focus on serving in-school youth with disabilities, the Division recently changed its service delivery model to serve Vermonters across the age continuum. There are now 14 dedicated In-School Transition Counselors serving students during their educational careers, 14 Young Adult Counselors serving youth once they have exited school, and 16 Adult Counselors serving the remainder of the caseload.

Supported Employment and the JOBS Program

Supported employment gives Vermonters with significant disabilities the opportunity to be employed in their own communities at real jobs with competitive wages. The JOBS program (Jump On Board for Success) is a unique collaboration between DVR and Children's Mental Health. The Program serves young Vermonters with severe emotional and behavioral disabilities, helping them secure employment in order to stabilize their lives.

Benefits Counseling Program for Social Security Disability Beneficiaries

VR has been a leader in promoting employment among Social Security beneficiaries who have the most serious disabilities and face the greatest disincentives to working. Vermont was among four states nationwide to participate in the Social Security Disability Insurance Benefit Offset Pilot, and was the first to demonstrate statistically significant results in this random assignment study.

Rural and Agricultural Vocational Rehabilitation

This innovative program is a collaboration between University of Vermont Extension and the Division to offer VR services specifically to farmers and rural families living and working with disabilities. VCIL staff conduct farm site visits to determine the vocational needs of farmers with disabilities, and 9 VR Counselors statewide work with farmers and their families to identify accommodation needs and other supports that allow the farm to continue to operate successfully.

Rehabilitation Counselors for the Deaf or Hard of Hearing

A wide range of services for the Deaf, hard of hearing, and late-deafened are available from DVR through our specialty Rehabilitation Counselors for the Deaf (RCDs).

Veterans Program

Since 2009, ten DVR counselors from nearly every district office in the state meet quarterly with the VA Vocational Rehabilitation and Employment (VR&E) counselors who serve Vermont veterans with disabilities at the VA Hospital in White River Junction.

Offender Reentry Program

DVR has worked with the Department of Corrections, the Community High School of Vermont, local Community Justice Centers and others to serve offenders with disabilities as they re-enter the community.

Vermont Assistive Technology Program

Assistive technology, or AT, helps people of all abilities achieve a wider range of tasks and independence at home, school and in the workplace. The Vermont Assistive Technology Program (VATP) offers a range of services.

Invest EAP

Invest EAP provides employee assistance program services on a fee-for-service basis to employers across the state, from large organizations such as the State of Vermont and the Vermont League of Cities and Towns to many small Vermont businesses.

Work4Kids

A unique collaboration between the Office of Child Support and DVR, Work4Kids receives referrals from Court Magistrates who have determined that a non-custodial parent needs support in securing employment in order to meet their child support obligations. Initially started as a pilot in Chittenden and Franklin counties, Work4Kids is now expanding statewide.

Adult Services Division (ASD)

The Adult Services Division is responsible for long-term services and supports for older Vermonters and adults with physical disabilities. This includes management of the Choices for Care (CFC) High and Highest Needs program, the Moderate Needs (CFC) program, the Money Follows the Person (MFP) project, the Attendant Services Program, the Traumatic Brain Injury Program (TBI), Adult High Tech, Adult Day Services, Aging & Disabilities Resource Connections and other related contracts and grants. ASD is also responsible for management of the Vermont State Plan on Aging and all Older American's Act (OAA) related services. ASD works with private organizations to provide a broad array of long term services and supports, including: residential support, community support, case management, family supports, respite,

assistance with activities of daily living, assistive technology, nursing home level of care, rehabilitation services, support to live at home, information and referral, and personal care.

Older American's Act (OAA) Services

In November 2015, management of the Older American's Act and related work was reorganized to a new team within ASD, providing the needed support and leadership for key OAA activities including the Vermont State Plan on Aging. The OAA services support Vermonters age 60 and older and are designed to help older Vermonters remain as independent as possible and to experience a high quality of life. Services are provided through Vermont's five AAA's, Aging & Disabilities Resource Connections, and Vermont Legal Aid and include:

- Aging & Disabilities Resource Connections (ADRC)
- Information, Referral & Assistance
- Options Counseling
- Case Management
- Dementia Respite and Family Caregiver Support
- Health and Wellness
- Health Insurance Counseling
- Home Delivered Meals
- Legal assistance
- Nutrition Services
- State Long-Term Care Ombudsman

Vermont enhances the federally funded OAA work by funding services through the Area Agencies on Aging (AAA's) to support caregiver respite for people with dementia, support for people who self- neglect, and senior nutrition services through the Vermont Food Bank and Northeastern Organic Farm Association.

Choices for Care

Choices for Care (CFC) is a Medicaid-funded, long-term services and supports program that pays for care and support for older Vermonters and adults with physical disabilities.

Traumatic Brain Injury Program

The Traumatic Brain Injury (TBI) Program is a Medicaid funded program that provides rehabilitation to Vermonters with moderate to severe traumatic brain injuries., from hospitals and facilities to community-based settings.

Aging & Disabilities Resource Connections/No Wrong Door

Vermont's Aging Disabilities Resource Connections (ADRC) receives federal funding to provide people of all ages, disabilities, and incomes a "no wrong door" system for receiving the information and support they need to make informed decisions about long term services and supports.

Attendant Services Program

The Attendant Services Program (ASP) supports independent living for adults with severe and permanent disabilities who need physical assistance with activities of daily living to remain in their homes. Services are funded through three sources: Medicaid, general funds and social service block grant.

Adult Day Services

Adult day services are Medicaid funded community-based non-residential services designed to assist adults with physical and/or cognitive impairments to remain as active in their communities as possible.

Dementia Respite Grant Program

The dementia respite grant program is managed by Vermont's five Area Agencies on Aging. Grants are available for family members or other unpaid primary caregivers of a person who has been diagnosed with Alzheimer's disease or a related disorder and meets certain financial criteria.

Food and Nutrition Programs

Older Americans Act federal funds help support two programs designed to provide healthy meals and nutrition services for older adults; the congregate meals program and the home delivered meals program.

Mental Health Elder Care Clinician Program

The Elder Care Clinician Program (ECCP) provides mental health services to older adults through the collaboration of Vermont's Area Agencies on Aging (AAA) and the designated mental health agencies.

Older Americans Act Services

The Older Americans Act (OAA) provides funding through the local Area Agencies on Aging for a range of programs that offer services and opportunities for older Vermonters to age well and remain as independent as possible.

Long Term Care Ombudsman Program

DAIL contracts with Vermont Legal Aid to operate the statewide Office of the Long Term Care Ombudsman funded with both federal and state General Funds. The Ombudsmen is federally mandated to protect the safety, welfare and rights of Vermonters who receive care in a licensed nursing facility or residential care home. Vermont expanded those services for people receiving home and community-based services under the Choices for Care program.

The State Health Insurance Program

The State Health Insurance and Assistance Program (SHIP) is federally funded through the local Area Agencies on Aging and provides information, assistance and problem solving support to Medicare beneficiaries and individuals dually eligible for Medicare and Medicaid, who need help selecting or managing public and/or private health insurance benefits.

Key Initiatives

1) Long term services and support workforce – critical issues with availability of the workforce to meet the programmatic needs of Vermont's programs; wages, benefits, training/skill are all major challenges. Across the board, providers describe high turnover and difficulty recruiting qualified workers as a crisis situation that must be addressed immediately in order to fulfill our commitment to caring for those in greatest need.
2) Health, payment and practice reform efforts and the development of strategies to ensure that long term services and supports, beyond traditional medical care fit appropriately into those efforts. These include VHCIP, Medicaid Pathway into the Accountable Care Organization (ACO) and the All Payer Model (APM)
3) Further development of our work on performance management and RBA; this would include efforts in the Adult Services and Developmental Services Division to identify and utilize measures for both the individual experience and the competency and effectiveness of providers and efforts to benchmark those measures against national standards. (NCI and CQL)
4) Bringing our Home and Community Based Services (HCBS) into compliance with the rules newly issued by CMS. This impacts our Choices for Care Program, our Developmental Services Program and our TBI Program and will require significant stakeholder and legislative process.
5) New Workforce Innovation and Opportunity Act (WIOA) rules are requiring significant retooling of practice, measurement, and funding allocation in the Divisions of Vocational Rehabilitation and the Blind and Visually Impaired. WIOA also requires a new level of focus on youth through the Pre-Employment Transition Services (PETS) and collaborations across state government.

6) Focus on alternatives to traditional supports for individuals with disabilities to include the creation and support of opportunities for post-secondary education and the exploration of supported decision making in lieu of traditional guardianship services.
7) Rulemaking for the Developmental Services System and an update to our current System of Care Plan.
8) The update of the Designation Standards for Home Health Providers
9) Supporting the Governor's Executive order to make state government a model in hiring people with disabilities.

Successes

1. Vermont senior health ranked #2 in US by United Health Foundation
2. VT is ranked #1 in the nation for number of people with DD who receive supported employment to work per 100,000 of the state population
3. Vermont is one of a very few states in the nation that does not institutionalize individuals with intellectual or developmental disabilities. Our community based system of care is one of the premier systems in the country and it is based on a strong network of community providers and designated agencies.
4. In Vermont, 53% of individuals who require nursing home level of care are served in the community and in their own homes- representing an impressive level of choice and the opportunity to age in place.
5. Our Survey and Certification unit consistently exceeds CMS standards for quality and excellence.
6. Creative Workforce Solutions has been highly successful in creating a single, AHS approach to employment for individuals with disabilities and significant challenges to employment.
7. The Division of Vocational Rehabilitation is ranked #1 in the nation for employment outcomes and for our Ticket to Work participation rate
8. Strong partnership with the Vermont Association of Business Industry and Rehabilitation (VABIR) to support relationships with Vermont businesses, job development and supports.
9. Operation of SOV cafés and cafeterias by blind operators through the Randolph Sheppard Act.
10. Celebration of the Mature Workers Initiative and those businesses across the state that hire and support mature workers with supportive policies and practices.

Challenges

1. Vermont's aging population: changing the cultural narrative that consistently paints this population as frail, needy and a drain on resources vs. celebrating the opportunities to age well.
2. Rising rates of disability among the population based on early diagnosis particularly in relation to increasing rates of diagnoses on the Autism spectrum
3. Rising rates of diagnosis of Alzheimer's and dementia and the significant economic impact of the costs of care, loss of pay for caregivers and the devastating impact on families
4. Stagnant Older Americans Act federal funding based on Vermont's "small state" status and not accounting for a changing census
5. Medicaid budget pressures: consistently increasing caseload based on aging and disability and care needs
6. Community provider financial instability due to inconsistent funding for infrastructure and operational needs and an inability to compete with competitive wages for the necessary workforce
7. Office of Public Guardian (OPG): OPG has experienced steadily increasing caseloads in the face of the level staffing. Caseloads are in the 30's and are unmanageable. In addition, we anticipate several retirements within the next 2 ½ years, losing experienced staff. The OPG regulations need updating to reflect both of the populations served and to institute ways to manage caseload.
8. Federal and State mandates related to wages which impact our contracted workforce and create additional budget pressures: Sick Leave legislation, Federal Department of Labor overtime rules, etc.
9. Maintaining current MCO investments
10. Aging technology in multiple divisions, particularly in Adult Protective Services, Choices for Care, and Developmental Services which makes it difficult to assess quality and outcomes and to track those against budget expenditures
11. Transportation supports and services is a major barrier and challenge for our populations – it creates isolation, difficulties in creating economies of scale for providers, and barriers to work and community inclusion.

12. Sustaining our Aging and Disabilities Resource Connections (ADRC) services, providing case management, information and referral and assistance with Medicaid applications for seniors and individuals with disabilities across the state.
13. Addressing a current challenge from CMS related to conflict free case management in our Choices for Care program and continuing our work to support choice for consumers.
14. Sustaining our Moderate Needs Group (MNG) program with a lack of consistent funding, a need to update the allocation methodology and a consistent wait list for services.
15. Anticipated high turnover rates in senior staff in both Survey and Certification and our Public Guardian Program

Opportunities

1. Long terms services and supports (DDSD and ADD) workforce initiatives: recruitment, retention, training, certification- we are reliant on this workforce and need to consider alternate methods to retain and improve quality for consumers
2. Capitalizing on both the mature workers and those with disabilities to meet Vermont' demographic challenges in relation to the labor market
3. Improving poor performance in specific senior health measures:
    a. Hospice use (rank #47)
    b. Excessive drinking (rank #42)
    c. Falls (rank #41)
    d. Suicide (rank #41)
    e. Food insecurity (rank #28)
4. Building diversity, access and policy infrastructure into community of practitioners in Autism treatment models
5. Strong community partners and stakeholder and self-advocate networks
6. The exploration of Supported Decision Making as a strategy to empower individuals with disabilities and vulnerable adults vs. an intensive use of public guardianship.
7. The creation of the Vulnerable Adult Fatality Review Team will enable us to identify areas for improvement in systems and practices in our work with our most vulnerable adults.

AHS Inter-Departmental Items and Collaborations

DAIL and DMH

Pilot proposal working group for a new wing of a nursing home, CLR, to address the needs of individuals with complex behavioral and medical needs.

DAIL and AHS

DAIL Vocational Rehabilitation leads **Creative Workforce Solutions (CWS)** to better coordinate and engage employers across the state in employment opportunities for all AHS populations.

AHS, DAIL, DMH

Medicaid Pathways work for the **Designated Agencies (DA's) and Specialized Service Agencies (SSA's)** and the **TBI/Choices for Care Providers (DLTSS)** to design health, practice and payment reform to connect long term services and supports to the ACO model and to the All Payer Waiver.

AHS Successful Aging Workgroup

A partnership between DAIL, DMH, VDH and DVHA born out of the sun setting Governor's Council on Successful Aging to further develop and implement recommendations from the Council.

AHS Suicide Prevention Coalition

Led by DMH with DAIL participation to address the high rates of suicide among older Vermonters and across the lifespan.

Governor's Commission on Alzheimer's, Dementia and Other Related Disorders (ADRD)

DAIL, VDH, DMH all participate to address the Commission's charge related to education, outreach, awareness and state planning in relation to the rising rate of diagnosis and the significant economic and emotional impact of this illness.

Medicaid for Working People with Disabilities Workgroup

DAIL and DVHA continue to partner to move forward a State Plan Amendment (SPA) to enact the legislation related to raising the asset limits to get more people on Medicaid into the workforce.

Vermont Taskforce for Supported Decision Making

DAIL's Developmental Services Division leads this with representation across the Agency to build a strategy for adoption of a framework of Supported Decision Making for individuals with disabilities and older Vermonters, empowering those individuals and reducing our reliance on public guardianship.

Statewide Inter-Agency Items and Collaborations

Workforce Innovation and Opportunities Act (WIOA)

Requires VR and DBVI to collaborate, plan and execute new federal requirements with the Department of Labor and the Agency of Education.

Governor's Awards for Business Excellence in Supporting Mature Workers

Governor's Commission on Successful Aging in conjunction with the Agency of Commerce and Community Development and the Department of Labor sponsoring the annual

Governor's Committee on the Employment of People with Disabilities

Division of Vocational Rehabilitation and Division for the Blind and Visually Impaired in conjunction with the Department of Human Resources and the Department of Labor participate on the Governor's Committee on the Employment of People with Disabilities with a subcommittee focused on the hiring of individuals with disabilities into the state workforce.

Vermont Achieving a Better Life Experience (ABLE) Savings Program

Office of the State Treasurer worked with Vermont stakeholders, State agencies, DAIL and legislators to draft and pass Vermont's enabling legislation of the federal ABLE Act. The Vermont Achieving a Better Life Experience (ABLE) Savings Program is intended to ease financial strains faced by individuals with disabilities by making federal tax-free savings accounts available to cover qualified expenses such as education, housing, and transportation.

Vermont Advisory Council for the Deaf, Hard of Hearing and DeafBlind

A Council with representation from DAIL, VDH, DCF, and the Agency of Education designed to offer recommendations in relation to strengthening the system of care, across the lifespan, for individuals who are deaf, hard of hearing or deafblind.

Newline Outreach Working Group

Working group led by DBVI and in partnership with the State Libraries, the Vermont Center for Independent Living (VCIL) and the Vermont Association for the Blind and Visually Impaired (VABVI) to promote the use of the Newsline service.

Vulnerable Adult Fatality Review Team

DAIL, VDH, Public Safety, Attorney General's Office, the Chief Medical Examiner, and additional stakeholder; this newly formed Team will review the fatalities of vulnerable Vermont adults to develop system-level recommendations for changes to the service system.

Key Dates and Decision Points

Legislative Reports

2017 DATE	REPORT CONTENT	DIVISION/UNIT
January 1st	CFC Financial	Business Office
January 15th	APS Abuse Report	DLP
	LTC Facility Complaints	LTC Ombudsman
	CFC Reinvestments (BAA)	ASD/Business Office
	AHS Performance Based Contracts	AHS/DAIL Policy Unit
	ABLE Savings Program	ABLE Task Force and Treasurer's Office /Commissioner/Legal
	DDS Plan Implementation	DDSD
	Alzheimer's Commission Findings and Recommendations	Commission and ASD
	Deaf/Hard of Hearing Council Recommendations on Interpreters by OPR	Governor's Advisory Council/Commissioner
February 1st	CFC Waiver Amendment Plan	ASD
March 1st	Multi-year Medicaid Budget	AHS/ DAIL Policy Unit
April 1st	CFC Financial Report	Business Office
While legislature is out of session	Medicaid Non-Emergency Transportation	DVHA/Deputy Commissioner
July 1st	CFC Financial Report	Business Office
October 1st	CFC Financial Report	Business Office
	CFC Annual Assessment	ASD
September 30th	Population Level Outcomes	AHS/ DAIL Policy Unit
January 15th, 2018	Vulnerable Adult Fatality Review Team Status	DLP
	Public Retirement Plan	Treasurer's Office/Commissioner/Legal/ DVR
	Medicare Supplemental Plan for Duals	DVHA/ DAIL Policy Unit

Monthly

DAIL Advisory Board Meetings
DDS State Program Standing Committee
ASD bi-monthly Home Health Stakeholder Meetings

Early CY2017

Begin rulemaking to amend Office of Public Guardian and Home Health Agency Regulations
Begin implementation of TBI and DS HCBS regulations work plan

January 2017

DAIL RBA Scorecard Updated and Annual Report Completed
Finalize AHS Fiscal/Employer Agent Contract for 2/1/17 start

February 2017

Finalize contract for National Core Indicators – Aging & Disabilities

April 2017
Renewal of grants/contracts for SFY18 begins

June 30, 2017
WIOA Reporting Due – VR, DBVI, AOE, DOL

July 1, 2017
Updated State System of Care Plan Effective Date (three-year)
Renewal of grants/contract for FFY18 begins
Begin work plan for Vermont State Plan on Aging Renewal (FFY19-FFY23)

August 2017
Act 186 population indicators to AHS

December 31, 2017
Randolph Sheppard Act Reporting Due to RSA (DBVI)
Annual Independent Living Report Due to ACL (submitted by SILC; signed off by DVR/DBVI)

June 2018
State Plan for Independent Living Update Due to ACL

Legislative Priorities
For the 2017 Vermont Legislative Session, DAIL is proposing to request legislation in three specific areas with placeholders for possible legislative requests in two additional arenas.

Legislative Proposals
Division of Licensing and Protection: Adult Protective Services (APS) 33 VSA, Chapter 69
Legislation to authorize APS to promulgate rules through the state rule making process as necessary in order to ensure that investigative procedures can be documented and consistent with state statute while remaining responsive to the conditions impacting vulnerable adults.

Developmental Disabilities Services Division: 18 VSA, Chapter 206, Act 248
Housekeeping legislation to clean up inconsistencies throughout the Vermont Statutes referenced by the Act. These would address current uncertainty in relation to jurisdiction and would establish procedures and timelines for hearings, annual reviews, clarify the Commissioner's authority and provide for rulemaking authority

Division of Licensing and Protection: 33 VSA, Chapter 71, Act 36
Legislation allowing for revisions to the Regulation of Long Term Care Facilities related to receivership to align with the recommendations from an outside review of the statutes commissioned by DAIL to improve the process, delineation of authorities, procedures and jurisdiction to ensure the health and safety of residents living in facilities that come under receivership.

Legislative Placeholders
Adult Services Division, Traumatic Brain Injury Program: 18 VSA, Chapter 206 and 13 VSA, Chapter 157, Act 158
Based on a November 16th report to the Legislature, we anticipate some potential changes to Act 158. Those changes could address eligibility for Act 158, a process for determining eligibility, and identify a funding allocation for the proposed services or repeal the Act in its entirety. Ultimately, a legislative proposal will be submitted by the Agency of Human Services in collaboration with DAIL, DMH and DOC.

Adult Services Division, Choices for Care Program

Based on the federal Centers for Medicaid and Medicare Services (CMS) response to DAIL's most recent query related to conflict free case management, we may need to address in statute significant changes to the rules for Home Health to align our practices with CMS requirements.

External Groups and Organizations

Service providers

Area Agencies on Aging; Adult Day Centers; Designated Agencies and Specialized Service Agencies; Home Health Agencies; Nursing Homes; Residential Care Homes; Senior Centers; Traumatic Brain Injury Service Providers; SASH- Services and Supports at Home; Vermont Association for the Blind and Visually Impaired; Vermont Association for Business and Industry Rehabilitation (VABIR); and the Vermont Crisis Intervention Network

Organizations that represent and advocate on behalf of their members

Vermont Care Partners/The Vermont Council of Developmental and Mental Health Services; Vermont Assembly of Home Health Agencies; Vermont Health Care Association; Vermont Association of Hospitals & Health Systems; Brain Injury Association, Statewide Independent Living Council (SILC); VT Legal Aid; Disability Rights Vermont; Vermont Center for Independent Living (VCIL)

Consumer advocates and other stakeholders

Green Mountain Self Advocates; Vermont Family Network; COVE- Community of Vermont Elders; AARP; the Health Care and Long Term Care Ombudsmen; UVM Center on Aging

Advisory Boards and Groups

DAIL Advisory Board; DS State Program Standing Committee; TBI Advisory Board; State Rehabilitation Councils for VR and DBVI; Governor's Commission on Alzheimer's, Dementia and Other Related Disorders

Federal/National Organizations

NASUAD- National Association for State Units on Aging and Disabilities; NASDDDS– National Association of State Directors of Developmental Disabilities Services; NCSAVR- National Council of State Administrators of Vocational Rehabilitation

Department for Children & Families

DCF's mission is to foster the healthy development, safety, well-being, and self-sufficiency of Vermonters. We envision Vermont as a place where people prosper; children and families are safe and have strong, loving connections; and individuals have the opportunity to fully develop their potential.

DCF is comprised of three support units: Commissioner's Office, Business Office and Information Technology and six programmatic Divisions:

- Child Development Division
- Economic Services Division
- Family Services Division
- Office of Child Support
- Office of Disability Determination Services
- Office of Economic Opportunity

Commissioner's Office, Business Office and Information Technology

Provides administrative oversight and support to the six operating divisions; is responsible for policy and budget development; maintains relationships with other state agencies, the legislature and federal officials; and manages consumer complaints and concerns. The Child Protection Registry Review Unit is administered by the Commissioner's Office.

Child Development Division (CDD)

CDD improves the well-being of Vermont children by ensuring access to high quality, sustainable child development services. Direct services for children and families include:

- The Child Care Financial Assistance Program (CCFAP) – In FY 15, $46.7 million in child care financial assistance helped a total of 14,301 children access child care and after school programs.
- Children Integrated Services (CIS) – provides a continuum of early intervention services, treatment, family supports and parent education for children with high needs and their families.
- Licensing and regulation of child care and after school programs – CDD's Licensing Unit licenses and monitors registered family child care homes and licensed programs operating in Vermont.
- Child care resource and referral for families.
- Step Ahead Recognition System (VT Stars) which supports improvements to child care and after school programs to ensure high quality care and education.
- Technical assistance and professional development opportunities to Vermont's early childhood and afterschool workforce.

Economic Services Division (ESD)

ESD administers programs that promote pathways out of poverty and provide a safety net for individuals and families who may be experiencing unemployment, part time or low wage employment, single parenthood, aging, temporary or permanent disability, the death of a family member, or other life-changing events. Services are provided primarily through 12 district offices and a call center; program services include:

- Reach Up for families with children - provides cash assistance for basic necessities and services that support work and self-sufficiency
- 3SquaresVT - the federal Supplemental Nutritional Assistance Program (SNAP), provides food to needy households.
- Essential Person Program - this program allows aged, blind or disabled individuals to stay in their home by contributing to the cost of essential care.
- Lifeline and Link-Up - Lifeline is a discount of at least $13 off the monthly phone bill. Link-Up cuts in half the cost of getting phone service connected.
- GA/EA (General Assistance/Emergency Assistance) - for individuals and families in a crisis situation. Benefits include help with temporary housing, utilities, food and personal needs, and emergency dental or medical assistance.
- LIHEAP Fuel Assistance - provides assistance to eligible Vermonters to pay their home heating bills during the winter months. There is also a crisis component to assist individuals in a home heating emergency and a weatherization component that is administered through DCF home weatherization program.

Family Services Division (FSD)

FSD operates the child protection and youth justice programs. FSD serves approximately 3,000 families each year. Approximately 1,400 children are currently in the custody of the Commissioner. Services include the following:

- Child abuse and neglect interventions – FSD intervenes following reports of child abuse and neglect. In 2015, there were over 5,600 such interventions.
- Ongoing child protective services to children and families - FSD provides case management, support services, parent education and treatment services, initiates court actions where needed, supports children who are placed in the custody of the state, and facilitates adoptions for children who will not be able to return home.

- Juvenile Justice - FSD promotes community protection, offender accountability, community restoration, and positive youth development. Specific services are provided to offending youth and their families through juvenile probation supervision and care and supervision of youth placed in the custody of the Commissioner. This area includes operation of the Woodside Juvenile Rehabilitation Center, Vermont's only locked treatment facility for youth.
- Substitute care, treatment, and permanency planning for children in the custody of the Commissioner. This includes operation of the foster care and residential care system. Over 2,000 children currently received post-adoption subsidy.
- Transition services for youth support adolescents as they transition to independent living as adults though the Youth Development Program and funding for extended care.

Office of Child Support (OCS)

OCS improves the economic security of children by supporting efforts to cause non-custodial parents to pay their child support. Services include:

- Filing and appearing in Court to establish, modify and enforce child support orders. In 2015 OCS was scheduled for 9108 court events.
- Assisting parents/guardians who have cases handled by out-of-state agencies and courts.
- Collecting, processing and distributing child support payments to custodial parents.
- Locating non-custodial parents.
- Establishing parentage if parents were not married when their children were born.

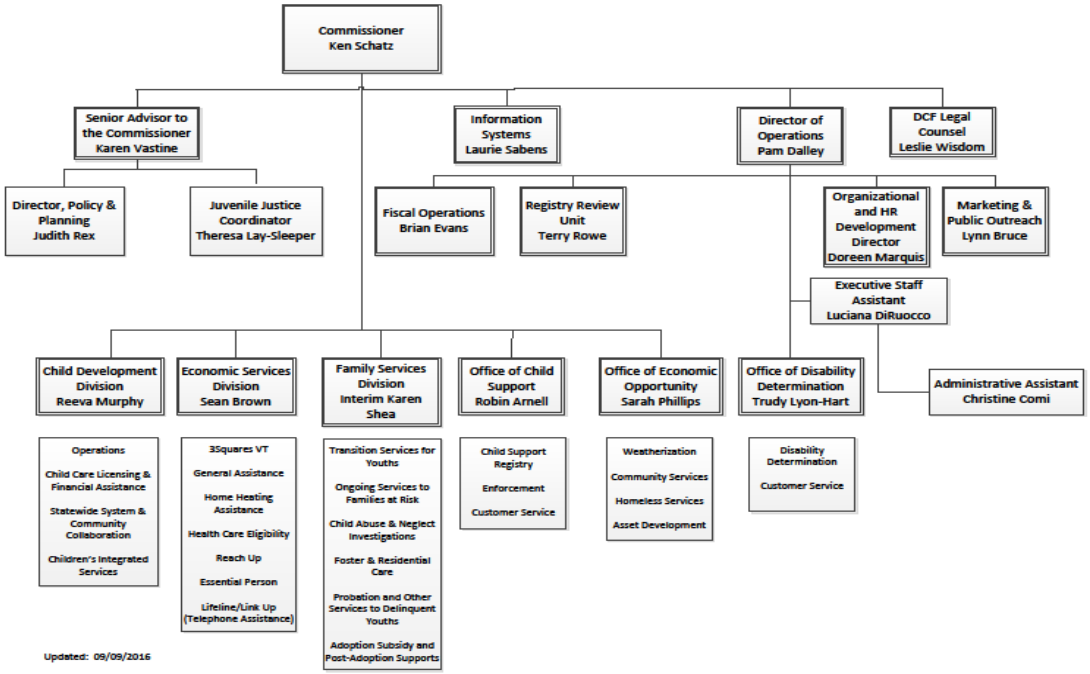
Office of Disability Determination Services (DDS)

DDS serves Vermonters who apply for disability benefits under three programs: Social Security Disability Insurance (SSDI), Supplemental Security Income (SSI), and Medicaid. Its mission is to provide applicants with accurate decisions as quickly as possible. DDS makes disability determinations for over 5,000 applications filed by Vermonters each year. This program is operated under strict guidelines specified by the Social Security Administration.

Office of Economic Opportunity (OEO)

OEO works in partnership with the private sector, community based organizations, and other groups to increase the self-sufficiency of Vermonters, strengthen Vermont communities, and eliminate the causes and symptoms of poverty. The office administers more than $20 million in grants annually to support the work of Community Action Agencies, homeless shelters and service providers, and weatherization programs. OEO provides training and technical assistance to the network of programs to advance the practice and policies that promote long term financial and housing stability. The Office also works to foster linkages between anti-poverty initiatives within the community and government. OEO Programs include:

- Asset Building & Financial Capability:
  - Individual Development Account Program (matched savings)
  - Micro Business Development Program
- Community Services for low income Vermonters (CSBG)
- Homeless Assistance Programs:
  - Housing Opportunity Grant Program (HOP) – core funding for emergency shelter and services, homelessness prevention and rapid re-housing
  - Family Supportive Housing – permanent supportive housing for homeless families with high needs
- Weatherization Services for low income Vermonters



Budget

Number of Positions: 1,172

Funding for SFY 2017

General Funds	$121,584,308
Special Funds	$ 38,746,007
Interdepartmental Transfers	$ 837,139
Global Commitment Funds	$ 78,448,968
Federal Funds	$159,645,192
	$399,261,614

Budget Pressures

DCF currently operates with 13 programs managed by 6 divisions with the Economic Services Division comingled with departmental support services (commissioner's office, business office, and department IT). DCF would like to renew our SFY16 legislative request to adjust our dept ids to reflect our current operating structure: departmental support services and the six divisions; requiring 7 dept ids.

AHS recently implemented a new cost allocation program to better adhere to the new Federal super circular requirements. DCF business office is analyzing the changes in earnings due to this implementation and the changes in administrative allocation due to the implementation of random moment time study tracking of benefit specialists time. The net effect of this analysis might result in a general fund need due to the shifting of funding allocations to capped federal funding sources.

Major and Evolving Issues

Child Care Financial Assistance Program (CCFAP)

Despite a $1 million-dollar increase in FY 17, child care subsidies continue to be a critical need for Vermont families which impacts their ability to enter the workforce. Rates in the CCFAP are currently at the market rate for 2008/2009 creating co-payment challenges for families and sustainability issues for the industry. Although eligibility for assistance was raised to 300% of the federal poverty level in 2016, families at that income level receive a nominal 10% benefit, so usage is low and families are not receiving the financial assistance needed to

afford dependable, good quality child care. A Blue Ribbon Commission on Access to High Quality Affordable Child Care was convened by the Legislature in 2016 to study these issues. Recommendations are anticipated in December of 2016. If an appropriate funding source is identified, DCF would support increasing the child care subsidies and rates to make quality child care more accessible to low-income Vermont families.

Child Care Licensing

In 2012, CDD embarked on a major revision of all child care licensing regulations which has recently been completed. New updated regulations took effect in September of 2016. Some providers have found it challenging to meet the new regulations. CDD is addressing these concerns with training and will continue to monitor the implementation of these new regulations. The federal Child Care and Development Block Grant (CCDBG) of 2014 also included new requirements for annual inspection of every regulated child care program. CDD currently operates with 9 Licensing Field Specialists (LFS) responsible for monitoring compliance with regulations. LFS caseloads are currently one of the highest in the country at 1:160. Each year, the Unit strives to visit every program to manage complaints, compliance issues and provide technical assistance, but it is very challenging at these staffing levels.

Children Integrated Services (CIS)

The early childhood component of AHS's Integrated Family Services (IFS) approach to transforming how Vermont provides services and resources to help children and families reach their full potential. Between 2010 and 2016, the CIS model of referral and intake from many sources (no "wrong door") followed by multi-disciplinary teaming and integrated care coordination has been implemented in every region of VT. CIS community partners report positive benefits for the children and families they serve. One challenge for the program is keeping up to the growing demand. In particular, early intervention and evidence-based home visiting programs are not able to serve the entire state without additional resources.**)**

Individuals with Disabilities Education Act (IDEA) Part C

A federal grant program that supports early intervention services to infants and toddlers with disabilities. Developmental therapies are not included in the CIS bundle of services; they are bill fee-for-service as required by Part C. DCF has used Part C funds to pay for these costs, but it is also responsible for excess expenditures as the Payer of Last Resort when federal funds are exhausted. DCF has covered these costs with general fund dollars which has created budget pressures due to an increased demand for developmental therapies. A review of treatment services has indicated that some services paid with Part C funds could be Medicaid billed services. DCF, DVHA and AHS should pursue a review of the current program utilization to assure that children who have a medical diagnosis are accessing Medicaid to pay for authorized services, rather than the state General Fund.

Early Learning Challenge Grant (ELCG)

CDD is one of four key partners in Vermont's $39.7 million Early Learning Challenge grant. CDD manages the grant and division staff are responsible for 12 of the 24 projects funded under the initiative. The purpose of the grant is to improve and expand high quality early childhood services for high needs children and has allowed CDD to improve, expand and evaluate it programs and services.

3SquaresVT

Also known as Supplemental Nutrition Assistance Program (SNAP), is a federal USDA Food and Nutrition Services (FNS) program administered by EDS that provides healthy food to needy households. Challenges within this program include compliance with federal regulations of an extremely complex federal entitlement program with ever-changing policies. An example of one such challenge is the on-going effort to reach an agreement with FNS on the administration of the SNAP Employment Training Program. These complexities are deepened by administering the program via DCF's Legacy Access IT System that is difficult and time-consuming to update. There are a large number of ongoing routine audits with FNS that require substantial staff time, data collection and correspondence.

Jobs for Independence (JFI)

A 3-year $8.9 M federal grant. It funds a state-wide pilot project which is studying the impact of support services on employment outcomes. State and local agencies coordinate and collaborate to provide services to Vermonters with substance abuse, mental health challenges, inadequate housing and or a history of incarceration.

LIHEAP

Vermont's Fuel Assistance program and is funded predominantly by the federal LIHEAP Block grant, however the program relies on state funding to provide supplemental heating and crisis benefits to households over the federal income threshold of 150% of FPL. A major impediment to the successful operation of the program each year is the lack of a predictable base appropriation for the state share of the program. Without a base appropriation, the program is never sure of funding, placing the operation of the crisis program in jeopardy each year.

General Assistance (GA)

Since 2015, due to increased use and expense of GA emergency housing, the DCF housing team has worked to foster community-based alternatives to the GA motel program. Results of the first year are encouraging; spending came in on-budget, and we are making strides towards a better service model that includes buy-in from community partners and critical supports for clients. Of note is cooperation from DV partner agencies to administer emergency housing benefits for survivors of domestic violence. While much focus has been placed on the emergency housing facet of GA, another GA area that requires attention is the Personal Needs & Incidentals (PNI) benefit. Increased spending suggests that we need to reexamine ESD's relationship with Vocational Rehabilitation (VR) regarding helping GA clients transition from emergency assistance to SSI or gainful employment. A third GA area of concern is utilization of TANF dollars. Emergency housing uses a combination of federal TANF funding that can be used for the first 28 days for families with children, and General Fund for individuals and families with children needing housing beyond the 28 days. Recently, TANF revenue has been declining and requiring a shift to General Fund. Two steps that are being taken involve training staff on proper coding and making sure new grants that create community alternatives that serve families with children are capturing the necessary data to utilize TANF funding. Finally, given the widely lauded success of the Vermont Rental Subsidy (VRS) program, an examination of replicating or expanding that program to serve other populations (e.g., seniors, survivors of DV, etc.) should be conducted.

Reach Up

While the Reach Up caseload has dropped, the families remaining face significant barriers to employment including mental and physical health issues, substance use, legal issues, homelessness, lack of childcare, and lack of transportation. We need to identify and provide meaningful work opportunities for these families that will allow them to transition off of Reach Up and into the workforce. The Reach Up program is also looking for ways to promote Post-Secondary Education (PSE) as an effective path towards self-sufficiency through rule changes, proposed statutory changes, and marketing the program to current Reach Up participants. Using caseload savings, Reach Up is proposing to provide a supplemental food benefit to 3squaresVT families who are meeting the Reach Up work requirement. This would help families by easing the benefits cliff. Additionally, it would alleviate the current challenge of not meeting the federal Work Participation Rate, as we would be allowed to count those families in the rate, thereby eliminating the potential for future financial sanctions.

Life Line

Vermont is the only state in the country that administers Lifeline eligibility and is required to do so by state statute. This program was recently expanded to cellular telephone carriers and will eventually expand to broadband internet providers. ESD will have to make a significant investment in staffing and IT programming to manage this expansion. We are recommending that the responsibility of eligibility be given to the utilities, many who already manage Lifeline in the other states where they operate, which will allow them to draw down federal funds for the work. As a state, Vermont cannot draw down these funds. This will require a statutory change. Without this change, the financial impact of additional positions and IT is significant.

Continuous Quality Improvement Unit (CQI)

Developed to create a culture in which ESD will use a framework of defined improvement techniques that are process based and data driven. CQI will engage and empower all staff to identify ways to be more efficient and improve quality of service. To support this new initiative, the ESD CQI Leadership Team has:

- Partnered with VTrans to have 5 ESD staff become Green Belt certified in Lean
- Trained all ESD Managers and Supervisors in CQI principles and techniques
- Identified and trained CQI Coaches in every ESD District Office and Work Unit

CQI formed a Workload Management Workgroup to examine all of the current processes we use to manage and complete our work to identify areas for Division wide improvements. In advance of any new technology, processes will be identified and prioritized for improvement opportunities using Lean techniques. The Workload Management Workgroup will also serve as the future ESD CQI Steering Committee.

Family Services (FSD)

In 2014, Family Services had two high profile child fatalities which were followed by a number of reviews of Vermont's child protection system. These reviews resulted in a number of reports and recommendations by the VT Agency of Human Services, the VT Citizen Advisory Board (VCAB) and Casey Family Programs (Casey). In addition, the third round of the Child and Family Services Review (CFSR) took place in the spring of 2015 by the Children's Bureau which conducts this review in all 50 states every 6-8 years.

Highlights of the recommendations from the reviews include:

- Reinforcing that FSDs first and primary mission is to promote child safety
- Reviewing safety and risk tools and updating training on these tools
- Increasing staffing capacity in our workforce
- Developing more comprehensive policies for several areas of practice including investigations and assessments, reunification, and information sharing
- Providing staff training in a variety of areas including assessment and safe planning
- Public access to online data
- Collaborating with partners around substance abuse related issues

FSD has implemented many changes based on the recommendations of the reviews which were summarized in a report in the Spring of 2016 titled *Commissioner's Response to the 2014 Systems Evaluation by the Vermont Citizens' Review Board and Casey Family Services*. Family Services has also developed a Program Improvement Plan (PIP) to address areas needing improvements as highlighted by the recent CFSR report. FSD has approximately two years to implement practice strategies that will result in achieving the federally required level of improvement in these specific areas.

Caseload Pressures

Since 2008, there has been a 100% increase in the number of accepted reports. In 2015, over 5600 reports were assigned for a child safety intervention (investigations or assessments). Custody numbers have also risen. Since 2011, there has been a 43% increase in the number of children and youth in custody, with current number totaling approximately 1,400. These increases are due in large part to the state's current opioid/substance abuse crisis. These numbers have translated into increased caseload pressures for social workers, foster homes, and available local resources designed to serve vulnerable children and families. In 2016, the administration proposed and the legislature supported additional staff resources to address caseload increases. Even with the additional staff, the statewide caseload average is 1 worker to 15.7 families with a range of 13.3 to 20.6 families served per worker. This assumes that all positions are filled at all times, which they are not, and this has a

significant impact on available social worker capacity to respond to statutory requirements. (The statutory caseload goal is 1 social worker to 12 families)

Over the last year, FSD has deployed and relied on temporary human services case aides to perform duties that are core to FSDs service delivery. Case aides have been able to take on specific tasks that otherwise would fall on social workers, but that do not require the knowledge, skill and training of a social worker. Converting these temporary positions to permanent case aide positions would stabilize and support FSD's capacity to provide quality child welfare services.

PNMI Increase

Each year, Private Non-Medical Institutions (PNMI) are rate adjusted by Rate Setting based on the actual costs two years prior. This format for adjusting rates for PNMIs has proved problematic because of the gap in years and because the inflationary increase was not taken into account under this model. As such, in the last year, programs have requested a rate increase or extraordinary relief. These unplanned/unbudgeted adjustments end up impacting our budget at the end of the year. The Division of Rate Setting has recommended an inflationary increase of 2% which is being contemplated for the budget request which would cost DCF approximately $365,000 in FY18. In order for DCF to support this budget request, it would need to be linked to our overall initiative to reduce spending and utilization of residential settings for children in our custody both in and out of state.

Safety

Child and staff safety continues to be the priority for Family Services. Not only have efforts been made to improve FSDs approach to assessing risk and safety during child safety inventions and throughout the life of a case, but also how the division responds to situations impacting staffs' safety. FSD recently created the Staff Safety Coordinator position which will support the division in efforts around staff safety. FSDs also believes in the correlation between worker caseload, social worker capacity to engage families and community partners, and child and worker safety. When workers have manageable caseloads, they are able to engage with families and community partners more frequently, which helps build relationships and promotes safety for both child and worker. Significant efforts have been made over the last year to ensure that staff are adequately trained to address their own safety needs and the safety needs of children. These efforts are on-going.

Residential Reduction and System of Care Enhancement

Over the last year, based on research that indicates children and youth do better in family settings, FSD has been committed to reducing the use and duration of residential care. This reduction in use would also have a corresponding reduction in spending. Steps have been taken to increase access to in-home supports that could either prevent the need for residential placement or assist in a shorter length of stay for the child or youth. This work includes the development of assessment capacity for children between the ages of 4-5 years old, as well as an increase in the number of short-term assessment beds for older youth with the goal of properly identifying their needs and then matching the child or youth with the appropriate community services. Lastly, FSD has begun exploring effective approaches to enhancing Vermont's foster care system, which includes evaluating how to best recruit, train, support, and develop specialized foster care to support higher needs children and youth so they can remain in their community.

Juvenile Justice

During the 2016 legislative session, H. 95/Act 153 was enacted into law which reforms Vermont's juvenile jurisdiction system to more closely align with best practices and adolescent brain development research. As a result, effective January 1, 2017, Vermont will charge 16-year old youth who commit an offense in family court. In January 1, 2018, 17-year old youth will be charged in family court. In addition, effective January 1, 2018, DCF supervision of 16 and 17-years old youth charged in family court may be extended up to 19.5 years. There are many layers to this bill which are currently being evaluated to determine not only the practice and policy changes that will be required, but also the inevitable case load implications which may be substantial and require resources to address.

Woodside Juvenile Rehabilitation Program

In need of a new facility. The present facility was built 30 years ago as a Detention Center, but has since transitioned to a therapeutic residential treatment facility to meet the mental health and health needs of youth. Over the years several changes have been made to the physical structure to accommodate changes in population and programming. However, the physical structure continues to deteriorate and presents safety hazards for residents. The FY 16-17 Capital Budget included funding for an architect to help with planning and design of a new facility. An RFP was issued and an architect should be selected within the next few weeks. It is our intent to include facility replacement in the FY 18-19 Capital Budget cycle.

FSD Technology

Family Services is reliant on information technology systems that are antiquated and at significant risk of major disruption. In 2016, both of the legacy systems failed for several days resulting in an inability for the Division to fulfill its core mandates around child safety. FSD is in the early phases of completing a feasibility study to help determine the best approach to developing and implementing a cost-effective case management system that will assist Vermont to better serve children, youth, and families. In addition, the Children's Bureau has recently issued instructions requiring planning for implementation of a new Comprehensive Child Welfare Information System (CCWIS). Only Limited federal funding is available to state title IV-E agencies to develop and maintain their own automated case management system.

Office of Child Support (OCS)

The Vermont Office of Child Support (OCS) is responsible for operating a child support program pursuant to Title IV-D of the Social Security Act. In FFY15, OCS collected $47,000,000.00 in child support payments and leveraged over $1M in federal funding to the Family Division of Vermont Superior Courts. Nationally, OCS ranks eighth in federal performance measures.

The federal Office of Child Support Enforcement (OCSE) has encouraged states to shift from an automated enforcement approach to one that adopts a family-centered approach. The following two projects represent steps OCS has taken toward a more family-centered approach:

- Work 4 Kids. OCS and the Division of Vocational Rehabilitation (VR) have partnered to offer an employment program for non-custodial parents who have court-ordered child support obligations and need assistance with securing employment in order to meet those requirements. This project was initially piloted in a few counties but will soon be implemented statewide.

- Behavioral Interventions for Child Support (BICS) Grant. OCS is one of seven states that received a federal BICS demonstration grant. The primary focus of the BICS grant is to use behavioral interventions in order to engage parents. OCS' intervention focuses on resolution meetings which are pre-court discussions held in the child support office. The meetings give both parents a chance to negotiate critical issues in a less adversarial way.

OCS Technology

The Office of Child Support's (OCS) currently uses DCF's computer mainframe system (ACCESS) which is over 30 years old and has undergone numerous adaptations to meet ongoing program needs. Nevertheless, this system is unable to meet federal requirements and OCS's current program demands, which includes an interface with ESD programs. This situation requires extensive human resources to function on a day-to-day basis. ESD and OCS are currently investigating the extent to which child support money is inappropriately disbursed to parents rather than transferred to the state. OCS has received numerous findings from IRS audits and would likely fail were the federal Office of Child Support Enforcement (OCSE) to audit Vermont's system. Moreover, the current system jeopardizes OCS' ability to qualify for hundreds of thousands of additional federal incentive dollars which DCF relies on to meet annual budgetary needs.

OCSE would fund approximately 67% of the design, development, and implementation of a new system, and the state would have to pick up the remaining cost of 33%. The Office of Child Support plans to issue a Request for Information by November 30, 2016 to seek cost-effective ways to replace or upgrade our dated mainframe system.

The Family Supportive Housing Program

Helps place homeless families in affordable housing and provides intensive, home-based service coordination and case management. The grant program supported 3 community partner sites in its inaugural year of 2014. Promising results led to additional funding in 2015, allowing the program to expand to 2 new communities. An independent evaluation found that 86% of families remained stably housed, in addition to improvements on a variety of family outcomes. Ensuring a family supportive housing option in each AHS district, is a key goal in the Agency's strategic plan initiative to end family homelessness. In SFY 2017, the program is shifting to Medicaid billing for targeted case management, which will allow for further expansion.

Integrating Financial Empowerment with Reach Up

In partnership with Community Action Agencies to provide matched savings, financial education, and microbusiness development, the Office has built expertise in asset-based strategies to help households achieve long term financial stability such as financial incentives, behavioral economics, matched savings, and integrated financial capability services that include financial coaching, credit building and banking services. OEO has partnered with national leaders in the field of asset building and financial capability to bring training and technical assistance to Vermont. Most recently, OEO is supporting a partnership between Reach Up and Community Action Agencies to build the capacity of Reach Up case managers to help participants address financial issues.

Weatherization funding

In 2017, the funding for the Weatherization special fund shifted from a gross receipts tax to a per gallon tax. This should help to stabilize funding for the program, as it mitigates some of the fluctuation in the heating fuel market that have undermined financial stability for the program. The Weatherization program helps Vermont work towards it's thermal energy efficiency goals, improve the health and safety of homes, and puts money back into the pockets of low income Vermonters to help make housing affordable. Efficiency Coaches provide one-to-one education and information to help household members shift their behavior to maximize energy savings; they also refer households for a range of other services through the One Touch Referral program.

Inter-Agency/departmental Items

- Residential Care – Turn the Curve (FSD, DMH, AHS)
- Jobs for Independence (JFI) pilot project involving ESD, VT Community Action Programs, VDOL,
- DAIL – VR Employee Assistance Program and Community College of VT
- Substance Abuse Team Coordination (SATC): substance abuse screening and referral for FSD families and ESD Reach Up clients. AHS, DCF, VDH
- Children's Integrated Services (CIS) Evidence-based Home Visiting - Partners include CDD, AHS, VDH
- DCF Housing Team – development of new service delivery model for GA emergency housing: ESD, OEO and DCF Commissioner's office
- Roadmap to End Homelessness – strategic planning effort to end homelessness: AHS, DCF, OEO

Inter-Agency Items

Act 166

Universal Pre-Kindergarten Initiative: AOE, AHS, DCF - CDD

Workforce Development

Coordination to improve workforce systems and address barriers to employment. AHS, VDOL, DCF/ESD – Reach Up & OEO, DAIL - VR

Early Childhood Interagency Coordination Team

To strengthen and align leadership at the state level around shared work in the early childhood arena. Membership includes AOE, AHS, VDH – Maternal Child Health Unit, DCF - CDD, DMH and Building Bright Futures Advisory Council

Act 46

School Consolidation Bill: Interagency report on collaboration around poverty, substance abuse and supporting children: AOE, AHS, DCF, DMH

External Groups and Organizations

Community Action Programs (CAP)

DCF contracts with the five CAP agencies to provide a range of services to families living in poverty. Services vary but can include food and nutrition, housing, weatherization, financial capability services, Head Start and other economic services.

Parent Child Centers

DCF contracts with the network of 15 parent child centers that help families make sure children get off to a healthy start. They primarily provide services to CDD and ESD – Reach Up.

Area Agencies on Aging

Provide support to people 60 years and older to remain independent. Triple A's work with DCF around economic services such as 3SquaresVT for Vermont's elderly population.

United Way (211)

Provides information and referral to Vermonters in need of a range of social services including benefit programs administered by ESD.

VT Care Partners

Designated Mental Health Agencies and Developmental Services Providers: DCF contracts with the designated agencies for a range of programs and services.

Vermont Foster and Adoptive Families Association (VFAFA)

VFAFA is a well-organized advocacy and support group for families involved with children in the custody of the Department. DCF works very closely with this organization.

VT Coalition of Residential Programs (VCORP)

This is a network of all the providers in VT which provide residential treatment for children. DCF works very closely with this organization.

VT Coalition to End Homelessness

The coalition is the umbrella organization for the 12 local homeless Continuum of Care (CoCs). OEO works closely with each HUD CoCs whose role is to support planning on efforts to end homelessness, measure performance of the homeless system of care and make decisions on federal HUD CoCs funding.

Vermont Foodbank

ESD is involved in joint efforts with the Vermont Food Bank

Hunger Free Vermont

An educational and advocacy organization working to end hunger in VT and works to improve Vermonter's access to and participation in 3SquaresVT.

VT Network Against Domestic & Sexual Violence

A network of 14 domestic and sexual violence programs and shelters. OEO provides grant funding to the shelter programs and the GA program works in partnership with shelters to address emergency housing needs for survivors of domestic violence.

DCF Legislative Initiatives and Concepts for 2017

Office of Child Support

Address overpayments that can occur for SSDI recipients to ensure that custodial parent still receives maximum benefit.

Economic Services Division

Reach Up Program

- Supplemental Food Benefit – create $10/month food benefit with Reach Up Caseload savings for 3 Squares Families who are meeting the Reach UP work requirement
- Waive PSE requirement re: 2nd parent working
- Increase asset limit

Lifeline

- Amend statute to transfer eligibility for program from DCF to tele-carriers who can take advantage of reimbursements for administrative costs.

Family Services Division

Emergency Housing for Minors

- Extend the length of stay for minors at Commissioner Designated Shelters to be consistent with fed regulations which would allow for more intervention time.

Human Service Board Hearings and Child Abuse & Neglect (Formerly known as H398 from previous session):

- Allow for hearsay exception in HSB appeals for children who've experienced child abuse and neglect.
- Include HSB decisions involving cases of Child Abuse & Neglect to authority of AHS Secretary's to overturn.

Mandatory Reporting

- Address duplicative reporting created by Act 60.
- Create civil penalty for mandated reporters who fail to report.

Post-Adoption Contact Agreements

- Create requirement that agreements cannot be signed the same day as TPR hearing to avoid foster parents feeling/being coerced to sign agreement.

Act 153/H95 correction

- Add Youthful Offender to DOC's T28 Probation Chapter.

Admission to Woodside Juvenile Rehabilitation Center

- Modify statute to have all pre-disposition placements to Woodside ordered only by a judge

Quality Assurance Program

- Address need for confidentiality with respect to quality assurance reviews of child abuse and neglect cases with the goal of system improvement.

Child Development Division

Pre-K and Fingerprint Supported Background Checks

- Clarify implementation of Act 166 in Title 16

Child Care

- Technical Correction for Family-child care homes
    - Enabling authority to fine illegal operation of child care

Commissioner's Office

Re-authorize position pilot authority
Please note: these concepts are still under development and are subject to change.

Human Resources

Article 16 of the State's non-management and supervisory collective bargaining agreements requires Classification Requests for Review (RFR) to be requested between July 1st and August 31st of each year. DCF is currently reviewing requests for 21 job classes affecting approximately 429 positions within the department. To-date, 3 classes have been reviewed resulting in 31 positions being reclassified to a higher paygrade. The DCF Classification Committee has until the end of the calendar year to complete the reviews making the actual financial impact of these reviews unknown until such time. We are projecting that the cost could be significant. Such class action RFR's will be processed during the period of September1 through December 31 following their submissions.

Safety and Security

DCF has been addressing the safety and security needs of its employees and clients on many different levels: policy and practice, building security and emergency planning and preparedness. During the last year, the Family Services Division (FSD) has created a Staff Safety Coordinator position to provide multi-level consultation and support to division staff before, during, and after critical incidents. In collaboration with the UVM Child Welfare Training Partnership, FSD has provided staff safety training specific to social work practice to every district office.

FSD has also finalized a staff safety policy that includes a research-based internal reporting system for threats and safety-related incidents. A department-wide safety committee has been established that is building on FSD's work to develop and implement a staff safety protocol and reporting system for all DCF divisions and employees. DCF also serves on the AHS Safety committee where a comprehensive safety training for all AHS staff is in development. DCF continues to work with AHS and BGS to address on-site security issues with DCF district offices. The threat level continues to be high, especially for FSD. The department does pay local law enforcement for on-site security on a case by case basis when needed.

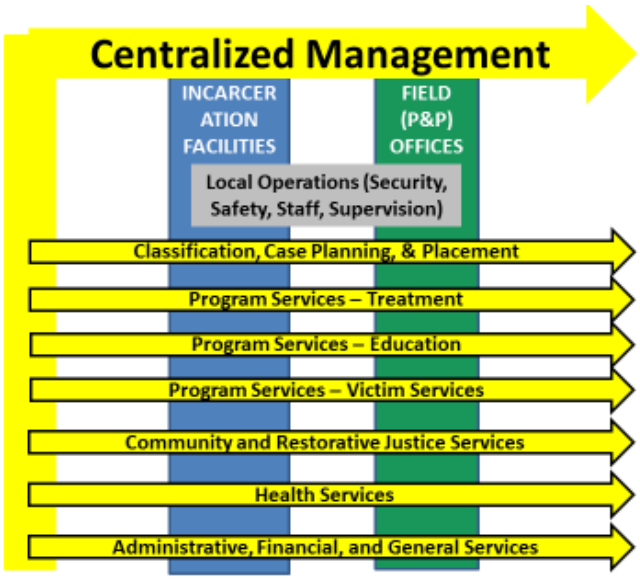
Department of Corrections

The mission of the Department of Corrections (DOC) is to support community safety by ensuring offenders serve their sentence, take responsibility for their crimes and have the opportunity to make amends to their victims. The department partners with Vermont communities to manage offender risk and assure accountability. It provides disciplined preparation of offenders to become productive citizens.

DOC operates an integrated system of incarceration and field supervision services to meet the sanctioned requirements placed on offenders. The DOC operates 7 correctional facilities and 11 field supervision offices. On a daily basis, the DOC directly serves approximately 10,000 people. It also provides indirect services to law enforcement organizations, victims, and the public.

The delivery of Correctional services is a blend of local actions and department-wide guidelines and direction. Unlike many States, Vermont operates as a unified department to manage offenders throughout their terms of custody, across incarceration and field supervision. Even while incarcerated, a sentenced inmate has both an onsite caseworker and an assigned field officer to coordinate the planning of the individual's case.

The graph below provides a high level view of the Department's structure.



Budget

DOC operates with an overall budget of approximately $157 million. Of this, $144 million is General Fund. These funds are necessary for the staffing and operation of 7 in-state correctional facilities, 1 contracted out of state correctional facility, 11 Probation and Parole offices, the Corrections Education and Offender Work Programs, Parole Board, and Central Office. DOC employs approximately 1,100 staff, including 40 temporary employees. See attachments – FY2017 DOC Budget Presentation, Approved FY17 Ups and Downs, Total FY17 DOC Appropriations by Fund Source chart.

Level Funding

The Governor's Recommended Budgets have been level-funded for the previous 3 fiscal years, but have included staff cost of living adjustments and inflationary items of nearly $4.5 million annually. See attachment – "Expenditure History", page 24 of 2017 DOC Budget Presentation.

Budget growth

In the late 1990's and early 2000's, DOC's budget was growing annually by amounts as much as 12%. Over the past several years, the average has decreased significantly and has for the past 5 fiscal years been below the rate of GF revenue growth at a statewide level. See attachment – "Expenditure History", page 24 of 2017 DOC Budget Presentation.

Appropriations

DOC has 7 different appropriations:

1. Administration – this appropriation is for staff salaries and office expenses for the Commissioner's Office and Administrative/Business Office Staff based at Central Office (25 total staff). This is all general fund.
2. Parole Board – this appropriation is for staff salaries and office expenses for the operation of the Parole Board (2 total staff). This is all general fund.
3. Education – this appropriation is for staff salaries and all operating costs for the Corrections Education program (47 total staff). This consists of Education Fund and Interdepartmental Transfer Fund (IDT) which includes grant funds transferred from the Agency of Education.
4. Correctional Services – this appropriation is for staff salaries, service contracts, operating expenses, and grants, for the operation of correctional facilities, probation and parole offices, and central office divisions (966 total staff). This includes general fund, global commitment (Medicaid-eligible MCO Investments), Federal Funds, Inter-Departmental Transfer Funds (IDT), PILOT (Payment In Lieu of Taxes)

Funds, and the Supervision Fee Fund. This appropriation supports all Program Services, Inmate Health and Mental Health contract costs, and Transitional Housing and Community Justice investments.

5. Out of State (OOS) – this appropriation is for the contract for a private prison facility (currently in Michigan) to house inmates for which there is not in-state capacity. This is all general fund.
6. Inmate Recreation Fund – this appropriation is for staff salaries and operating expenses related to the recreation costs for inmates (7 total staff). These funds are collected as commissions on inmate phone calls, and purchases made from inmate commissary and inmate kiosks/tablets. This fund supports the purchase of items such as televisions for housing units, and the cost of subscriptions to cable television, newspapers/periodicals, and the maintenance/replacement of gym and other recreational equipment.
7. Vermont Offender Work Program (VOWP) Fund – the VOWP fund is a proprietary fund, wherein revenues are received for items purchased through the Vermont Correctional Industries (VCI) and from work services performed by facility work camps and probation and community work crews. Correctional Industries includes a wood/furniture shop, print shop, plate shop, and sign shop. This appropriation pays for the salary and administrative expenses for VCI (14 total staff).

Overtime and Position Pilot

DOC had nearly $5 million in overtime expenses in FY16. Overtime at correctional facilities accounted for the great majority of this. In an effort to reduce facility overtime, which leads to attrition and staff fatigue, DOC did analysis for a position pilot, which was approved by the Legislature as part of the Big Bill (Act 172, Sec. E.100.1(d)(1). This states that "The Department of Corrections is authorized to add only Correctional Officer I and II positions.". These positions will be used to mitigate the need for overtime worked in the correctional facilities. By utilizing these positions for replacement of overtime, the cost of these classified positions is offset by the savings on overtime costs. At this time, we have not received approval from AHS to implement the pilot.

Position turnover and training

Correctional Officers are required to attend the Correctional Academy and to shadow staff at correctional facilities, at a cost of 8 paid weeks, and a significant training cost. Position turnover remains a challenge, and the inability to retain staff has tremendous costs, both in the vacancies and the overtime resulting from this, as well as the recruitment and training of new staff. DOC has begun conversations around signing bonuses, and incentive bonuses for completing milestones such as the end of probationary period and one year later for example. After speaking with Labor Relations, other departments that have done this have seen an increased retention rate. This is an incentive program that could achieve positive results while ultimately creating savings.

Offender and Inmate Records Rule

The DOC was required to create a rule concerning offender and inmate records. Unless changed or delayed, effective in May 2017, DOC will be required to provide complete files annually, albeit redacted, to each inmate and offender who chooses to request his or her file. An additional copy, which would include only items that have been added/changed since the time of the full file request, can be requested in the same calendar year. There are some significant challenges related to this, including the need to scan potentially millions of documents, upload them to the Offender Management system or at least the network drive, and then review/redact these files before being able to print them upon request. The estimated time and cost of this could be as much as $25 million if every offender and inmate requests a file within the first year. If staff need to complete some of this work by May, the potential exists that several staff (administrative and casework staff have been identified) at each DOC site will be offline until this project is complete. There will be significant overtime costs as well as additional costs for scanners and specialty software for redacting.

Facility Planning

The Department was tasked with assembling a committee and providing a report with recommendations to the House and Senate Institutions Committees. VT DOC is challenged both operationally and fiscally by having several small facilities (by corrections standards). The Department is not able to benefit from economy of scale; for example, larger facilities would not need to utilize space for several medical areas, and the staff required to maintain the basic needs of inmates. In comparison, multiple smaller facilities require multiple medical areas

and staff at each site, effectively creating higher costs for the same services. The facility planning will review the anticipated costs of maintenance at existing facilities, provide a number of potential options for increasing in-state capacity, along with the financing options related to these recommendations, and potentially provide a starting point for further exploration of the construction of a larger multi-purpose facility.

Under 25

DOC management is currently planning for the male inmate population under 25 years old to be moved to either one facility or to a separate unit in each of the existing facilities. There are many potential issues and risks with this, but from a budget perspective, this creates costs for transport, additional security, and loss of in-state capacity, which results in more inmates out of state.

Out of State (OOS)

Currently there are 251 inmates housed in an OOS facility located in Michigan. DOC contracts for these services. The per capita cost, while less costly than an in-state bed, results in higher costs overall to the Department. The in-state facilities have relatively fixed costs with regard to staff and operational expenses, but the lack of capacity for the incarcerated population necessitates additional space to house sentenced inmates.

Increasing population

The sentenced inmate population had been steadily declining for the past couple years, but has more recently seen an uptick, particularly with the detention numbers. As the population rises, this places stress upon the facilities which become increasingly crowded. It also adds pressure to the budget, as the Department may need to transport more inmates to the OOS facility, which has not been factored into the OOS appropriation.

Facility projects

As a result of the necessary and sometimes emergency maintenance of correctional facilities, there are several ongoing and upcoming projects that may limit capacity at each site. For example, Southern State had lost the use of 50 general population beds for the past several months so that pipes in the living units could be replaced. Working with BGS, there are other projects with similar scopes that are upcoming and will add to the pressures of the increasing population and limited funds for OOS beds. In addition to these projects, there are many other facility initiatives ongoing, such as the replacement of camera surveillance systems at each site. Through funds appropriated to BGS on DOC's behalf through the Capital Bill, DOC helps manage these projects and, in some cases previously, needs to identify funds when projects exceed the initial estimated budget.

CCWC

Closure of the Caledonia County Work Camp was proposed in the FY17 Governor's Recommended Budget. The Legislature added language into the Big Bill (Act 172, Sec. E.338.1) that stated the DOC would seek to reach an agreement with the Town of St. Johnsbury in order to repurpose one unit in the building for offenders who are not work camp eligible, but are a) classified as minimum security, b) have completed their minimum sentence and are eligible for furlough or parole, but lack appropriate housing, and c) are not serving time for a sex offense conviction unless the offender is a resident of St. Johnsbury.

To date, an agreement with the Town has not been reached. As a result, there are 50 vacant beds, which prevents DOC's ability to return 50 inmates from OOS.

MCO Investments

There are several grants that DOC has for Transitional Housing and Program Services that are providing Medicaid-eligible services. By leveraging state general funds (i.e. Global Commitment fund) DOC has approximately $5 million of MCO investments. The Center for Medicaid and Medicare Services (CMS), which AHS works closely and negotiates with, has recently begun to deny expenses related to several agreements that have been in place for years. DOC has not yet been negatively impacted by these changes, but the eligibility requirements and restrictions have been growing in number and could present future challenges.

Key Initiatives

Aging Population

Planning for the appropriate setting to address the needs of **inmates who are aging,** have mental health and/or substance abuse needs, and people with disabilities. The Department has engaged in conversation with AHS sister departments, advocates and other stakeholders in an effort to find a solution to the challenges of incarcerating this population. A report is due to the Legislature in February 2017 that will outline the scope of the problem and deliver recommendations.

Probation and Parole

Probation and Parole Division is stable, at this time the focus is on continuing to implement evidence-based best practices and decision making in our day to day activities. Most of the initiatives out of Probation and Parole are in support of other divisions. They are attached to our Recidivism Reduction Grant, EPICS trainings, the new Case Management Directive, and Staff Competency/training work.

Transitional housing

In order to best serve the reentry population, the Community and Restorative Justice Unit has conducted a housing needs assessment focused on the characteristics of inmates on the "Lack of Housing (B1)" list and those currently residing in our Transitional Housing programs. The Department has made several efforts in the past few years to release this population into the community when they are eligible. Due to the characteristics of this group, those efforts had a small impact. Additionally, offenders who were released often returned to incarceration for violating behavior. Our current analysis indicates the following 3 inmate demographics are most in need of housing: those with convictions for sexual offenses; those requiring nursing home and/or assisted living services; and those designated as having Serious Functional Impairment (SFI). Based on this, we intend to build the corresponding service capacity through issuing Requests for Proposals (RFP) for housing programs designed to serve these target populations. The RFP process will be conducted during the current Fiscal Year (FY17) in order to support new and/or expanded programs in FY18. We continue to grant manage the 43 programs that presently provide 327 statewide transitional housing beds along with search and retention services, as well as provide release monies to approximately 75 reentrants per year.

Criminal Justice Center reentry program capacity building and Circles of Support and Accountability expansion

20 statewide Community Justice Centers each provide a full range of restorative programing ranging from pre-charge to reentry services. Restorative reintegration capacity originally built through our federal Second Chance Act grant has been sustained and incorporated into CJC base grant agreements. CJCs have the capacity in FY17 to develop and operate between 78 -116 CoSA groups for high risk/high need individuals, as well as provide reintegration panels for furloughees, reentry navigation, educational workshops and community forums all designed to foster enhanced engagement and improved reentry outcomes for the individual and the community.

Community High School of Vermont (CHSVT)

Transition of the school to a Therapeutic School model and integration with risk reduction intervention services: 1) eligibility population expanded to include moderate – high risk of recidivism offenders; 2) organization structure changed to Program Services Unit and Headmaster is team peer with Chief Clinical Specialist; 3) Year 1 of 3 Year plan for model development, cross cultural and professional training, phased implementation of integrated intervention services screening, assessment, engagement, services plan development, intervention menu and schedule, integration and development of software system for intervention services data and documentation, procedural guidance, staff professional development and competencies development plan and evaluation, quality assurance and improvement mechanisms.

Second Chance Act Grant

1) re-writing and creating a new set of policy documents for the DOC

2) Training DOC staff in evidenced based practices to reduce recidivism (multiple training strategies that cross a wide range of topics)
3) Establishing a collaborative reentry process to stabilize offenders within first 90 days of release

Staffing

A study conducted by the Association of Corrections Administrators stated that DOC needed 74 additional staff members to adequately cover posts at all the correctional facilities. The Department continues to experience the impact of understaffing. Current staff work extensive overtime to maintain safety and security. The DOC is currently participating in the position pilot as one method to mitigate some of the impact.

Successes

Peer Support

DOC continues to build a plan that addresses organizational trauma, traumatic stress, as well as training and building capacity with the DOC Peer support team. The current DOC leadership is committed to developing a plan that works in conjunction with our efforts to build department resilience.

Population management/ lower incarceration numbers

The number of people in Vermont facilities has dropped 18% since 2008.

Prison Rape Elimination Act (PREA) Compliance

In 2014, all Vermont correctional facilities underwent an audit for compliance with the national PREA standards. Each facility was found compliant. Audits are conducted every three years and the next series will begin in the Spring of 2017. DOC continues to provide intensive support and training to all facilities in order to maintain this high level of compliance. A particular focus this year is to improve the prevention, detection and investigation of PREA allegations. This requires significant stakeholder engagement from partners such as the Agency of Human Service Investigation Unit, Vermont State Police and the Department of Human Resources.

Circles of Support and Accountability (COSA) Model

This model has received national/international recognition for its success it Vermont.

DOJ awards/National recognition

The Department has received several awards from the Department of Justice through Second Chance Act funding. The DOJ continues to recognize Vermont as a leader in implementing corrections best practice.

Policy Development Process

The Department has been identified as a national model for its process of developing policy. The Council of State Governments is preparing materials to include in its resource center about the process and will present it as a model for other states to replicate.

Organizational Resilience

DOC began an organizational resilience initiative that focuses on safety, workforce wellness, individual resilience, reward and recognition, peer support and leadership development.

New England Council on Crime and Delinquency Conference

Vermont DOC hosted the New England Council on Crime and Delinquency Conference formalizing the theme of Courage, Competence, and Compassion for Corrections Professionals. There were over 200 attendees and considerable support and enthusiasm for the many trainings addressing primary and secondary trauma of the corrections professional.

Safety

DOC is a major contributor on the agency safety committee and training development. Staff have been leading and supporting agency partners in addressing safety in the work place. Peers Support and Crisis Intervention

training has proven successful. The DOC will continue to support these efforts with advanced training and capacity building.

Peer Relationships

DOC has excellent relationships with the Association of State Correctional Administrators (ASCA) and the Northeast Association of Corrections Administrators (NACA). ASCA conducted the above mentioned staffing study and provided significant research in corrections best practice. Commissioner Menard hosted the annual NACA conference in Vermont on October 7-10, 2016.

Challenges

Staff Safety

- Some field staff are asking to be armed for safety purposes.
- Workforce safety and emergency preparedness planning continues with significant overlapping between DOC and other Agencies resources. DOC has expertise in this subject matter.

Recruiting

- The Department is in a constant state of recruitment for Correctional Officers. Most CO's are hired as temporary positions which creates demand for replacement. The temporary status and nature of the work has made it challenging to hire enough CO's to cover all shifts.
- Behavioral services are contractual and require significant training and supervision resources to develop criminal justice competency with complex population.

Potential lawsuits stemming from use of segregation

Several states have experienced lawsuits resulting in court judgements or consent decrees that require departments to meet conditions within certain timeframes. These timeframes often impose a financial and other burdens on the departments. DOC is also under scrutiny from advocacy organizations regarding housing decisions that place mentally ill people in segregation. DOC is actively working to address these concerns in order to mitigate the possibility of lawsuits.

Meeting needs of aging and ill population

Including persons with acute mental health challenges: In line with national trends, DOC is experiencing an increase in the number of incarcerated offenders over 55 years of age. This trend has significant impact on the delivery of health and mental health services. It is also impacts facility operations as more people experience mobility issues. Additionally, the State has not planned well for the increasing number of people in the criminal justice system with acute mental health needs. Successfully addressing this issue will require new models for integration and operations in addition to resources for training and staffing.

Physical structure of facilities

DOC operates 7 correctional facilities of varying designs and ages. At this time there is $86, 735,197 of deferred and scheduled maintenance identified to keep the facilities operational.

Offender Management System/Database

DOC transitioned to a new database in March 2015. From an IT perspective the new system is more stable (the old system was 30 years old and crashed frequently). From a staff perspective the system has not lived up to its promise. Staff members find it cumbersome. The new system also presents problems from a data perspective. Reports and statistics are also not easily accessible which makes it difficult to respond to requests from the Legislature and other stakeholders.

Implementation of requirement of Act 137 related to offender records: Act 137 requires DOC to make all records related to inmate/offender available to that inmate/offender at least once a year. They are also able to make a

second request for additional records/changes during the same calendar year. The impact of implementing this requirement will have significant financial and staff impact. A complete economic impact is outlined in the rule paper work

Opportunities

- The DOJ grant continues to provide many opportunities to provide staff with training and support needed to be successful at their jobs. The grant has also identified and is actively working on breaking down barriers between partners to work together to support people under the supervision of the DOC.
- In Partnership with VCJTC, VSP and the Vermont Fair and Impartial Policing Committee, we are further researching a non- bias supervision model that will include training initiative that addresses **explicit and implicit bias training** content for all employees and leadership.
- In Partnership with VCJTC International Association of Chiefs of Police we are researching opportunities for interagency training on an advanced Leadership in Police Organizations (LPO), Leadership Training.
- All of the challenges listed above are also opportunities for DOC to continue successfully meeting its mission.

Intra-Agency or Inter-Departmental Items

1) The U.S. Department of Justice is looking into issues related to services for people with mental illness. Related to DOC, the DOJ is looking at whether mentally ill inmates are being held longer because of their mental illness and barriers to release such as a lack of support and services within the community.
2) DCF: DOC is collaborating with DCF on Youthful Offender Supervision and implementation of H.95.
3) DMH: The DOC faces intense scrutiny from advocate organizations regarding the treatment of people with mental illness housed in correctional facility. There has already been litigation on some cases. The Agency and the State need to work on a sustainable solution before a lawsuit forces us to take action.
4) Department of Health, Division of Alcohol and Drug Abuse: DOC and ADAP are working with support from a SAMSHA grant to expand the capacity to provide medically assisted treatment (MAT) capacity in both the community and three pilot facilities.
5) PREA: In partnership with AHS IU, DHR, DOC, VSP and the MOSS Group, we are currently working to identify areas for improvement in the prevention, detection and Investigation of PREA allegations, staff sexual misconduct and misconduct in general. Challenges will be to continue momentum absent PREA Grant funds that will expire September 30, 2016. The department is currently revising a draft collaborative Gap Analysis that addresses the needs areas with regards to legal issues, agency liability, first responder and evidence collection duties, prosecutorial collaboration, and agency culture dynamics.

Inter-Agency Items

1) Department of Education: The Community High School of Vermont must meet educational standards of the Vermont Department of Education and of the NESAC.
2) DOC work crews completing work for the AOT and Department of Parks and Recreation.
3) Electronic Monitoring Pilot: DOC is working with the Windham County Sherriff's Office and the Association of States Attorneys and Sherriff's Departments to expand the Electronic Monitoring Program. This program has significant support from the Joint Justice Oversight Legislative Committee; the House Committee on Corrections and Institutions, and the Senate Judiciary Committee. Act 125 allows the court to place someone on electronic monitoring when released prior to trial. It allows for the expansion of the Windham County Electronic Monitoring program to other parts of the state and requires the DOC to enter into an MOU for oversight and funding of the electronic monitoring program.
4) The Pre-Trial Services Program transitioned to the Office of the Attorney General on September 1, 2016. Statutorily, the DOC still has responsibility for the program until the language in ACT 195 is updated. It is unclear how this shift will impact the DOC budget in the future. At this time, funds for the program are appropriated to the DOC.

Key Dates and Decision Points

- Facility Study Report due on 2/1/17
- Transgender staff: Decision as to how transgender staff will conduct strip and pat searches and how overnight accommodations will be handled when staff travel on state business
- Accepting detainees from ICE in light of the Fair and Impartial Policing Policy: Should the DOC continue to accept detainees who are in custody only for immigration status
- PREA Audits begin spring 2017
- Report due on 11/15/16 to the Joint Legislative Justice Oversight Committee regarding Offenders with Mental Illness

Legislation

Feasibility of Developing a Forensic Psychiatric Unit/Facility

This legislative proposal would appropriate funding in order to assess the feasibility of developing a forensic psychiatric unit or facility. Ideally, the facility or unit could be paid for with Medicaid or other insurance dollars. Currently, there is a designation of "Delayed Placement Persons," meaning those who have been found to meet criteria for an inpatient psychiatric bed, but no bed is available and therefore, the patient remains in the custody of Corrections (DOC) until a placement can be made. DOC is not an appropriate placement for patients who should otherwise be in an inpatient psychiatric setting, and the DOC and the Agency of Humans Service as a whole are vulnerable to litigation until this issue is resolved. The purpose of the proposed forensic psychiatric unit would be to house patients who meet criteria for in-patient psychiatric treatment and who have a history of involvement with the criminal justice system in the most appropriate, least restrictive setting.

Offender and Inmate Records

As mentioned above, legislation passed last year related to offender records poses a significant burden for the department. DOC is unable to provide the offender and inmate records as mandated by the effective date. The process to provide the information will include scanning, uploading, reviewing, redacting, and printing millions of sheets of paper. The estimated time needed in order to have all required documents digitized, reviewed, and redacted is significant, and could amount to almost 400,000 hours. If this must be done, it will mean taking caseworkers and other staff completely offline until this initial process is completed.

Telephone Monitoring for Response Supervision

This legislative change would expand the use of the telephone monitoring system to include all cases assigned to response supervision. The change will maximize the benefit of the telephone monitoring system and allow the department to free up resources to focus on higher risk offenders.

Pre-Approved Furlough and Treatment Furlough

This legislation would clarify the legal status and types of programming used by the DOC. Currently, the 808a(a) language is not for treatment (i.e. Inpatient substance abuse). Instead, the language applies to two programs operated by the department: Risk Reduction Programming 808e(a) and our Community Restitution Program (work crew) 808e(b). This proposed language will separate these two types of programs. The legal status Pre-Approved Furlough is currently used by the criminal justice system and is written on the sentencing mitts. Pre-Approved Furlough allows the court to place an offender directly on furlough to participate in either of our programs instead of going to jail.

Additionally, the language will authorize the department to make the recommendation for programming. When section 808 was reorganized in statute that authority was left out. The new language allows the department to review and investigate the 808e(a) cases prior to sentencing to ensure that Pre-Approved Furlough is appropriate for the offender. This is necessary to make sure the offender meets the necessary program requirements.

Home Confinement

The statute on home confinement was changed in the last legislative session. The Department is looking to clean up some of the language regarding changes to an offender schedule. Currently the DOC has the authority to change a listed crime, but not a non-listed crime, the language has it backwards. This proposal is to correct the statue.

The proposed changes separate home confinement based on listed and non-listed. For listed crimes, which are the most serious crimes, the court is the sole authority to make approved absences and when approved notification to the prosecutor's office, so they have time to notify the victim. For non-listed offenders, the Department can make the changes and there is no notification to the prosecutor's office. These are non-violent crimes and victim notification is not necessary for public safety**.**

External Group and Organizations

1) Prisoner's Rights Office
2) Vermont Judiciary
3) Sheriff's and States Attorneys Association
4) Disability Rights Vermont
5) Council of State Governments
6) American Association of Corrections Administrators (ASCA)
7) American Corrections Association (ACA)
8) American Probation and Parole Association (APPA)
9) Human Rights Commission
10) Vermont Commission on Women
11) Community Justice Networks
12) Vermont State Police
13) Local Law Enforcement
14) Community Mental Health Agencies
15) National Institutes of Corrections (NIC)
16) U.S Department of Justice (DOJ)
17) National PREA Resource Center
18) Association for Women Executives in Corrections (AWEC)
19) Vermont Criminal Justice Training Council
20) Vermont Center for Crime Victim Services

Department of Mental Health

It is the mission of the Vermont Department of Mental Health to promote and improve the mental health of Vermonters.

Mental health will be a cornerstone of health in Vermont. People will live in caring communities with compassion for and a determination to respond effectively and respectfully to, the mental health needs of all citizens. Vermonters will have access to effective prevention, early intervention and mental health treatment and supports as needed to live, work, learn and participate fully in their communities

As restored by Act 15 in 2007 and updated by Act 79 in 2012, the Department of Mental Health (DMH) has a broader legislative mandate than it had when it was the Department of Developmental and Mental Health Services. As Vermont's Mental Health Authority, DMH's responsibilities include:

- Maintain and improve a system of care for children and youth experiencing a severe emotional disturbance and their families and for adults with severe mental illness
- Centralize and more efficiently establish the general policy and execute the programs and services of the state concerning mental health, and integrate and coordinate those programs and services with the programs and services of other departments of the state, its political subdivisions, and private agencies, so as to provide a flexible comprehensive service to all citizens of the state in mental health and related problems
- Offer a continuum of community and peer services, as well as a range of acute inpatient beds throughout the state
- Operate the Vermont Psychiatric Care Hospital (VPCH) and the Middlesex Therapeutic Community Residence
- Coordinate services for mental health, physical health, and substance abuse across both public and private health-care delivery systems in Vermont
- Provide leadership and direction for the public mental-health system
- Conduct program and service monitoring and assessment to:
    - assure adherence to state and federal regulations
    - manage the quality of mental-health services and supports delivered by the state's designated agencies (DAs), also known as community mental health centers, and the single Specialized Service Agency (SSA) for children and adolescents and their families

As referenced above, the Department of Mental Health is responsible for mental health services provided under state funding to special-needs populations including children with serious emotional disturbances (SED) and adults with severe and persistent mental illnesses (SPMI). Funding is provided through the Vermont Agency of Human Services Master Grants to ten Designated Agencies and two Specialized Service Agencies. These agencies are located across the state of Vermont for the provision of Community Rehabilitation and Treatment (CRT) services for adults with severe and persistent mental illness; Adult Outpatient for adults who are experiencing emotional or behavioral distress severe enough to disrupt their lives but who do not have long-term disabling conditions; Emergency Services for anyone, regardless of age, in a mental-health crisis; and child and adolescent mental health services including children who have a serious emotional disturbance and their families. The Department also contracts with multiple peer (individuals with the lived experience of mental illness) and family-run organizations to provide additional support and education for individuals and family members who are seeking supplemental or alternative supports outside of the Designated Agency in their catchment area. Peer and family-run organizations also help educate individuals and families to advocate for their needs within the Designated Agencies and across multiple service provider organizations.

DMH has two major divisions: Mental Health Central Office and Vermont Psychiatric Care Hospital.

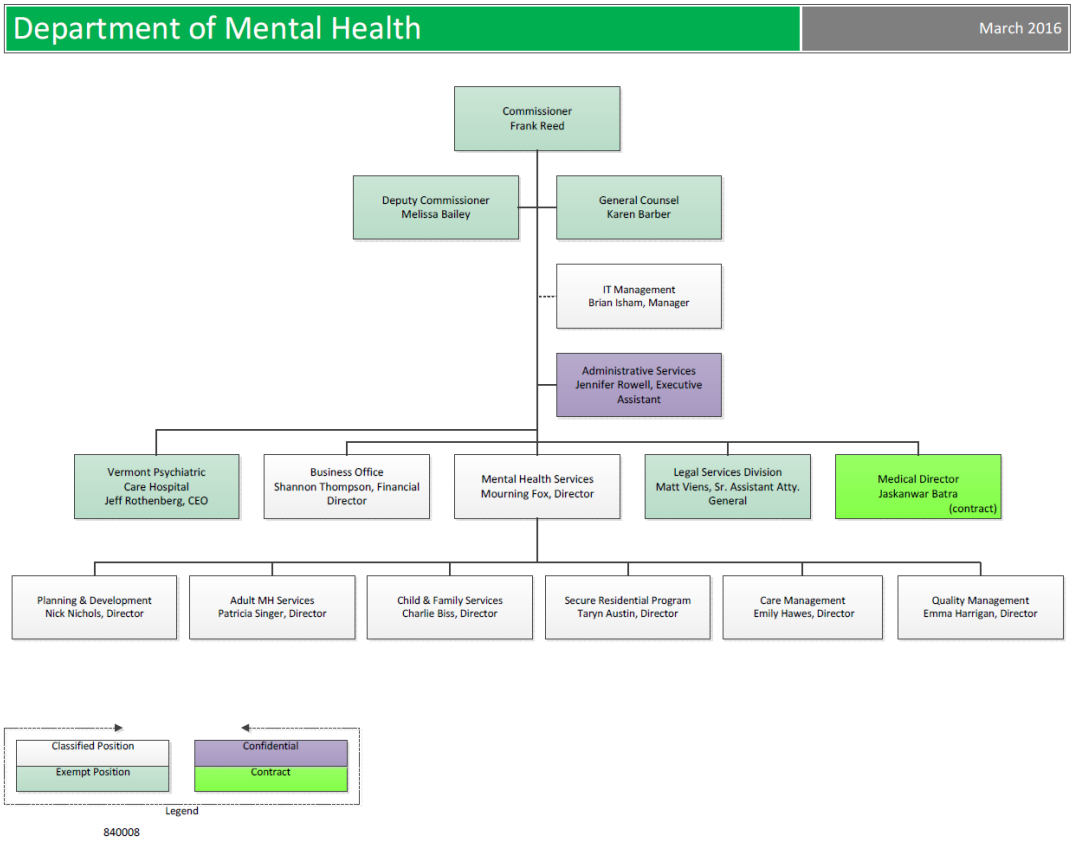
Mental Health Central Office

The Mental Health Central Office (DMH-CO) includes all central office staff necessary to oversee and manage the Designated Agency and Hospital systems and the overall mental health system of care. This DMH-CO also oversees operation of the Middlesex Therapeutic Community Residence, a 7-bed secure residential program operated by the state in Middlesex, VT. Core personnel of the DMH-CO include: 3 Exempt Positions (Commissioner, Deputy Commissioner, General Counsel); 38 Classified Positions; 3 Contract Positions; and 8 Assistant Attorneys General (positions with Attorney General's Office) for a total of 52 positions.

The DMH-CO is comprised of nine units:

1. Commissioner's Office and Administrative Support Unit: Provides overall departmental oversight and coordination of administrative support to the DMH-CO
2. Financial Services Unit: Oversees and manages all fiscal operations for DMH, including all grants and contract
3. Legal Services Unit: Provides legal representations and support services for DMH, including civil litigation for cases involving involuntary treatment, which can be either inpatient (Order of Hospitalization), outpatient (Order of Non-Hospitalization), or orders for Involuntary Non-Emergency Medication
4. Research & Statistics Unit: Provides comprehensive data analysis and reporting of provider services and outcomes.

5. Clinical Care Management Unit: Ensures coordination of care and appropriate transitions for individuals under the care and custody of the Commissioner of DMH across levels of mental health care (e.g. hospital, residential, crisis bed, community placement)
6. Policy, Planning & System Development Unit: Supports mental health policy and planning across departmental units
7. Quality Management Unit: Oversees Agency Designation, plans and oversees the outcomes of quality-improvement activities, reviews key reports and service indicators, monitors and reports on provider and system resources, identifies unmet needs, and recommends system-improvement initiatives
8. Children, Adolescent and Family Unit (CAFU): Oversees management of child and family services funded by DMH and supports broader systems development to improve care and support to improve the wellness and resilience of children and families
9. Adult Mental Health Services Unit: Oversees management of all adult services funded by DMH and supports broader systems development to improve care and support for Vermonters with mental health needs



Budget

Community Mental Health

The current DMH appropriation is $224M, funded with 97% Global Commitment, 2% federal grants and 1% that is a mix of state general funds, special funds and interdepartmental transfers. The vast majority of appropriated funds are for direct services provided by the designated mental health agencies, with less than 4% of the overall budget spent on state administrative staff and operating expenses.

In FY13-FY16, the state invested over $50M of Global Commitment funds to replace the almost $23M in General Fund that it cost to run the Vermont State Hospital. This paid for expansion of emergency services, acute inpatient beds, additional crisis and residential beds and other intensive outreach and support programs in response to Act 79 after Hurricane Irene.

The Success Beyond Six (SBS) program has increased by almost $13.5M from FY12-FY17, and in FY 15, kids residential program received a $1.1M increase.

Inpatient Care

Vermont Psychiatric Care Hospital (VPCH) has a budget of just over $20M, which funds 179 classified state positions, contracts and general operating expenses. This facility is funded primarily with Global Commitment investment, with just over 2% being funded with special funds (Medicare, other traditional insurances and patient self-pay).

Middlesex Therapeutic Community Residence (MTCR) has a budget of just under $3M, and is funded through the CRT program with Global Commitment dollars (investment as well as program), and patient self-pay.

Budget Pressures

- In FY 17, Designated agencies were given a 2% Medicaid rate increase for a 10-month period beginning September 1, 2016. This creates an additional pressure in FY 18 to annualize this expenditure.
- DOL Rule: The new DOL FLSA Overtime rule increases the salary threshold for paying overtime to $47,476. This creates a pressure in FY 17 of $1.6M, and $2.8 Million in FY 18.
- PNMI increase: Each year, Private Non-Medical Institutions (PNMI) are rate adjusted by Rate Setting based on cost two years prior. An inflationary increase of 2% is being contemplated for the budget request totaling $164K.
- DMH is proposing an increase to cover the loss of HUD funding that some Designated Agencies will sustain, having an impact of almost $364K.
- Impacting both inpatient care facilities, in FY 17 DMH invested $265K to increase nurse salaries as well as market factors in an effort to maintain current staffing and attract qualified nurses. This was a preliminary estimate prior to recommendations from the committee researching salaries across the state. After completion of the analysis, an additional $340K will be necessary in both FY 17 BAA and FY 18 to base fund these increases.
- In FY 18, There will be a "yet to be determined" financial planning cost for continuing development of bed capacity for individuals not needing inpatient care, but not ready for community based voluntary services.
- Despite achieving savings during their first years of operation, Vermont's two Integrated Family Services pilot sites are now reaching the upper limits of their budgets and facing waiting lists for services.

Designated Agencies

Operating under *Administrative Rules for Agency Designation* (June 2003), DMH contracts with ten private nonprofit Designated Agencies (DAs) to provide service coverage to all areas of the state and with two private nonprofit Specialized Service Agencies (SSA's) to provide specialized mental health services to address identify gaps in the system of care. The Commissioner of DMH confers designated or specialized service agency status when he or she confirms that an agency meets state and federal laws, regulations, and quality standards for the provision of mental health services. Each DA is responsible for providing core capacity services in a given region; one SSA (Northeastern Family Institute) provides intensive services to adolescents from anywhere in the state, and the other SSA (Pathways-Vermont) provides housing-based mental health services in selected regions of the state.

Clara Martin Center serving Orange County
Counseling Services of Addison County serving Addison County
Health Care and Rehabilitation Services of Southeastern Vermont serving Windsor and Windham Counties
Howard Center serving Chittenden County
Lamoille County Mental Health Services serving Lamoille County
Northeastern Family Institute serving children statewide
Northeast Kingdom Human Services serving Orleans, Essex and Caledonia Counties
Northwest Counseling and Support Services serving Franklin and Grand Isle Counties
Pathways-Vermont serving adults in Addison, Chittenden, Franklin, Washington, Windham and Windsor counties
Rutland Mental Health Services serving Rutland County

United Counseling Services serving Bennington County
Washington County Mental Health Services serving Washington County

Each Designated Agency provides four major programs: Adult Outpatient (AOP), Community Rehabilitation (CRT), Children and Family Services (C&F), and Emergency Services.

DMH contracts for approximately $160 million in community services annually and combined, the DA mental health programs and SSA's employ nearly two thousand full time equivalent staff and serve over 26,000 Vermonters each year.

Inpatient Care and Designated Hospitals

Vermont utilizes a decentralized system of inpatient care, where people in need of hospitalization are provided treatment at either the state-run inpatient facility or one of five *Designated Hospitals* throughout the state. Designated Hospitals provide treatment for both voluntary and involuntary inpatient stays. Involuntary hospitalization stays for people who are the most acutely distressed are defined as *Level 1* and are served primarily at the Brattleboro Retreat, Vermont Psychiatric Care Hospital, and Rutland Regional Medical Center. Level 1 hospital stays are a subset of all involuntary hospitalizations in Vermont.

Hospital	**Number of Beds**
Brattleboro Retreat – Brattleboro, VT	89 Beds (includes 14 Level I beds)
Central Vermont Medical Center – Berlin, VT	14 Beds
Rutland Regional Medical Center – Rutland, VT	23 Beds (includes 6 Level I beds)
University of Vermont Medical Center – Burlington, VT	27 Beds
Windham Center at Springfield Hospital – Springfield, VT	10 Beds
Vermont Psychiatric Care Hospital – Berlin, VT	25 Level I Beds

Vermont Psychiatric Care Hospital

The Vermont Psychiatric Care Hospital (VPCH) is a licensed 25-bed hospital designed and staffed to provide the most acute care in the state and inpatient evaluations for forensic referrals. VPCH is dedicated to improving the health and well-being of one of Vermont's most vulnerable populations. Offering a state-of-the-art facility designed to promote and enhance patient recovery, the 25-bed, acute care hospital offers patient areas designed for comfort and safety. Some of the features of the hospital include well designed yards, half basketball court, planting beds, jogging track, labyrinth, and other unique landscaping details. Some interior aesthetics include a library, a greenhouse, a large activity room, and a fitness room. Patients are encouraged to engage in activities and participate in all aspects of prescribed treatment to facilitate recovery.

VPCH serves approximately 70 involuntary patients annually and provides comprehensive psychiatric inpatient care, forensic evaluation, and general hospital services with 179 permanent FTE's and 8.0 Building and General Services (BGS) FTE's who work full time at VPCH. VPCH contracts for pharmacy services from Copley Hospital for 4.0 FTE's. Copley has agreed to continue its pharmacy contract with DMH through FY 17. DMH will need to plan, as part of the FY 18 budget development, to include these contracted services and positions as a budget up request. VPCH contracts for Psychiatric Services from the University of Vermont Medical Center (UVMMC) with 5.3 FTE psychiatrists and over 15 on-call psychiatrists (also contracted through UVMMC), who ensure 24/7/365 coverage. VPCH contracts for healthcare consultation and ancillary services from the Central Vermont Medical Center/UVMMC alliance.

VPCH has an annual budget of just over $20 million. VPCH is licensed for twenty-five beds inpatient beds. While VPCH is designed to optimize acute inpatient care, it continues to treat on average 4-5 patients who no longer meet hospital criteria due to legal issues or a protracted course of mental illness and require ongoing services that community resources are unable to safely manage given the needs of these higher acuity patients.

The workforce is primarily made up of mental health specialists and nurses. Vacancies in nursing positions require that DMH contract for temporary or "traveler" services with more than one firm to meet staffing requirements. The day-to-

day staffing at VPCH is driven both by the census and the acuity of patients. VPCH is licensed by the Vermont Department of Health, Board of Health, and is accredited by The Joint Commission and certified by CMS.
VPCH recently underwent a full re-accreditation survey and, following submission of a plan of correction to address deficiencies, is in good standing for another three years. VPCH must operate consistent with the standards of all acute care hospitals in Vermont, in addition to meeting other requirements for stand-alone psychiatric hospitals.

Key Initiatives

Development of a Secure Residential Program

DMH currently operates a 7-bed secure residential program in Middlesex (Middlesex Therapeutic Community Residence – MTCR) that was developed following Tropical Storm Irene to serve individuals who no longer require acute inpatient care, but who remain in need of treatment within a secure setting for an extended period of time. The MTCR was built as a temporary structure with plans to assess the capacity needed for a permanent SRR replacement over the following two years. DMH has previously recommended the development of a 16-bed permanent facility to replace the MTCR and is working on an RFP to explore development and operations options that will entertain bidding by non-state entities in accordance with Act 26 of 2014, which required DMH to "analyze the operating costs for the (SRR) 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"

Payment Reform via Medicaid Pathways

DMH is working with the Vermont Health Care Innovation Project, AHS, several AHS departments, and a broad array of community service providers to further develop the **delivery and payment system** for serving individuals with mental health, substance abuse treatment and developmental service needs, and promote integration of Mental Health, Substance Abuse Treatment, Long-Term Services and Supports for individuals with developmental service needs, Physical Health, Long-Term Services and Supports for individuals with physical disabilities and older Vermonters.

Level I (VSH replacement) Inpatient Bed Capacity

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

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

- Access by individuals to a mental health patient representative.
- Periodic review of individuals' clinical progress.

However, given the ongoing nature of this issue, additional future action may be warranted:

- Individuals who have been committed to inpatient care through a forensic order commitment are under the timelines of the judicial system and will, in some cases, remain in the hospital longer than is clinically indicated. As such, Vermont may need to re-examine additional legal and/or programmatic changes to address forensic commitments to reduce pressures on acute inpatient bed access.
- Individuals who have been hospitalized and refuse medication prescribed, but do not pose immediate danger to themselves or others, may remain unstable for extended periods of time until court ordered medications can be authorized. Despite recent changes to Vermont statute attempting to address timelier access to this type of treatment, re-examination of the current thresholds for expedited treatment may be necessary to address this issue.
- Vermont should continue to assess the types of beds created and the types needed to address delays in access. An increase in the number of secure residential beds for individuals who are not effectively treated during hospitalization or in a timely manner may be warranted.

Suicide Prevention

Vermont has the seventh-highest rate of deaths by suicide in the country and by far the highest in New England. DMH leads an AHS-wide workgroup with representation from every department in the agency to work on reducing that. Additionally, we work closely with non-state organizations interested in suicide prevention. This includes the Center for Health and Learning, Vermont Suicide Prevention Center (VTSPC), Veterans Administration, local schools and universities as well as providers such as the designated agencies. In all DMH allocates around $172,000 in grants to fund projects. Another source of funding for this work had been the Federal *Garrett Lee Smith* grant, but this grant has ended, and Vermont did not get the next round of funding. Currently there are four projects that DMH is supporting. They are:

- *UMatter:* A public health education campaign initially focused on youth, now across the lifespan to give people tools to discuss suicidal thoughts and tools for listeners to be able to offer support and direct them to help.
- *Zero Suicide:* A model of improving care of individuals who are receiving services from mental health providers. The project aims to improve skills of the clinicians, imbed an evidence-based approach and workflow to reduce suicides. This is a national model and showing great results in other areas of the country.
- *VT Gun Shop Project*: A collaboration between VTSPC, DMH, VDH and groups representing gun shop owners and gun owners (Vermont Federation for Sportsmen's clubs and Gun Owners of Vermont) to help educate gun shop owners about signs of hopelessness and suicidality and giving shop owners and customers material on seeking help.
- *Crisis Text Line*: This is a partnership with a national organization that provides assistance via texting for all Vermonters, all age groups. Its available free to the user and the partnership is free for the State.

Traumatic Brain Injury (Act 158)

In 2014 the legislature passed a bill tasking DAIL to collaborate with AHS, DMH, and DOC to come up with a program for people charged with crimes but are incompetent to stand trial as a result of a traumatic brain injury (TBI). The bill has many implementation problems not addressed in current legislation; and together the departments and AHS got an extension in the 2016 legislative session to delay implementation until July 2018. The workgroup was further tasked with outlining the current unaddressed needs to successfully implementing the legislation, as well as, better defining a program proposal and costs. The current law does not well define the extent of qualifying traumatic brain injury for this new program and does not allocate new funding for the

program. Additionally, there are not readily available best practice standards for longer-term program services for the program envisioned by the legislature.

School-Based Mental Health

DMH continues to work with AHS, the Agency of Education and Vermont schools to develop to more responsive school programming that addresses the emotional and behavioral needs of students, including support of Success Beyond Six programming and implementation of Positive Behavioral Intervention and Supports.

Integrating Family Services

DMH continues to work with AHS on the expansion of Integrating Family Services (IFS) within the Act 264 framework and within the *Medicaid Pathways* planning. IFS continues to focus on supporting outcomes driven, family-based care that is available to families earlier in their time of need. As part of this initiative, additional focus will be placed on making early childhood mental health more available within the Act 264 framework. Additionally, it is expected that the Medicaid Pathways payment reform will also support the flexibility necessary to better support this focus.

Vermont Psychiatric Care Hospital

The operations of VPCH carry all the intrinsic risks of any hospital setting. These expectations are complicated by its existing composition of civil and forensic admissions within the regulatory environment and a legal system whose timeline does not follow an acute care and treatment timeline for disposition. Current issues include:

- Since its opening in 2014, VPCH has faced a significant shortage of permanent nursing staff relying on traveling nurses to fill 50% of permanent positions. The results of statewide group that addressed issue resulted in significant nurse salary increases which has led to a slow increase in new nurses at VPCH over the past few months.
- There have been several consultant reports on the number of staff at VPCH, especially the number of nurses. Due to a variety of factors including the design of 4 small units, multiple areas to reduce stimulation, and lack of security at hospital, VPCH needs a staff-patient ratio that assures both adequate patient supervision and safety in the treatment environment. DMH believes the hospital has the correct number of employees. It may be possible to reduce the number of nurse positions and implementing a plan to safely move in that direction in the coming months
- VPCH ends up being used by other systems of care as a backup when other systems are unable to manage individual behavior or acuity safely. While the underlying etiology may not be mental illness or one that is responsive to hospitalization, VPCH must arrange the aftercare community services, which may take weeks to months to create for people. Examples of these situations can be individuals with developmental disabilities, traumatic brain injury, or who present with both behavior health management and physical health needs that require long-term care services.
- VPCH, as all other hospitals, focuses on safety. The hospital continues to implement the SAMHSA approved *Six Core Strategies to Reduce Seclusion and Restraint*, and has seen a significant drop in their number using the national standard that measures this, and for over a year now has maintained an average that is the lowest among the 3 Level 1 hospitals in Vermont and less than half that of the average for all hospitals (voluntary or involuntary) in the United States. The culture of the hospital is also in transition. The closure of the former Vermont State Hospital, the loss of almost half of the employees who worked at VSH, the subsequent opening of the 8-bed Green Mountain Psychiatric Care Center in Morrisville, and the transition then to VPCH in Berlin, has led to a significantly changed workforce. The educational level for mental health specialists was raised with many of the new staff bringing in experiences from the community and peer perspective. The current hospital CEO and new Medical Director are firmly invested in having the hospital be a clinical leader in Vermont, and staying current on training needs and emerging best practices. The recent addition/transition of 2 newly trained psychiatrists continues this trend. The hospital is also implementing its first Electronic Health

Record, consistent with its Certificate of Need (CON) for the new hospital with a Go-Live date of October 3rd planned.

Successes

Act 79

The Department has made significant progress since the emergency closing of the Vermont State Hospital in late August 2011 following Tropical Storm Irene. Inpatient care is being provided using a decentralized system which includes one state-run hospital and five Designated Hospitals located across the state. Community services have been enhanced and support hospital diversion through expanded crisis services and increased residential treatment using the least restrictive setting that is appropriate for the level of care required. In many cases, treatment can be provided closer to individuals' homes. The new Vermont Psychiatric Care Hospital, which opened in July 2014, has been in operation for over two years and has attained Centers for Medicare and Medicaid Services (CMS) certification and The Joint Commission (TJC) accreditation. The Level 1 units at the Brattleboro Retreat and the Rutland Regional Medical Center are fully operational and have remained at capacity. Local hospital emergency departments in collaboration with the Designated Agencies throughout the state provide screening, stabilization, and limited treatment until admission to a psychiatric inpatient bed can be facilitated. As part of "decentralizing high intensity inpatient mental health care," (Act 79) the Department is also working to preserve the quality of treatment services afforded to patients who experience involuntary hospitalization in Vermont. Under Act 79, the Department continues its collaborative work to strengthen Vermont's existing mental health care system. This work has included the development of enhanced community services, including emergency/crisis responses, residential services and support, housing, and inpatient treatment capacity. Specific enhancements by category include:

Hospital Services

- Operating a new 25 bed psychiatric hospital (July, 2014) that is both CMS certified and TJC accredited
- Ongoing operational capacity for Level 1 inpatient care at both Rutland Regional Medical Center and Brattleboro Retreat
- 45 Level 1 beds with a total of 188 adult psychiatric inpatient beds across the system of care
- Emergency Involuntary Procedure Rule-making process completed with Legislative Committee on Administrative Rules (LCAR)

Community Services

- Increased capacity within Community Rehabilitation and Treatment and peer programs to provide community support, outreach, and crisis response continues to develop
- Broad utilization of non-categorical case management services for Adult Outpatient and Emergency Services programs
- Increased capacity to provide mobile crisis responses to those needing screening and intervention in the community
- Increased and additional training for Team Two collaboration between law enforcement and mental health responders
- Additional availability of soft-restraints for law enforcement transports for mental health hospitalizations
- Resources to assist individuals in finding and keeping stable housing

Residential and Transitional Services

- Soteria, a five-bed, peer supported alternative residential program opened in Chittenden County
- Maintaining full occupancy at the secure residential recovery program, the Middlesex Therapeutic Community Residence, serving 7 individuals.

- Continued planning for permanent replacement capacity for the Secure Residential Program

The Department is continuing to monitor the functioning of the clinical resource management system to "coordinate the movement of individuals to appropriate services throughout the continuum of care and to perform ongoing evaluations and improvements of the mental health system" as written in Act 79. This system encompasses the following functions:

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

Workforce Development

Training throughout the community and hospital systems is an ongoing need. In addition to the training opportunities made available this year through the department's 2015 statewide conference, DMH has partnered with the Vermont Cooperative for Practice Improvement and Innovation (VCPI) and other community partners to support numerous training, technical assistance and practice improvement initiatives for the clinical system of care. VCPI is entering its third year of facilitating a statewide initiative to reduce seclusion and restraint in designated hospitals, using the "Six Core Strategies to Reduce the Use of Seclusion and Restraint ©"and is also providing trainings in the following clinical areas: Integrated Treatment for Co-Occurring Mental Health and Substance Use Disorders, Promoting Recovery for Young Adults First-Episode Psychosis, Core Competency for Direct Care Staff, Dialectical Behavior Therapy, and Open Dialogue.

Child and Adolescent Needs and Strengths (CANS)

DMH has been successfully working with the DAs on implementation of a family functioning tool that measures needs and improvement for a child and their family while accessing mental health services and cuts across all AHS programs. This tool was created by examining all the domains that child-serving AHS departments and providers, as well families, identified as the most important to assess. The purpose of the CANS is to accurately represent the shared vision of the child and family. The CANS will also allow for the effective communication of this shared vision for use at all levels of the system.

Success-Beyond-Six

DMH has been very successful working with the educational system to improve access to mental health care in schools. Over 800 FTE's are now working in schools across the state to support children with mental health needs

Challenges

Designated Agency Workforce

The evidence about mental health services strongly show that treatment works and that people can and do recover from serious mental health conditions. Advances in parity, decreasing stigma associated with mental illness, and ongoing economic stresses contribute to demand for mental health services. At the same time, fixed funding and low reimbursement rates restrict the capacity of the DAs to meet service requests at the local level. One of the greatest current challenges is to hire and retain quality staff; the DAs are not able to match the salaries and benefits of many other state initiatives competing for the same limited skilled workforce. Designated Agencies continue to report significant issues with recruiting and retraining competent staff. DAs are reporting that increasing disparities between DA staff salaries and the salaries of equivalent positions in state government, schools and health care providers have led to never-before seen challenges of high vacancy and turnover rates.

Health Care Reform

The uncertainty of a federal waiver for Vermont's All-Payer Model represents additional potential change to the way the mental health system is funded and managed. This presents Vermont with both challenges and opportunities.

Forensic Inpatient Capacity

As mentioned earlier, capacity for forensic admissions, who have longer lengths of stay due to timelines of the court, may need to be examined. This demand competes with acute care bed needs in the emergency departments of hospitals across the state.

Secure Residential Beds

The current number of beds has been fully utilized in this program temporarily sited in Middlesex. Additional beds to serve a variety of needs such as incarcerated individuals with severe mental illness, individuals ordered for evaluation and waiting for inpatient beds, step-down needs from inpatient care, and diversion capacity for individuals not requiring inpatient care, but at risk of further decompensation in the community may need re-examination.

Titles 13 and 18

Efforts to revise both the criminal and civil commitment statutes should be considered as current language continues to contribute to access delays for acute care or efforts to disposition individuals who no longer require acute, inpatient services in hospitals.

Information Technology

DMH faces challenges in adequate and effective technology and the resources to support legacy and new technology. The largest computer systems, among many, which support the work of DMH were created in the early 90's. Mental Health Services (MHS), Kids Win and MSR processing rely extensively on these legacy systems that are entwined with Vermont Department of Health's (VDH) environment. Maintaining the Mental Health Service application to keep production up and running is time-consuming due to the complex engineering of the system originally built by VDH. The processing of the Designated Agency's MSR files typically results in errors in the application each month.

Opportunities

Reinvigoration of Act 264

DMH is gearing up to re-focus Vermont's adherence to Act 264, which requires that human services and public education work together, involve parents and coordinate services for better outcomes for children and families. The act developed a coordinated system of care so that children and adolescents with a severe emotional disturbance and their families receive appropriate educational, mental health, child welfare, juvenile justice, residential, and other treatment services in accordance with an individual plan. A reinvigoration of Act 264 will further develop the current collaborations with AOE, DCF, and DCF CDD with the goal of serving families better.

Increased Primary Care and Designated Collaboration

With the continuing emphasis on the integration of health and mental health care, DMH will be working to support increased collaborations between primary care physicians and DA's, including a focus on improving access to early childhood mental health.

Turning the Curve on Use of Children's Residential

DMH will be collaborating with DCF to support an Interagency Planning Director position to provide policy, program, data management and financial planning to create and sustain a comprehensive system of community-based services in order to reduce children and youth going into residential care as well as adult services necessary to support families. Extensive interaction and collaboration with 12 local AHS areas and their local leadership at state district offices, private non-profits, schools and primary care services in order to support working partnerships to support children, youth and adults.

Results-Based Accountability

Increased emphasis on Results-Based Accountability has increased the performance focus of DMH oversight, including constructive conversations with the DAs and SSAs on how to improve access and quality services to the people in need.

Hospital Diversion for Children and Adolescents

DMH has been working with DVHA to assess the feasibility for creating hospital diversion programming in Southern Vermont to address the disproportionate use of inpatient hospitalization for children and adolescents in that region of the state.

Intra-Agency or Inter-Departmental Items

Intra-Agency and Inter-Departmental collaboration is built into the vast majority of DMH's work and the system of care as a whole. Given the high prevalence of mental health issues among Vermonters, partnerships among DMH and other AHS stakeholders is essential. Partnerships are an essential strategy if DMH is to achieve its mission and vision. The interagency system of care for children and adolescents has a robust history of partnership with families, education, child welfare, vocational rehabilitation, and juvenile justice. It is taking major strides into its next developmental stage under Integrated Family Services, which is a new way of doing business across all AHS departments serving children and families. Adult mental health has been working with alcohol and drug abuse providers around treatment for co-occurring disorders of mental illness and substance abuse, with public and private entities around housing initiatives, and with the Division of Vocational Rehabilitation to provide Supported Employment. Examples of these partnerships include:

Addressing Mental Health Needs of Justice-Involved Individuals

DMH works regularly with DOC to focus on the mental health needs of incarcerated individuals and the improvement of re-entry services for people leaving prison. This work includes regular team planning meetings and assignment of a DMH care manager to act as liaison with DOC.

Long-term Care

DMH regularly works with the Department of Disabilities and Independent Living on addressing long-term care and mental health needs of individuals with significant physical disabilities;

Utilization Management

DMH works with DVHA to perform utilization management and service improvement for individuals who are high utilizers of Medicaid-funded mental health services through DVHA.

Co-Occurring Mental Health and Substance Use Disorders (COD)

DMH works with ADAP in a number of ways to support integrated treatment for individuals with COD, including the funding of joint COD training for clinicians, the Substance Abuse Treatment Coordination Initiative, and the Vermont Alcohol and Drug Abuse Council.

Child Welfare

DMH works with DCF on a number of initiatives to better address the emotional and behavioral needs of children and families that part of the child welfare system, including Integrated Family Services, focusing on Local Interagency Teams and their working relationships within leadership, and the DMH/DCF plan to "Turn the Curve" on the significant rise in residential treatment for children over the past several years.

Wellness and Health Promotion

DMH is working with VDH to promote improved health and wellness among DA clients and continue to grow the understanding that improving wellness improves overall health meaning physical and mental health.

Older Adult Mental Health

DMH works closely with DAIL on addressing the mental health needs of the older adults, including support of a DA Eldercare Program and collaboration on the *Preadmission Screening and Resident Review* (**PASRR**) process to ensure that individuals with mental health needs are not inappropriately placed in nursing homes for long term care

Complex Care

DMH works closely with other AHS department (DAIL, DVHA, DOC) senior staff to discuss complex care plans that include services overseen by multiple departments.

Health Care Reform

Under federal and state health care reform, the Vermont Blueprint for Health, the Vermont Health Care Innovation Project, and DMH's charge under Vermont Act 15, there are many opportunities as well as beneficial reasons to work with physical health care providers to create a more integrated and seamless system of health care for Vermonters of all ages.

Employment

DMH partners with DAILS's Vocational Rehabilitation (VR) Division to support adults and transition-aged youth with mental health needs prepare for and obtain employment suited to their interests, knowledge, and skills.

Inter-Agency Items

Mental Health in Schools

DMH collaborates with the Agency of Education and Vermont's school system on several areas of interest:

Success Beyond Six

This program is a funding partnership between DMH, DAs, and schools whereby schools provide the state general funds to match Medicaid, the DAs provide access to mental health services for Medicaid-eligible students, and the schools and DAs jointly hire children's mental health staff for a variety of programs which serve children referred by the schools. It is currently being reviewed to further complement the educational evidence-based practice of Positive Behavioral Supports (PBS).

Act 264

Act 264 was passed by the Vermont legislature in 1988 and signed into law by then-Governor Madeline Kunin. It required a partnership between families, the departments for education, mental health, child welfare, and juvenile justice to create an interagency system of care and to provide a *Coordinated Service Plan* to each eligible child who was experiencing a severe emotional disturbance (SED) and needed services across agencies. It also created a unified definition of SED and a system of regional Local Interagency Teams and a State Interagency Team to oversee the system's development and to help resolve difficulties in implementing

Coordinated Service Plans. A Governor-appointed Advisory Board was created and charged to advise the various commissioners on the interagency system of care's development and results. A great amount of progress has been made through the efforts of many people. Services and supports to children and their families have been created, coordination has become the expectation, and families have become partners.

Public Safety

DMH has been working closely with law enforcement to address how law enforcement interacts with the mental health system and individuals with mental health issues. A statewide inter-disciplinary training program known as "Team Two," between law enforcement personnel and mobile crisis responders has grown and expanded to include further training opportunities this coming year, for dispatchers and 911 call center staff. This continues to be an area of need for further collaboration across many jurisdictions that are served by multiple law enforcement agencies. The Department has welcomed the support of the Department of Public Safety in achieving the goal of integration of these services in the interest of quality psychiatric care and public safety.

Key Dates and Decision Points

Replacement of MTCR – 2017 Legislative Session

During the 2017 Legislative Session, DMH will be expected to report its plan for the permanent replacement of the Middlesex Therapeutic Community Residence (MTCR). This plan will need to include the administration's commitment to additional resources for the planning and development of the facility and may also include intentions to privatize the new facility.

Mental Health Block Grant Application – September 1st, 2017

DMH will be submitting its application for the federal Mental Health Block Grant program on this date. This grant is expected to provide approximately $840 million in flexible federal funding for the mental health system of care.

Legislative Reporting – January 15th, 2017: DMH's required legislative reporting, including the ACT 79 report on the status of the adult mental health system of care and the Act 114 report on involuntary treatment, will be due on this date.

Legislation

Suicide Fatality Review Team

DMH is proposing legislation to create a Vermont Suicide Fatality Review Team. This team would:

1. examine select cases of deaths by suicide and preventable deaths by suicide in Vermont
2. identify system gaps and risk factors associated with those deaths
3. educate the public, service providers, and policymakers about suicide-related fatalities and preventable deaths of Vermonters and strategies for intervention
4. recommend legislation, rules, policies, procedures, practices, training, and coordination of services to promote interagency collaboration and prevent future deaths by suicide.

This legislation would also earmark funding to support a .5 FTE position to support both the Vermont Suicide Fatality Review Team and the Child Fatality Review Board. Establishing a Review Team through legislation would raise the awareness and responsibility of the State to consistently examine, analyze and act on current trends in deaths by suicide.

External Group and Organizations

DMH and its contractors work with a variety of other organizations.

Designated and Specialized Service Agencies

As described above, DMH contracts with 12 non-profit providers to administer the core community mental health services that support the state's system of care. As specified in the *Administrative Rules on Agency Designation*, the Commissioner of DMH shall designate one agency in each geographic area of the state to

assure that people in local communities receive services and support that are consistent with available funding, the State System of Care Plan, the local System of Care Plans, outcome requirements, *etc*.

Agency of Education (AOE)

Approximately 50% of all child mental health services are delivered through Success Beyond Six contracts between DA's and schools/supervisory unions. AOE is also a mandated partner under Act 264.

Law Enforcement

Vermont needs law enforcement personnel (town, city, county, state) who are trained to recognize and work with adults, children, and adolescents with mental health issues in order to avoid unnecessary escalation of crisis situations and entanglements with the court system.

Local Hospitals

About 5% of all Emergency Department admissions are made for persons with mental health and/or substance use conditions. An even higher number of persons have such disorders as a secondary condition to their need for care. DMH and VDH have engaged with hospitals to address better service outcomes and supports for this population. DMH also contracts with the University of Vermont Medical Center to provide psychiatric services to VPCH.

In addition to working with many other state departments on joint programs, DMH works with numerous external groups and organizations:

- Consumer, peer and family advocacy and support program, including Vermont Psychiatric Survivors, Vermont Friends of Recovery, Vermont Federation of Families, Alyssum, Another Way, • National Association for the Mentally Ill - VT (NAMI-VT)
- Other advocate groups: Disability Rights Ve1mont and the Mental Health Law Project of Legal Aid.
- Vermont Care Network, a state-wide organization representing the community mental health centers

General Information

Stakeholder Meetings

Stakeholder input is essential all of DMH's planning and development work, and we have a number of stakeholder groups that we meet with regularly:

Adult and Children and Families State Standing Committees

As required by the ADMINISTRATIVE RULES ON AGENCY DESIGNATION, DMH is required to support State Standing Committee for the Adult and Children and Families services systems to advise the department on the performance of the system and participate in the Agency Designation process. These committees are comprised of peers and family members and meet monthly.

Mental Health Block Grant Planning Council

As part of the Mental Health Block Grant (MHBG) requirements, DMH supports a stakeholder committee to advise on the development and implementation of Vermont's MHBG and the system of care. This committee meets two times per year.

Act 264 Advisory Board

This Advisory Board is made up of nine members appointed by the governor, including equal numbers of parents, advocates, and providers. This board meets monthly, often in conjunction with scheduled meeting of the Children and Families State Standing Committee. The Board's purpose is to advise the secretaries of the Agency of Human Services and of the Agency of Education, and the commissioners for mental health, child welfare, and disabilities on:

- matters relating to children and adolescents with any disability and their families;
- the development and status of the interagency system of care; and
- yearly priorities for the interagency system of care.

VPCH Advisory Board

This peer and family stakeholder committee monitors and advises DMH on the operations of the Vermont Psychiatric Care Hospital. The committee meets monthly.

Emergency Involuntary Procedures Review Committee

The Emergency Involuntary Procedures (EIP) Review Committee is a committee convened by the Commissioner of the Department of Mental Health (Department) to review inpatient hospital emergency involuntary procedures. The Committee's responsibilities are to review aggregate data, review inpatient hospitals' adherence to the requirements of the CMS and Joint Commission standards, to review the appropriateness of the decision(s) to use emergency involuntary procedures to ensure that there is external review and oversight of emergency involuntary procedures, and to prepare an annual report to the Department summarizing its work, providing suggestions and recommendations regarding the hospitals' adherence to CMS & Joint Commission standards. This committee meets quarterly

Provider Meetings

DMH regularly attends the monthly meetings of a number of provider groups to seek input and discuss service system issues. These include meetings of the following programs:

- Designated Hospitals
- Designated Agency Programs, including: Executive Directors, Chief Financial Officers, Information Technology Directors, and the Directors of the CRT, AOP, Emergency Services, and Children and Family Programs
- Peer Providers

Department of Vermont Health Access

DVHA's responsibilities and prominence within the state's priorities and budget have increased substantially since it was first created as a separate 'Office' in the AHS reorganization of 2004.

The Vermont Medicaid program is the largest health insurer in Vermont, providing comprehensive coverage for over 190,000 citizens; commercial insurance premium assistance for over 17,000 Vermonters; and pharmacy only benefits assistance for over 11,000 Vermonters.

With the Centers for Medicare and Medicaid (CMS) approval of Vermont's Global Commitment to Health (GC) 1115 demonstration waiver in 2005 (and subsequent renewals), OVHA also became a statewide Public Managed Care Entity, with oversight responsibility for all statewide Medicaid programs and expenditures. In this role, DVHA also must comply with federal regulations related to Managed Care Organizations.

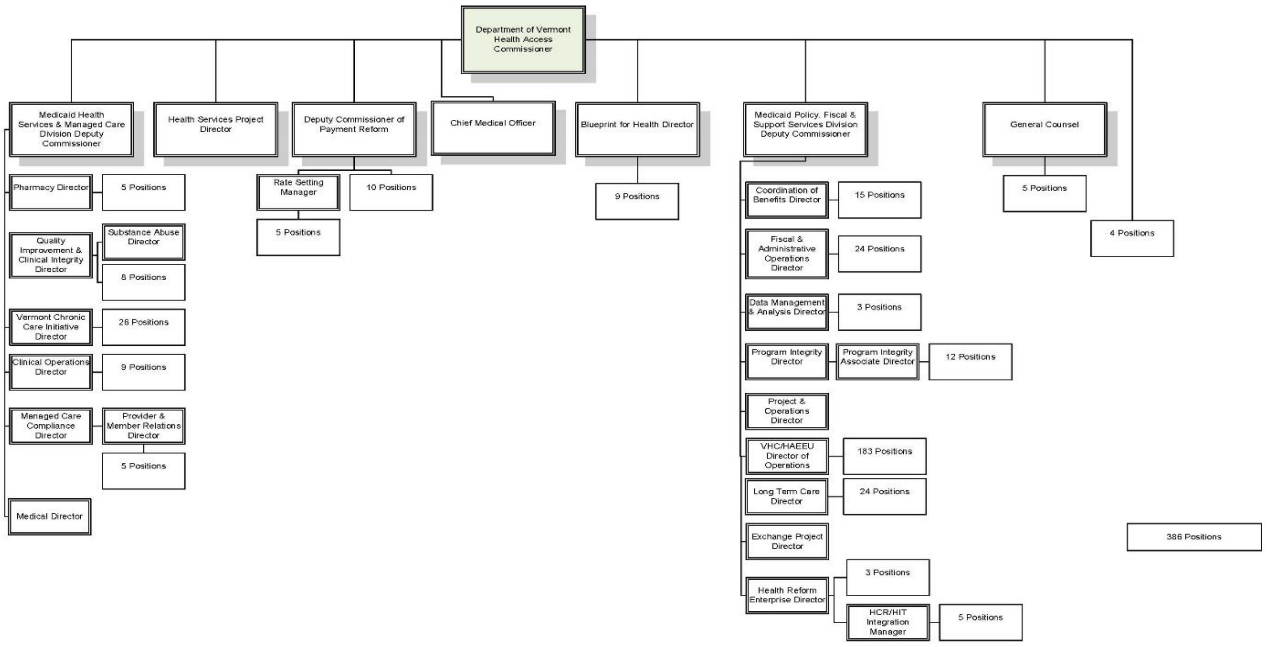
As of December 2008, OVHA added the organizational responsibilities of coordinating Vermont's comprehensive health care reform efforts, statewide health information technology (HIT) planning and oversight, and implementation of federal health care reforms.

As of July 2010, in recognition of the expanded scope of its mission and focus, the Office became the Department of Vermont Health Access. DVHA also became the home of the Blueprint for Heath, a program for integrating a system of health care for patients for improving health outcomes and controlling health care costs.

As of July 2016 the Health Access Eligibility and Enrollment Unit (HAEEU) and Long Term Care (LTC) Unit have merged with DVHA adding approximately 160 positions to DVHA, bringing the position total to 386 positions.

With a budget of over $1.2 billion, DVHA ranks first in the State of Vermont's programmatic expenditures. The following five highest programmatic expenditures account for more than 50% of the annual expenditures:

1. Pharmacy (gross; after rebates, it is 5th highest expenditure)
2. Hospital Inpatient
3. Hospital Outpatient
4. Physician Services
5. Nursing Homes



Division of Health Services and Managed Care

The Clinical Operations Unit (COU): COU monitors the quality, appropriateness, and effectiveness of healthcare services requested by providers for members. The unit ensures that requests for services are reviewed and processed efficiently and within timeframes outlined in Medicaid Rule; identifies over- and under-utilization of healthcare services through the prior authorization (PA) review process and case tracking; develops and/or adopts clinical criteria for certain established clinical services, new technologies and medical treatments; assures correct coding for medical benefits; reviews provider appeals; offers provider education related to specific Medicaid policies and procedures; and performs quality improvement activities to enhance medical benefits for members.

Pharmacy Unit

The pharmacy benefit for members enrolled in Vermont's publicly funded healthcare programs is managed by the Pharmacy Unit. Responsibilities include ensuring members receive medically necessary medications in the most timely, cost-effective manner. Pharmacy Unit staff and DVHA's contracted pharmacy benefit manager (PBM) work with pharmacies, prescribers, and members to resolve benefit and claims processing issues, and to facilitate appeals related to prescription drug coverage within the pharmacy benefit.

Quality Improvement & Clinical Integrity Unit

This unit collaborates with AHS partners to develop a culture of continuous quality improvement. The unit maintains the Vermont Medicaid Quality Plan and Work Plan; coordinates quality initiatives throughout DVHA in collaboration with AHS partners; oversees DVHA's formal performance improvement projects as required by the Global Commitment to Health Waiver; coordinates the production of standard performance measure sets including *Global Commitment to Health* measures, Healthcare Effectiveness Data and Information Set (HEDIS) measures, CMS Adult and Children's Core Quality measures and Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey measures; and is the DVHA lead unit for the Results Based Accountability (RBA) methodology for performance improvement and produces the DVHA RBA Scorecards.

Vermont Chronic Care Initiative (VCCI)

VCCI is a healthcare reform strategy to support Medicaid members with chronic health conditions and/or high utilization of medical services to access clinically appropriate healthcare information and services; coordinate the efficient delivery of healthcare to these members by addressing barriers to care, gaps in evidence-based treatment and duplication of services; and to educate and empower members to eventually self-manage their conditions.

Managed Care Compliance

The Managed Care Compliance Unit is responsible for ensuring DVHA's adherence to all state and federal Medicaid managed care requirements. This unit also manages DVHA's Inter-Governmental Agreements (IGA) with other AHS departments and coordinates audits aimed at evaluating the compliance and quality of managed care activities and programs. If a compliance issue is identified, the Compliance unit is responsible for creating and managing a corrective action plan, which is reviewed and monitored by the Managed Care Compliance Committee.

Provider and Member Relations (PMR)

This unit ensures members have access to appropriate healthcare for their medical, dental, and mental health needs. The unit monitors the adequacy of the Green Mountain Care (GMC) network of providers and ensures that members are served in accordance with managed care requirements. The Green Mountain Care Member Support Center contractor is the point of initial contact for members' questions and concerns.

Medicaid Policy, Fiscal, and Support Services

Coordination of Benefits (COB)

The COB Unit works to coordinate benefit and collection practices with providers, members, and other insurance companies to ensure that Medicaid is the payer of last resort. COB is responsible for Medicare Part D casework including claims processing assistance, coverage verification, and issue resolution. The unit also works diligently to recover funds from third parties where Medicaid should not have been solely responsible. Those efforts include estate recovery, absent parent medical support recovery, casualty recovery, patient liability recovery, Medicare recovery, Medicare prescription recovery, special needs recovery, and trust recovery. The unit has been able to increase Third Party Liability (TPL) cost avoidance dollars, a direct result of ensuring that correct TPL insurance information is in the payment systems and being used appropriately.

Data Management and Analysis Unit

This unit provides data analysis, distribution of Medicaid data extracts, reporting to state agencies, the legislature, and other stakeholders and vendors. It also delivers mandatory federal reporting to the Centers for Medicare and Medicaid Services (CMS), develops the annual Healthcare Effectiveness Data and Information Sets (HEDIS) for reporting, and provides ad hoc data analysis for internal DVHA divisions and other AHS departments and state agencies.

Fiscal and Administrative Operations Unit

This unit supports, monitors, manages and reports all aspects of fiscal planning and responsibility. The unit includes Accounts Payable/Accounts Receivable (AP/AR), Grants and Contracts, Business Administration, Fiscal

Analytics, and Programmatic Accounting and Compliance. The unit is also responsible for researching, developing and implementing relevant administrative processes, procedures and practices.

Information Technology Unit (IT)

This unit provides direction, assistance, and support for all aspects of information technology planning, implementation, and governance. In conjunction with AHS IT and the Department of Information and Innovation (DII), the unit is responsible for researching, developing, and implementing relevant administrative processes, procedures, and practices related to computer systems and applications operations management.

Program Integrity Unit (PI)

This unit works to establish and maintain integrity within the Medicaid Program. PI contains three units: Medicaid Audit and Compliance (MACU), Oversight and Monitoring (O/M), and Beneficiary Healthcare Integrity (BHI). MACU engages in activities to prevent, detect, and investigate Medicaid provider fraud, waste, and abuse. Data mining and analytics, along with referrals received, are used to identify and support the appropriate resolution of incorrect payments made to providers. O/M facilitates DVHA's participation in state, federal, and independent audits and examinations, and ensures that information shared is consistent, accurate and timely. BHI joined DVHA in July 2015 and is responsible for conducting audits and investigations to detect and prevent healthcare eligibility fraud.

Projects and Operations Unit

This unit is responsible for operationalizing select new program initiatives and ongoing projects, in particular those requiring cross-functional or cross-Agency involvement. Responsibilities include the MMIS Care Management project – which is part of the Agency of Human Services' Health and Human Services Enterprise (HSE) – the Graduate Medical Education (GME) Program, and Medicaid Health Home initiatives and related State Plan Amendments (SPAs). This unit also oversees implementation and tracking of the Vermont Health Connect (CMS) Mitigation Plan, special VHC development projects, Automated Asset Verification, the Medicaid portion of the All Payer Model, legislative reporting, and assessing operational impacts of new legislation.

Vermont Medicaid Management Information System (MMIS) Program Team

The MMIS program is a core element of the AHS HSE vision, aligning Vermont's MMIS with new federal and state regulations stemming from the federal Affordable Care Act and Vermont's healthcare reform law, Act 48. The state processes over $1 billion in Medicaid claims annually. The new MMIS will integrate with a Service Oriented Architecture (SOA), creating a configurable, interoperable system, and will be compliant with the CMS Seven Standards and Conditions. When operational, this new system will efficiently and securely share appropriate data with Vermont agencies, providers, and other stakeholders involved in a member's case and care. Health Information Technology (HIT) and Health Information Exchange (HIE) activities also are overseen by this unit. HIE/HIT enables providers to share clinical and demographic data through a secure digital enterprise network that connects the electronic health records of different health care providers and practices.

Vermont Health Connect (VHC) Operations and Health Access Eligibility and Enrollment Unit (HAEEU)

This unit oversees the operations of VHC, Vermont's health insurance marketplace, created as a result of the federal Affordable Care Act and Vermont Act 48. VHC integrates Medicaid and private health insurance eligibility, enrollment, and case management, and includes MAGI-based Medicaid, Dr. Dynasaur, and Qualified Health Plans (QHP), including federal and state-based financial assistance. The HAEEU is responsible for eligibility and enrollment in Vermont's health care programs through VHC and Green Mountain Care.

Long Term Care (LTC)

This unit determines financial eligibility for LTC services and supports. It works collaboratively with the Department of Aging and Independent Living (DAIL) long term care staff, who make clinical LTC eligibility determinations, to provide training and improved quality assurance as LTC applications have grown increasingly complex.

Medicaid Payment Reform and Reimbursement

DVHA Medicaid Reimbursement Unit

This unit oversees rate setting, pricing, provider payments and reimbursement methodologies for a large array of services provided under Vermont's Medicaid Program. The unit works with Medicaid providers and other stakeholders to support equitable, transparent, and predictable payment policy in order to ensure efficient and appropriate use of Medicaid resources. The Reimbursement unit is primarily responsible for implementing and managing prospective payment reimbursement methodologies developed to align with CMS Medicare methodologies for outpatient, inpatient and professional fee services.

Payment Reform Team supports the Vermont Healthcare Innovation Project (VHCIP), a program developed from a three year, $45 million State Innovation Model (SIM) grant awarded to the State of Vermont by the Centers for Medicare and Medicaid Innovation (CMMI). The grant, jointly implemented by DVHA and the Green Mountain Care Board, is focused on three primary outcomes: 1) an integrated system of value-based provider payment; 2) an integrated system of care coordination and care management; and 3) an integrated system of electronic medical records.

The primary areas of focus for Medicaid payment reform are to support the design, implementation, and evaluation of innovative payment initiatives, including an accountable care organization (ACO); shared savings program (SSP); and an Episode of Care (EOC) program for Medicaid. The payment reform team supports an array of payment reform and integration activities; ensures consistency across multiple program areas; develops fiscal analysis, data analysis, and reimbursement models; engages providers in testing models; and ensures the models encourage higher quality of care and are supported by robust monitoring and evaluation plans.

Since 2014, the Payment Reform Team has been responsible for implementation of the Vermont Medicaid Shared Savings Program, a payment model in partnership with two Vermont Accountable Care Organizations (OneCare Vermont and Community Health Accountable Care) impacting approximately 85,000 Medicaid members. The Payment Reform team has also been actively involved in the development of an ACO-based All-Inclusive Population-Based Payment model for Medicaid members to be implemented in 2017. This model, based on CMS' Next Generation ACO model, is intended to complement other concurrent payer initiatives in Vermont that are collectively in support of the All Payer Model. Going forward, the Payment Reform Team will have responsibilities for evaluation of current Medicaid payment models, implementation of future models, and planning for DVHA's active participation in Vermont's efforts toward health care delivery system transformation on an ongoing basis.

Blueprint for Health

The Vermont Blueprint for Health is a state-led, nationally-recognized initiative transforming the way primary care and comprehensive health services are delivered and reimbursed. The foundation of this transformation is quality improvement inside healthcare organizations. Participating organizations also are incentivized to work together with other health and human services organizations to create and reinforce an integrated system of care. The result is whole-person care that is evidence-based, patient and family centered, and cost effective.

Community Health Teams (CHTs) are funded by Medicaid, Medicare, and major commercial insurers for barrier-free patient access (no co-payments, prior authorizations, or billing). CHTs supplement services available in Blueprint Patient Centered Medical Homes (PCMHs) and link patients with the social and economic services that make healthy living possible. CHT services include:

- population/panel management and outreach
- individual care coordination
- brief counseling and referral to more intensive mental health care as needed
- substance abuse treatment support
- condition-specific wellness education and more

The services may be co-located with the practices ("embedded") or centralized in the Health Service Area (HSA). Actual service configuration, staffing, and location are determined by local leaders based on community demographics and health needs, identified gaps in available services, and the strengths of local partners.

Hub & Spoke

Beginning in July 2013, a Medicaid State Plan Amendment (SPA) created a Health Home for beneficiaries with opioid addiction. This SPA made beneficiaries categorically eligible for Health Home services as defined in the Affordable Care Act (ACA) and include care coordination, referral to community services, and patient and family supports. In collaboration with the Department of Health, DVHA enhanced the staffing at opioid treatment centers (Hubs) and embedded nurses and master's-prepared, licensed mental health or addictions clinicians in general medical settings (Spokes) where buprenorphine and vivitrol are prescribed to treat opioid addiction. These staff members provide the additional clinical support and care coordination that Medication Assisted Treatment (MAT) patients require. Through the Hub & Spoke approach, each MAT patient has an identified medical home, a single MAT prescriber, a pharmacy home, and access to all CHT services. Hubs are regional opioid addiction treatment centers located around the state that treat patients with especially complex needs, using either methadone or buprenorphine. Spokes are primary care and other specialty practices where buprenorphine is prescribed.

Key Issues

All Payer Model

- DVHA is actively engaged in a procurement process for Accountable Care Organization (ACO) participation in a population-based payment model that is based on the CMS *Next Generation* ACO Model. As an evolution of the *Vermont Medicaid Shared Savings Program*, this new program 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 members, and to distribute payments to their contracted network providers for covered services rendered on behalf of Medicaid members using alternatives to fee-for-service reimbursement. The goal of this agreement is to improve the quality and value of the care provided to members of Vermont's public health care programs.
- Ensuring coordination with the All Payer waiver negotiations between the State and the Federal government is a top priority that will continue to require significant staff effort to successfully execute a contract, as well as complete an ACO readiness review prior to program implementation on January 1, 2017.
- DVHA leadership is also engaged in planning for internal operational readiness, recognizing the need for strengthened capacity in areas such as contract oversight, data analytics, quality monitoring, and financial monitoring. Ensuring adequate staffing is available across these areas in 2017 has been prioritized.
- DVHA plans to sign an agreement with an ACO to achieve enhanced integration of health care services, with the potential to integrate additional Medicaid-covered services in future program years. Program implementation will be in support of Vermont's broader efforts to develop an integrated health care delivery system under an All Payer Model.

Medicaid Pathways

- The Vermont Medicaid Pathway (VMP) advances payment and delivery system reform for services not included in the initial implementation of Vermont's All Payer Model. The ultimate goal of this multi-year planning effort is the alignment of payment and delivery system principles through both the All Payer Model and VMP to support a more integrated system of care, including integrated physical health, long-term services and support, mental health, substance abuse treatment, developmental disability services, and children's service providers.
- Obtaining provider buy-in is challenging as it requires changes to traditional practices. Lack of additional funding for Designated Agencies (DA's) minimizes ability to provide incentives for these changes.
- The development of Global Budgets also will be challenging.

- APM/ACO collaboration in a more integrated health and human services system, including shared governance and a strengthened overall network.
- Optional models may also be developed to encourage creativity and provider and member choices.

VHC Reconciliation

- VHC solidified its reconciliation team structure in the VHC Enrollment unit to address the reconciliation inventory on a monthly basis. 2016 also saw the remediation of multiple defects affecting integration and causing system discrepancies, as well as the implementation of additional tools to review and fix discrepancies. Reconciliation reports were enhanced to include tracking and aging of discrepancies.
- Finally, VHC staff achieved access to review the SOA layer internally (without vendor reliance).
- Challenges related to reconciliation include:
  - No automated functionality to effectuate changes across plan years.
  - Inadequate resources to track and fix discrepancies on a timely basis.
  - Carrier reporting accuracy, uniformity, and frequency.
  - On site availability of M&O support.
- For 2014 and 2015, DVHA has had to engage in a financial reconciliation with carriers to account for expenses incurred when coverage dates did not match across carrier and VHC systems. More timely reconciliation will mitigate this going forward.
- Improved reconciliation reporting mechanisms and delivery will result in greater customer and carrier satisfaction (may require additional contracting).
- M&O vendor training and reconciliation support resources are needed.

Blueprint for Health

- Successfully implemented the program statewide. Analytic capability links claims and clinical data for all payers. Independent evaluations by CMS and peer reviewed publications show the program has reduced the growth in health care costs.
- Has demonstrated capacity to design and implement other service reforms (e.g., Hub & Spoke, SASH, Women's Health)
- The demonstration authority under which Medicare participates in the Blueprint payments ends 12/30/16. Continued Medicare funds depend on the All Payer Model being approved.
- Lack of alignment between health system and human services reform efforts undermine integration and capacity to support population health approaches.
- Aligning Blueprint, ACO networks, and human services providers to operate as part of a well-coordinated data driven network in an All Payer Accountable Health System (APW, VCO).
- Research, planning, and statewide implementation of health & human service models for high risk populations and complex needs.
- Integration with Medicaid Pathways.

Care Management

- A new Care Management solution developed by eQHealth Solutions was launched in December 2015, initially to support VCCI care management operations, member assessment and management, financial trending, predictive modeling and analytics.
- Additional functionality is being released periodically and the system is intended to ultimately support care management activities provided by programs across the Agency.
- Transition to the new system has resulted in smaller VCCI staff caseloads due to start-up efforts, training and the learning curve in the new system. In addition to case management, staff are concurrently assigned to user acceptance testing (UAT), deliverable reviews, training, and workflow and policy adjustments.
- State wide provider use or interfacing, including ACOs, allowing for robust information for all Medicaid members.

Pharmacy

- Launched new Pharmacy Benefits Management System (PBMS) in January 2015, with the vendor Goold Health Systems (now Change Healthcare). The PBMS provides routine PBM services, supports interoperability with other health care systems to reduce provider burden, supports a medication therapy management (MTM) program, and helps the state control escalating drug costs.
- The MTM will be implemented Fall 2016 and provides the framework for coordinating care among the member, PBM clinical pharmacist, prescriber, DVHA case managers, and other DVHA units providing services. It will provide increased management of high-cost drugs and help optimize medication adherence, minimize adverse events, and improve clinical outcomes, particularly among members with high pharmacy costs.
- Required implementation of a new Covered Outpatient Drugs final rule that addresses key areas of Medicaid drug reimbursement and changes made to the Medicaid Drug Rebate Program by the Affordable Care Act. It is designed to ensure that pharmacy reimbursement is aligned with the acquisition cost of drugs and that the states pay an appropriate professional dispensing fee. Reimbursements are to be based on actual acquisition cost to achieve a more accurate estimate of marketplace prices while still ensuring sufficient beneficiary access. It also requires that dispensing fees paid to pharmacies reflects the cost of the pharmacist's professional services.
- Pharmacists were granted provider status during the last legislative session, recognizing their integral role in the health care team.
- MTM has been demonstrated to be an effective strategy in managing drug costs, medical costs, drug adverse reactions and interactions, and adverse health outcomes. DVHA should evaluate the benefits of paying pharmacists for MTM and other clinical activities in addition to paying for claims activity.

Eligibility and Enrollment Mitigation Plan

- The mitigation plan describes the mitigation strategies and operational workarounds that Vermont is implementing to support eligibility and enrollment of Medicaid beneficiaries. The mitigation plan has been approved by CMS and is considered to be Vermont's path to compliance regarding verification and renewals for the MAGI Medicaid populations.
- The plan addresses the Medicaid application, verification, and renewal processes for Vermont residents, pending full implementation of the required eligibility system and the state is fully in compliance with federal statutory and regulatory requirements.
- If deadlines in the plan are not met, enhanced federal matching will be jeopardized and the State will face severe audit findings.
- Deadlines set forth in the mitigation plan are aggressive, so close monitoring and prioritization is necessary in order to meet targets set forth in the plan.
- If targets are in jeopardy of being met, transparent communication to CMS is needed to potentially modify the plan.
- Adherence to the plan, milestone and deadlines will allow Vermont to continue to be eligible for enhanced federal matching funding (90% for system development and 75% for system operations).

Global Commitment Waiver Renewal

- Vermont has longstanding success in its partnership with CMS and the Global Commitment (GC) to Health (1115) waiver.
- The model has eroded from its initial design. In the most recent negotiations, Vermont has committed to finding alternative funding (e.g., general fund) for $78 million of investments that currently are matched with Medicaid funding.
- CMS has many flexibilities under its 1115 waiver authority to support states in designing a health system that aligns with its mission.

Managed Care Responsibilities

- The managed care design of the GC waiver has afforded great flexibility to the state in the use of Medicaid funding to invest in alternative treatment strategies.
- Although this arrangement identifies the Agency as the entity that purchases services from DVHA as the managed care authority, functionally that is not the way we operate. This puts DVHA at risk for decisions made outside its domain.
- Using the existing contract vehicles (AHS/DVHA and DVHA/Other AHS Depts.), clear lines of responsibility could be drawn to address this issue.

Full-Benefit Duals Co-Pay Coverage

- When Medicare Part D was implemented in 2006 it was decided that those who are dually eligible for Medicaid and Medicare (Duals) will automatically be deemed for Low Income Subsidy (LIS), which requires the member to pay co-payment out of pocket cost. At that time, the maximum LIS copayment for a single prescription was $5.00.
- The copayment amount has slowly increased each year and the maximum in 2017 will increase to $8.25,
- Members, pharmacies and advocates are indicating this has become a hardship and challenging for members to afford. Some members choose alternatives such as not taking medications.
- Because the Dual's have the lowest FPL percentage with limited resources, the state should consider paying the LIS copayment.
- Estimated Dual eligibility count: 22,000
- Estimated Dual drug cost: $2,808,960.00 per year.
- These costs can be mitigated as follows: Members unable to pay the higher co-pay amounts are likely to apply for General Assistance (GA) to cover these costs. GA is totally state funded. However, if we receive an approved State Plan Amendment to change our coverage, the $2.8M becomes matched so state funds are 45.6 % instead of 100%.

VPharm Renewals (outside mitigation plan)

- On August 15, 2016 the adopted VPHARM Rule B16-10F was filed with the State Office of the Secretary (SOS) and the Legislative Committee on Administrative Rules (LCAR) with an effective date of 9/1/16. The purpose of Rule B16-10F was to permit the Department of Vermont Health Access to change the VPHARM program to be reviewed on a monthly rolling review cycle and to end the hold harmless provision as required by the 33 V.S.A. Sec. 2072(c).
- The Department of Vermont Health Access (DVHA) receives approximately 20-55 VPHARM review applications daily. Since the 9/1/16 effective date, the DVHA, COB unit has received and processed approximately 600 Pharmacy Review applications. The vast majority of these review applications are processed the day they are received by the COB unit.
- At this time, we are not able to estimate the number of beneficiaries, who are scheduled to have their VPHARM benefits close due to not sending in a review application and we are not able to provide an estimate of the number of beneficiaries whose VPHARM benefits will close due to them no longer being eligible for the program.
- As predicted in the Economic Impact Statement of this rule change, a significant number of beneficiaries are being moved to different pharmacy benefit levels; these changes are estimated to save the State $165,420.00 annually.

MMIS Deployment: 1. Program Integrity (PI) 2.Provider Enrollment

- Program Integrity: The PI unit evolved from a Surveillance & Utilization Review System unit in 2007 to a Medicaid Audit & Compliance Unit (MACU) responsible for preventing, detecting and investigating provider fraud, waste and abuse. The unit has grown and has continually increased cost avoidance and recoveries from $1,233,042 in SFY10 to $8,972,961 in SFY16.
- Program Integrity: The Vermont Medicaid program paid approximately $1.3 billion in claims payments in SFY16. National statistics indicate 10-20% of Medicaid payments are for fraudulent services, which would

equate to $130M to $260M of our Medicaid budget. With the PI unit's currently available staffing and tools, it is only able to impact just over ½ of 1 percent (0.007). Consequently, PI must rely heavily on referrals of fraud, waste, and abuse and often some are unfounded. Increasing cost prevention and recovery rates to 10% would result in a cost avoidance and recovery of over $130M.

- Provider Enrolment: The current manual provider enrollment process averages 20 weeks to enroll a provider. Manual cross referencing with CMS is cumbersome and error prone. Stricter ACA requirements will require more technical assistance.
- Program Integrity: Robust PI tools and solutions exist to analyze Medicaid claims data and conduct both pre and post analytics to detect and reduce the rate of fraud, waste and abuse. PI solutions for states are eligible for 90/10 FFP and can be fully integrated with most MMIS solutions for predictive analytics, although they do not need to be integrated to be effective. The procurement of a PI solution would provide a positive ROI in a very short period of time, help reduce fraud, waste and abuse in the Medicaid program, and ensure tax dollars are appropriately spent.
- Provider Enrollment: Prioritizing procurement of an Enrollment Module in MMIS replacement activities would result in a more efficient, accurate, and provider friendly enrollment process.
- Bringing HPE staff into DVHA operations would allow for direct oversight and reallocating those dollars at HPE to DVHA.

Program Integrity Oversight and Monitoring

- The Oversight and monitoring unit was created in the Fall of 2015 to help facilitate and manage the volume of audits and reviews that DVHA participates in. The unit has three dedicated staff members and has already facilitated a combination of 26 audits, surveys and required PERM pilots.
- A significant challenge is in the collaboration with so many different stakeholders, all with varying responsibilities to each of these audits. With this being a fairly new unit, the process for managing the full scope of all the audits and reviews is a completely manual process and requires a significant amount of time in tracking and maintaining the magnitude of details and documents.
- Having a dedicated unit to manage and collaborate DVHA's participation in State, Federal and independent audits will ensure a consistent message, and will help to reduce and/or eliminate repeat findings in future reviews. The O/M unit hopes to engage in the creation of a SharePoint site, or other means of sharing and maintaining documentation for auditors and reviewers. This will allow for better collaboration between AHS, DVHA and the various AHS Departments to ensure timely reviews and responses to inquiries. This will make anticipating and planning for the next cycle of each audit easier

Program Integrity - Beneficiary Healthcare Integrity

- In July 2015, DVHA created a Beneficiary Healthcare Integrity unit (BHI). This unit was the direct result of the merger of the DCF/ESD HAEU unit with DVHA. It will enable DVHA to better investigate potential fraud, waste and abuse in the Medicaid program around beneficiary eligibility and enrollment.
- Beneficiary fraud investigations historically, have mostly focused on programs such as Three-Squares, TANF and other entitlement programs. Healthcare fraud has not been a primary focus but now with dedicated resources, a more thorough approach to beneficiary enrollment and eligibility fraud can be taken. Like with MACU above, there are robust PI tools and solutions that facilitate the analysis and investigation of enrollment and claims data to detect beneficiary healthcare fraud. These PI solutions are eligible for 90/10 FFP. The procurement of a PI solution would provide the tools necessary to be successful.
- Beneficiary healthcare fraud investigations cannot be completely decoupled from the other DCF beneficiary fraud activities that continue to take place. A solution that can integrate both DCF and DVHA to allow for shared, yet separate functionality would be a step in the direction of collaboration and efficiencies.

Health Information Exchange and Health Information Technology (HIE/HIT)

- There are over 276 Vermont Health Care Organizations utilizing over 900 connections via the Vermont Health Information Exchange (VHIE) to share clinical health data, resulting in more informed and timely

patient encounters. These connections represent over 55% of primary care settings and 100% of hospital settings.

- The HIE Program and Vermont's SIM grant, known as the Vermont Health Care Innovation Project (VHCIP), have successfully collaborated since the inception of the SIM grant to accelerate health care organization connectivity, improve clinical data quality, and expand care coordination service offerings to Vermont providers.
- Vermont Department of Health owns and operates the State's Immunization Repository, which is a critical component of Federal Meaningful Use (MU) mandates. This data is shared via the VHIE for addressing encounters and reporting needs.
- DVHA's Electronic Health Record Incentive Program (EHRIP) Program has enabled and supported provider implementation and utilization of electronic health records (EHR). Over 60% of providers have progressed from first payment year to achieving Meaningful, above the national average of 48.5%.
- Vermont Information Technology Leaders (VITL) is designated in Legislation to operate the VHIE. VITL is under contract with the State to provide this service. This creates challenges with regard to accountability and understanding that VITL is a vendor/ contractor to the State.
- Many of the more than 1,300 providers in Vermont, including specialty and long term service care, remain to be connected.
- VITL performs multiple services for Vermonters and its residents. Many of these services are sole sourced to VITL as the operator of the VHIE. According to Statute, the State is not required to sole source any service to VITL that is not considered part of the VHIE. This would create a competitive situation in which the State can maximize funding to obtain the best services and support at the most opportune financial level.
- For continued progress to address the "Triple-Aim" goals, there has to be the effective, efficient and secure sharing of data. The ability to provide this relies on the effective operationalization of a Governance Council to create, implement and support processes and protocols to govern data management in alignment with the draft 2016 revision of the Vermont Health Information Technology Plan (VHITP) and Federal guidance regarding sharing and interoperability of health data.

IT Resources

- DVHA is the signatory to multiple million dollar technology contracts. With respect to compliance issues, bids, pricing, architecture and software, DVHA has no expertise to advise regarding contractor positions during contract performance. This lack of expertise is a resource issue.
- We have an opportunity with the ability to hire persons with technology expertise that could advise the department when contractors take positions regarding compliance, offer bid pricing, advise that a software product will work or advise that another contractor is the problem with completion of a project. This resource could very much assist DVHA.

Involuntary Medication

- Persons who are involuntarily psychiatrically hospitalized for acute psychosis and who refuse the standard of care treatment (i.e., medication) are held against their will for periods of time that are orders of magnitude longer than anywhere else in the country. Some of the unintended consequences of Vermont's unique practice include, but are not limited to:
    - Pending the application of due process on the question of treatment, the person who is involuntarily hospitalized is deprived of their freedom for significantly longer lengths of time than are found elsewhere in the country. Some legal scholars have interpreted this practice as a violation of the Americans with Disabilities Act.
    - While awaiting the application of due process on the question of treatment, involuntarily hospitalized persons are significantly more likely to assault other patients or staff. This creates an unnecessarily dangerous and non-therapeutic environment for care and results in avoidable staff and patient injuries.
    - The capacity of all remaining psychiatric hospital beds in Vermont is dramatically decreased because of the uniquely long lengths of stays for involuntarily hospitalized psychiatric patients.

- Alter Vermont's method of practicing due process so that we are not the national outlier with regard to providing timely due process for persons suffering with serious mental illness whose personal liberty has already been deprived.

Care/Case Management billing codes and service nomenclature

- Case Management or service coordination is offered in many programs across the Agency and almost universally involves a person-centered assessment, and coordination and monitoring of necessary
- services across medical, social, educational, and other life domains.
- When individuals receive 'case management' based on the billing 'code,' they are ineligible for other case management services, *based on CMS rules,* despite a vast difference in the actual services, the provider type (lay staff for CRT case management or licensed staff for 'nurse case management') thus preventing the member from receiving the right service level or combination of services.
- Researching the variety and meaning of codes makes it nearly impossible to generate program eligibility 'rules' for preventing duplicative service delivery among those receiving case management from multiple state programs and services.
- These codes may also need to be considered in the risk based contracting and case management that is a condition of the Medicaid next gen ACO so there is not duplication of service per CMS rules.
- These issues require CM code standardization and/or approval via the DVHA Payment & Reimbursement unit. Also, duplication of CM services needs to occur followed with centralizing the case to the appropriate provider that is most appropriate and patient-centric.
- In 2015, care/case management codes were billed by various programs, as follows:

2015 Data:

CFC-ACCCS:	$3.5M
CFC-HCBS:	$1.0M
ADAP:	$3.0M
AOE-IEP:	$17M
CIS:	$8.9M
DMH-CRT:	$18M
DMH-Targeted:	$1.1M
DMH-Other:	$12K
DAIL:	$41M
HBKF:	$128K

Palliative Care

- Palliative care is a management approach that provides symptom relief and comfort care to patients with serious or life-threatening illnesses, with the goal of improving quality of life for both patients and their families.
- Unlike hospice care, palliative care can begin at diagnosis and is often provided along with treatment aimed at prolonging life, such as chemotherapy for cancer.
- One of the primary objectives of palliative care is to help patients prioritize their goals of care, and it may include conversations around advance care planning (e.g., a "living will") depending on the anticipated disease trajectory.
- Palliative care is a rapidly growing approach to the management of certain chronic diseases both nationally and in Vermont. It's proven to improve health outcomes, improve patient satisfaction and decrease the cost of care (i.e., the so-called "Triple Aim").
- DVHA has already started the process of facilitating the practice of Palliative Care. In doing this, DVHA will study the cost/benefit impact associated with wider use of this practice.

QHP/Medicaid Premium Processing

- QHP Reconciliation between systems has improved; using integration; documented end-to-end enterprise process and reconciliation caseworker process.
- Automated Change of Circumstance (Co) functionality improves premium processing functionality by keeping household on one contact ID.
- VHC is no longer sending standalone Medicaid plans with $0 premium to the Premium Processor, and will be removing all such plans from the Premium Processor system, resulting in administrative savings of $1.8 million annually.
- Wex system is built on QHP rules, which causes challenges on premium processing for Medicaid and inability to comply with rules.
- The VHC system is unable to allocate initial premium payments that will ensure Medicaid enrollment going forward. All premium payments are applied to the oldest month billed which creates access to care issues for the Medicaid applicant since Medicaid rules require allocation of payment to the newest month billed.
- The VHC system does not have the premium grace period functionality required by the State's Medicaid rules. Accordingly, Medicaid beneficiaries who fail to timely pay their monthly Medicaid premium are not being terminated for non-payment because the state cannot give them the non-payment grace period they are entitled to prior to termination.
- The VHC system is unable to enroll an individual in Medicaid that is a member of a mixed household (a household where another member is on a QHP) without receiving payment for both programs (Medicaid and QHP). This creates access to care issues for the Medicaid household member.
- Medicaid eligibility is not being canceled when someone fails to pay their initial premium bill timely. Individuals who are never enrolled in Medicaid (due to initial premium non-payment) are continuing to receive monthly premium bills indefinitely.
- Reconciling between 3 systems (VHC, Premium Processor and Issuers) is challenging.
- Remittances are sent to issuers once per week which causes lag in customer status on issuer systems.
- Carriers are not uniform in the late payment notice process (some do this based on their records; some do it based on VHC records).
- CoCs (changes) are sent as individual transactions (drop/add); each transition adjusts the customer's financial position at Premium Processor; pulling back funds from the carrier including VPA, which can then not be replaced until the next VPA monthly billing.
- Partial payments made by members are not remitted to carriers (held in bank account); no hierarchy in place to send to one carrier but not all; no payment threshold in place that allows remittance even in the case of a 1 cent shortfall.
- VHC system does not have the ability to identify a "Passive" renewal from an "Active" renewal to follow ACA rules relating to Member Intent for Open Enrollment.
- Contract discussions/ decisions do not always include operations; therefore, business processes are sometimes impacted by limitations.
- Consideration should be given to having issuers do premium processing instead of by a premium processor.

Vermont Health Connect

- Vermont Health Connect provides health care coverage to approximately 220,000 (more than one in three) Vermonters. In the past year, VHC has seen dramatic improvement in operational metrics. In the spring and summer of 2016, the State and Optum M&O collaborated to initiate three "Surge" project teams to deal with key deficiencies within the VHC system: the renewals form, integration across State and carrier systems, and enrollment reconciliation. This resulted in the remediation of at least 200 defects.
- Medicaid renewals: After having received a waiver to delay redeterminations for both MAGI and non-MAGI populations, Vermont Health renewed nearly its entire Medicaid population during 2016. Verification of eligibility will continue into 2017 under the CMS mitigation plan.

- Change requests: VHC receives approximately 1,000 change requests per week across its QHP and Medicaid customer base. The backlog of change requests decreased significantly during 2016. The goal is to complete changes requested between the 16th of a month and the 15th of the next month in time to be reflected on the following invoice. VHC's performance in relation to this service level target improved through 2016 and was at 88% as of August.
- Self-Service functionality: Self-service renewal and change reporting functionality was made available to customers during the summer of 2016.
- Tier 3 call center: VHC implemented a Tier 3 call center to handle qualified special cases that are escalated to a dedicated customer service team due to their complexity, medical or financial urgency, or inability to be resolved through normal channels.
- Organizational structure: The 2016 Legislative session codified the merger of all health care eligibility operations into the Department of Vermont Health Access. This move was completed in July 2016 and is making administration more streamlined, efficient and effective.
- Open Enrollment for 2017 runs from November 1 2016 through January 31, 2017. This is the annual period when new customers can enroll in a health plan and existing customers can decide whether to change plans. VHC's goal is to renew 95% of customers automatically and to work to get all existing customers into their 2017 health plans by December 15th.
- ORSD: DVHA entered a limited scope DDI contract with Speridian to implement functional enhancements to the system to improve the customer experience. Speridian is a firm that has experience both with Siebel systems similar to Vermont's and with the OneGate customer-facing software.
- SHOP: VHC has received transitional flexibility from CMS to not build an automated small business exchange as required under the ACA. Conversations are ongoing about the duration of the flexibility.

Quality of Care Process

- A process was developed and implemented for reviewing quality of care issues involving providers brought to our attention, typically by members
- This initiative was developed without additional staffing, which has presented challenges with tracking and monitoring. Additional staffing is needed to produce high validity of this project.
- Improved monitoring and tracking will enable enhanced quality control and integration into quality improvement projects.

Utilization Management Dashboard

- DVHA is successfully tracking medical expense trends in all categories of service across the State's hospitals and providers.
- Staffing challenges impede outreach to providers with 'outlier level' utilization and prevent this effort from moving forward in a way that promotes education, training, and awareness and ultimately prevent over utilization.
- Many quality issues could be identified through this effort, and many savings opportunities exist through reducing unnecessary or avoidable utilization.

ICD- 10 Conversion Project Implementation

- ICD-10 codes better describe the severity of illness and better management of inpatient stays. Implementation provides increased specificity review and successful claims processing.
- The extensive amount of pre-implementation code reviews and mapping, policy remediation, internal process and system workflow adjustments, and testing resulted in a smooth transition to ICD-10.
- Post deployment monitoring and adjusting diagnosis code lists is ongoing.
- A better data mining/analytics type solution would be valuable for monitoring codes and utilization trends, and provide better information to prevent misuse or inappropriate use of codes.
- A more sophisticated MMIS will allow more detail to the codes and better editing against misuse.

- A better data mining system providing detailed data will allow DVHA to identify patients in need of disease management, design health care delivery systems, payment models and strategic planning and track emerging public health threats. Credible data is contingent upon physicians accurately documenting medical conditions.

Call Center Transition

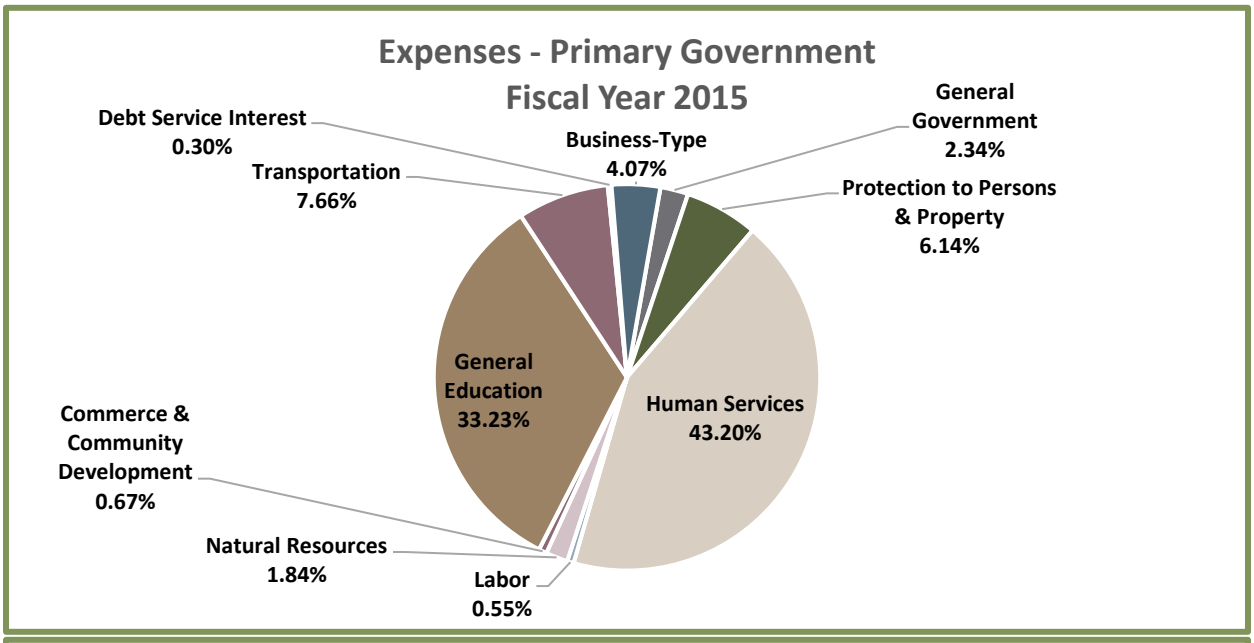
- The Agency has outsourced the customer service center work for Medicaid and expanded healthcare programs with Maximus since 1996. All phone calls from Vermonters enrolled in these programs are answered in this call center, as well as much of the pre-eligibility information and processing including the Bus Pass program. Complex, urgent or eligibility-specific issues are transferred to the state's Health Access Enrollment and Eligibility Unit.
- In 2013, the scope of this contract expanded to include Tier 1 customer service work Vermont Health Connect, increasing the number of Maximus front line staff almost five-fold from 25 to 118. The contract changed at this juncture from a fixed fee structure to a blend of a fixed base cost covering things like rent and administration, plus a variable cost based on actual work done. Service level requirements for calls with associated financial incentives and penalties were also added to the contract, as was a required disaster recovery plan.
- All Tier 1 healthcare customer service work is outsourced to the customer service center, which is the face of the department to the public. The need to re-procure these services and potentially transition to a new vendor is an administrative effort for the state. If a new vendor is selected, the transition both of people and technologies to a new partner requires significant integration management by the state, and could impact service to Vermonters during the transition period.
- When there are difficulties, the state must immediately ramp up resources to manage and monitor the corrective action process both from both a legal and service-level perspectives.
- Serving customers by distinct and physically separate business units requires management between the state contact center and the outsourced center to coordinate a seamless customer experience.
- Service levels have been difficult to achieve and the vendor has been slow to respond to trends, often relying on the state to raise a red flag.
- While bringing Tier 1 service in-house may not represent a significant cost savings, having an increased pool of staff would improve the state's ability to be flexible enough to maintain service levels during peak volume times, and provide more standardized service and staff support through a single management structure.

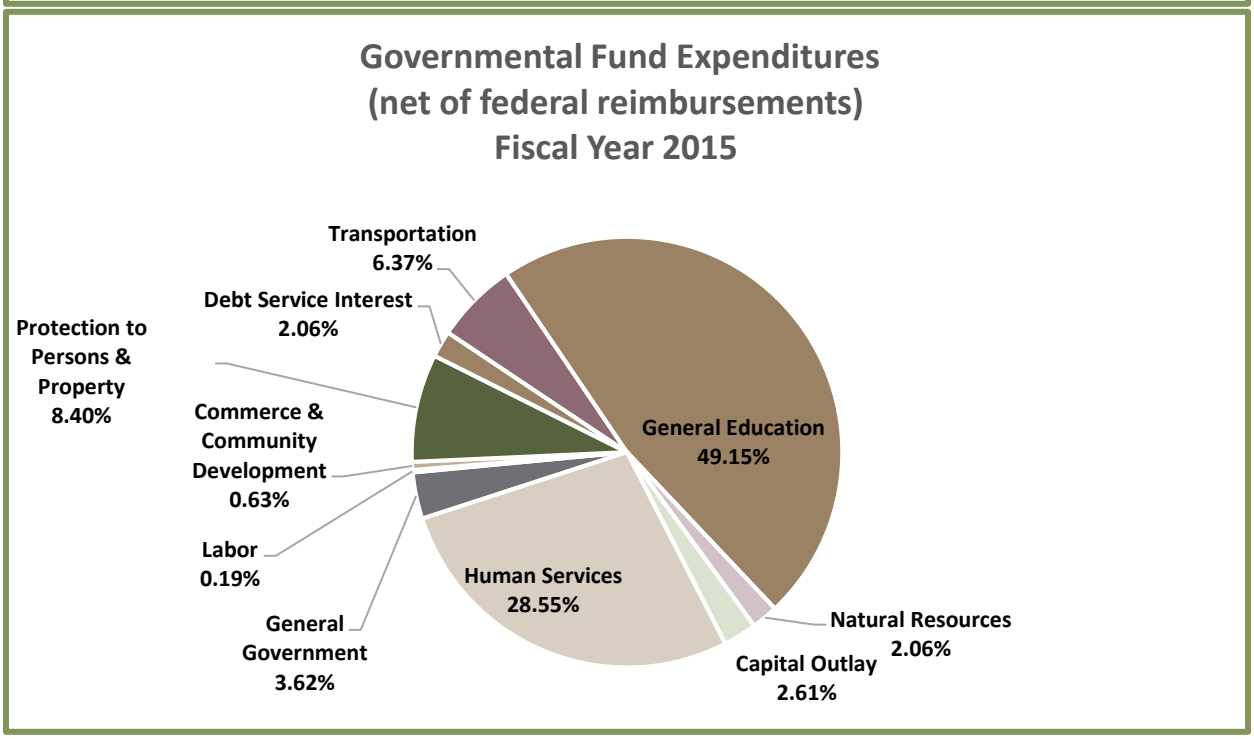
Budget

- Fiscal Year 2017: $8,520,840 (85% Global Commitment/15% State Funds)
- Fiscal Year 2018: $8,520,840
- Fiscal Year 2019: $8,520,840
- Fiscal Year 2020: $8,520,840
- Total: $34,083,360

Intra-Agency or Inter-Departmental Items

One of the Governor's top priorities is to support Vermonters' health through prevention and universal, affordable, and quality healthcare for all, in a manner that supports employers and overall economic growth, and that offers better care. The first chart below depicts the AHS total expenses as a percentage of the total State expenditures. The next chart shows the State fund portion of those expenditures. While AHS is the Agency with the largest expenses, it uses a smaller fraction of state funds than Education.





Inter-Agency Items

The Agency of Human Services, (AHS), its Departments and the Agency of Education (AoE) oversee and operate numerous programs designed to address the health and wellness needs of Vermont. The AHS' Department of Vermont Health Access manages the State's Medicaid program designed to provide traditional mandatory and optional healthcare services for low-income Vermonters. The remaining AHS Departments and the AoE are responsible for the oversight of specialized healthcare programs within Medicaid. Additional clinical determination may need to be met in order to access other Departments' specialized healthcare programs.

A partial list of Medicaid programs managed by other Departments is below.

Department	Division/Programs
Department of Vermont Health Access (DVHA)	Blueprint for Health Coordination of Benefits (COB)

	Mental Health and Substance Abuse Program Integrity (PI) Vermont Chronic Care Initiative (VCCI) Quality Reporting Vermont Health Connect (VHC)
Agency of Education (AoE)	School-based Health Services (IEP) Program
Department of Disabilities, Aging and Independent Living (DAIL)	Adult Services Division (ASD) Developmental Disabilities Services (DDS) Program Traumatic Brain Injury Services (TBI) Program
Department for Children and Families (DCF)	Child Development Division (CDD)—Children's Integrated Services (CIS) Program Family Services Division (FSD)—Contracted Treatment Service Programs
Department of Mental health (DMH)	Adult Mental health Division (AMH) Children's Mental Health Division (CMH)
Vermont Department of Health (VDH)	Alcohol and Drug Abuse Program (ADAP) Ladies First Program HIV/AIDS Program

The Departments manage services and programs that are similar, as seen below, but are targeted to unique age groups, disability types, and/or program goals. For example, case management services or service coordination is offered in all programs and almost always involves an assessment, gaining access to and coordination of necessary services across medical, social, educational, or labor domains. The Departments' programs require highly skilled specialized support staff who are capable of providing interventions specifically geared to the target group. Thus, while the services are similar in scope and, in some case, target the same population, these programs have very different coverage policies and reimbursement methodologies.

Service Category	AOE	DVHA	DMH	DDAIL	VDH	DCF
Assessment and Evaluation	x	x	x	x	x	x
Case Management	x	x	x	x		x
Day Services			x	x		
Emergency Services		x	x	x		
Employment			x	x		
Equipment	x		x	x		
Family Supports			x	x		x
Inpatient Hospital		x	x			
Mental Health Skilled Therapy	x	x	x	x		x
Personal Care	x	x		x		
Psychiatric		x	x	x		
Rehabilitation	x	x	x	x	x	x
Residential	x	x	x	x	x	x

Shared Living			x	x		
Transportation		x	x	x		

Key Decision Dates

- FY17 Budget Adjustment Act Ups and Downs – 9/21/16
- FY18 BAA Ups and Downs – 9/21/16
- FY18 Budget Language – 11/28/16
- All Payer Model Readiness Review – 11/30/16
- All Payer Model Start Date – 1/1/17
- Medicaid Pathways – 2018
- GC Waiver Renewal – 10/15/16 to execute agreement for 1/1/17 effective date
- Palliative Care – 1st Quarter 2017
- CMS Medicaid Mitigation Plan
    - Complete renewal noticing for VHC Medicaid population – 11/30/16
    - Complete verification and verification noticing for certain Medicaid populations; availability of further automation to support Medicaid renewals – 12/31/16
    - Complete renewal (including verification) for VHC Medicaid population – 4/30/17
    - Automation to support multi-benefit application, hospital presumptive eligibility, notices – 12/31/17
- Women's Health Initiative – 1/1/17
- Full Benefit Duals Co-Pay Coverage – 7/1/17

Legislation

DVHA has proposed 9 legislative initiatives this year. A summary of these proposals is as follows:

1. Extension of current eligibility calculation for health Vermonters and VPharm. Without an extension DVHA would be required to use a MAGI (Modified Adjusted Gross income calculation). We cannot accommodate this change and seek an extension of the current calculation method.
2. Convert Dr. Dynasaur Program income eligibility from 185% FPL (federal poverty level) to 195% FPL. Without the change fewer children will be eligible.
3. Alter provisions of the state insurance code to delete its applicability to Medicaid. Medicaid is not insurance as it is defined in state law.
4. Alter provisions of current Medicaid law to take into effect a U.S. Supreme Court Decision in 2006. The change would insure Medicaid receives a fair share of medical expenses paid by the Department when a member has a personal injury claim against another as a result of the medical care the state has provided.
5. Alter provisions of the Medicaid hospital tax to conform with a Superior Court decision rendered in 2016 and make the reporting of net patient revenue more consistent.
6. Alter the 20 day timeline for Medicaid tax appeals to DVHA. This timeline cannot be met given the complexities of each case.
7. Authority for emergency rulemaking when federal law contradicts state regulation and causes a loss of federal financial participation.
8. Alter law for Vermont Health Benefit Exchange to delete a requirement of "registered carriers". DFR (Department of Financial Regulation) no longer requires registered carriers on the HBEE.
9. Alter law for Vermont Health Benefit Exchange requiring contracts with insurers. A regulation has been developed. Contracting is not possible for a new plan to enter the market eliminating further competition on the Exchange.

Budget

- As noted on page 1, with a budget of close to $1 billion, DVHA ranks first in the State of Vermont's programmatic expenditures. The following five highest programmatic expenditures account for more than 50% of the annual expenditures:

    - Pharmacy
    - Hospital Inpatient
    - Hospital Outpatient
    - Physician Services
    - Nursing Homes
- Caseload, utilization, and policy issues (such as adding new beneficiary categories, adding new categories of service, rate increases or decreases, etc.) drive the DVHA budget. (See Attachment I for mandatory and optional benefits.)
- There are myriad federal Medicaid match rates across DVHA programs, but "rule of thumb" relies on 55% federal, 45% state.
    - State share includes revenues that are "creatively grown" through provider taxes, beneficiary premiums, new uniquely-identified taxes/funds (e.g., tobacco tax), and certified funds.
- Medicaid's options for reducing costs include:
    - Provider rate reductions
    - Elimination of optional services (may result in cost shift).
    - Increase in beneficiary cost share, provided out-of-pocket costs do not exceed 5%.
    - Capping/prior authorizing services.

Mandatory Benefits	Optional Benefits
• **Inpatient hospital services** • **Outpatient hospital services** • **EPSDT: Early and Periodic Screening, Diagnostic, and Treatment Services** • **Nursing Facility Services** • **Home Health Services** • **Physician Services** • **Rural health clinic services** • **Federally qualified health center services** • **Laboratory and X-ray services** • **Family Planning Services** • **Nurse Midwife services** • **Certified Pediatric and Family nurse Practitioner services** • **Freestanding Birth Center Services (when licensed or otherwise recognized by the state)** • **Transportation to medical care** • **Tobacco cessation counseling for pregnant women**	• Prescription Drugs • Clinic Services • Physical therapy • Occupational therapy • Speech, hearing and language disorder services • Respiratory care services • Other diagnostic, screening, preventative and rehabilitative services • Podiatry services • Optometry service's • Dental services • Dentures • Prosthetics • Eyeglasses • Chiropractic services • Other practitioner services • Private duty nursing services • Personal care • Hospice • Case Management • Service for Individuals Age 65 or Older in an Institute for Mental Disease (IMD) • Services in an intermediate care facility for individuals with intellectual Disability • State Plan Home and Community Based Services-1915(i) • Self-Directed Personal Assistance Services-1915 (j) • Community First Choice Option-1915 (k) • TB Related Services • Inpatient psychiatric services for individuals under age 21 • Other services approved by the Secretary • Health home for Enrollees with Chronic Conditions-Section 1945

- The Maintenance of Effort (MOE) requirements in the new federal reform bill (ACA) prohibit elimination of eligibility groups, increase in premium amounts paid by members, and changes to methods of eligibility determination that would be detrimental to potential beneficiaries.
- Current and future cost savings efforts such as the Blueprint for Health, the DVHA Chronic Care Initiative, clinical efficiencies through mechanisms such as utilization management, program integrity efforts, and aggressive collection of drug rebates are key to a sustainable budget.
- DVHA has three major contracts that are vital to its work that often are scrutinized due to their size:
    - HPE operates the Vermont Medicaid Management Information System (MMIS) for DVHA. HPE serves as Vermont's Fiscal Agent for Medicaid claims management and payouts along with Medicaid provider enrollment and outreach.
    - Goold Health provides DVHA Pharmacy Benefits Management Services for Medicaid and other pharmacy programs. Contracted deliverables: maintenance of a Preferred Drug List, increasing the use of clinically appropriate generic drugs, managing the drug benefits of beneficiaries through use of prospective drug utilization review, negotiation of lower process through multi-state supplement rebates, preventing fraudulent payment or duplicate claims and providing wraparound benefits to Vermont beneficiaries to be enrolled in Medicare Part D through the federally designed State Pharmacy Assistance Program (SPAP).
    - Maximus provides DVHA with Enrollment, Benefits, Counseling and Member Services for the Vermont Health Access Plan. Contracted deliverables: provide outreach and education for individuals eligible to enroll into managed care, benefits counseling for enrollment into managed care and enrollment activities, and provide member services to DVHA's Heath Care Programs.

External Groups and Organizations

- Health care providers and the organizations that represent and advocate on behalf of their professional practices: Vermont Medical Society, Vermont State Dental Society, Bi-State Primary Care Association, Dartmouth-Hitchcock Medical Center, Vermont Assembly of Home Health Agencies, Vermont Association of Hospitals & Health Systems, Vermont Health Care Association.
- Consumer advocates and stakeholders, including the Vermont Council of Community Mental Health Service, Vermont Center for Independent Living, Vermont Family Network, Community of Vermont Elders, AARP, the Health Care and Long Term Care Ombudsmen, Voices for Vermont Children.
- The Medicaid and Exchange Advisory Board (MEAB), a 22-member advisory board established by Federal statute in order to advise the AHS/DVHA on issues relating to Vermont's public health care programs. The MEAB meets monthly and includes representatives from the provider and advocacy organizations listed above, as well as consumers/beneficiaries.
- The Drug Utilization Review (DUR) Board, a seven-member advisory board of physicians and pharmacists, meets monthly. The DUR Board was established to assist in reducing the cost of providing prescription drugs to beneficiaries while maintaining high quality in prescription drug therapies, as well as to provide guidance on the development of a Preferred Drug List for Medicaid patients.
- The Clinical Utilization Review Board, composed of 10 members of diverse medical experience, is established to make recommendations to DVHA regarding coverage, unit limitations, place of service, and appropriate medical necessity of services in the state's Medicaid programs.
- Private health insurers: Blue Cross Blue Shield of Vermont, MVP, CIGNA.
- Other advocacy groups representing beneficiaries, providers, populations in need, etc.

General Information

The following DVHA management team can be helpful in understanding certain key topic areas:

Steven Costantino, Commissioner

As Commissioner of DVHA, he provides leadership and strategy for many of Vermont's health care reform initiatives to increase access, improve quality, and contain health care costs, including the federally funded State Innovation Model grant, Vermont Health Care Innovation Project (VHCIP), Vermont's Blueprint for Health, and development of an All Payer Model. He is leading plans to incorporate non-medical services (mental health,

substance abuse treatment, and long term care) into a value-based system of care. He has also been instrumental in the negotiation efforts with our federal partners around Vermont's 1115 waiver and other waivers in order to protect our ability to maximize Medicaid funding, which has included prioritizing compliance with Medicaid's health benefit exchange requirements and functionality. Prior to joining DVHA, he served as the Secretary of the Executive Office of Health and Human Services of Rhode Island and served 16 years in the Rhode Island legislature.

Lori Collins, Deputy Commissioner

Oversees the Policy, Fiscal, and Support Services Division and DVHA's operations, including being the escalation point for operational issues within VHC, the contract with DVHA's fiscal agent and claims processing vendor HPE, the MMIS replacement projects, large scale procurements, and highly visible ongoing and new projects and initiatives. Liaison with the Governor's office, Green Mountain Care Board, and CMS on VHC operational issues.

Aaron French, MSN, RN, Deputy Commissioner for Health Services and Managed Care

With 20 years' experience in healthcare providing direct care to patients and in leadership roles, he brings to DVHA a considerable amount of experience in clinical knowledge, healthcare systems expertise and leadership qualities. Provides oversight of clinical operations, pharmacy, quality improvement, clinical integrity, care management and compliance programs and initiatives within DVHA. As a clinician and quality improvement professional, assisted FQHC's in the rollout of the first Blueprint for Health initiative (St. Johnsbury), developing internal and external processes that would ultimately ensure the success of this Initiative that was then launched statewide. Primary contact for internal and external stakeholders that involve provider and member issues or concerns. Works with provider network, beneficiaries, advocacy groups and legislators to understand and better serve both of these stakeholders. Fosters collaborative and honest relationships across the Agency of Human Services as well as Vermont's healthcare system.

Carrie Hathaway, DVHA Fiscal and Administrative Operations Director

Oversees the DVHA budget, how it relates to the Global Commitment to Health waiver, category of service expenditures, eligibility groups, enrollment projections, etc. Oversees the DVHA business office. Provides expertise regarding Medicaid funding, expenditures, and cost projections for new initiatives and proposals. Oversees the DVHA business office.

Howard Pallotta, General Counsel

Leads the DVHA legal unit, which provides timely and well researched legal advice to the Commissioner and Deputy Commissioners regarding Medicaid compliance, Health Insurance Exchange compliance, Medicaid provider taxes, regulations and contracts. The unit also provides reviews and drafts contracts, negotiates contracts, assists in administrative appeal review before filing with the Human Services board and prepares Assistant Attorney Generals regarding litigation.

Tom Boyd, Deputy Commissioner

Oversees provider network payment mechanisms, including development and implementation of reimbursement methodologies for a vast array of healthcare providers, such as hospitals, physicians, FQHCs and ancillary providers. Also responsible for the design and implementation of value-based purchasing initiatives in Vermont Medicaid including payment models developed under Vermont's State Innovation Model (SIM) testing grant funded through the Centers for Medicare and Medicaid Innovation (CMMI). Responsible for financing and actuarial proposals related to the new ACO prospective payment arrangement projected to be implemented January 1, 2017.

Beth Tanzman, Interim Director of the Vermont Blueprint for Health

Provides expertise on physical and behavioral health integration and was a key leader in developing and implementing the Hub and Spoke model for Medication Assisted Therapy for Opioid Dependence.

Tom Simpatico, MD, Chief Medical Officer (CMO)

As CMO, Dr. Simpatico provides strategic medical leadership related to the Department's clinical policies and practices and serves as a liaison with health care providers and other state partners. He also plays a key role in ensuring that Vermonters receiving health coverage through Vermont's public health coverage program receive necessary care consistent with the best available clinical guidelines. Dr. Simpatico has an extensive history of leadership in innovative reform of health care delivery systems. He is board-certified in psychiatry and a professor of psychiatry and Director of the Division of Public Psychiatry at the University of Vermont (UVM) College of Medicine. Some projects for which he has a leadership role include the Hub & Spoke Model for Medication Assisted Therapy for Opioid Dependence, Vermont's unique involuntary psychotropic medication practice, and the rollout of the Palliative Care model (in collaboration with Blue Cross/Blue Shield of Vermont).

Cassandra Gekas, Chief Executive Officer, Vermont Health Connect
Vermont's health benefits exchange, which serves over 220,000 Vermonters enrolled in Medicaid and Qualified Health Plans. She also oversees all operations of the Health Care Eligibility and Enrollment unit.

Vermont Department of Health

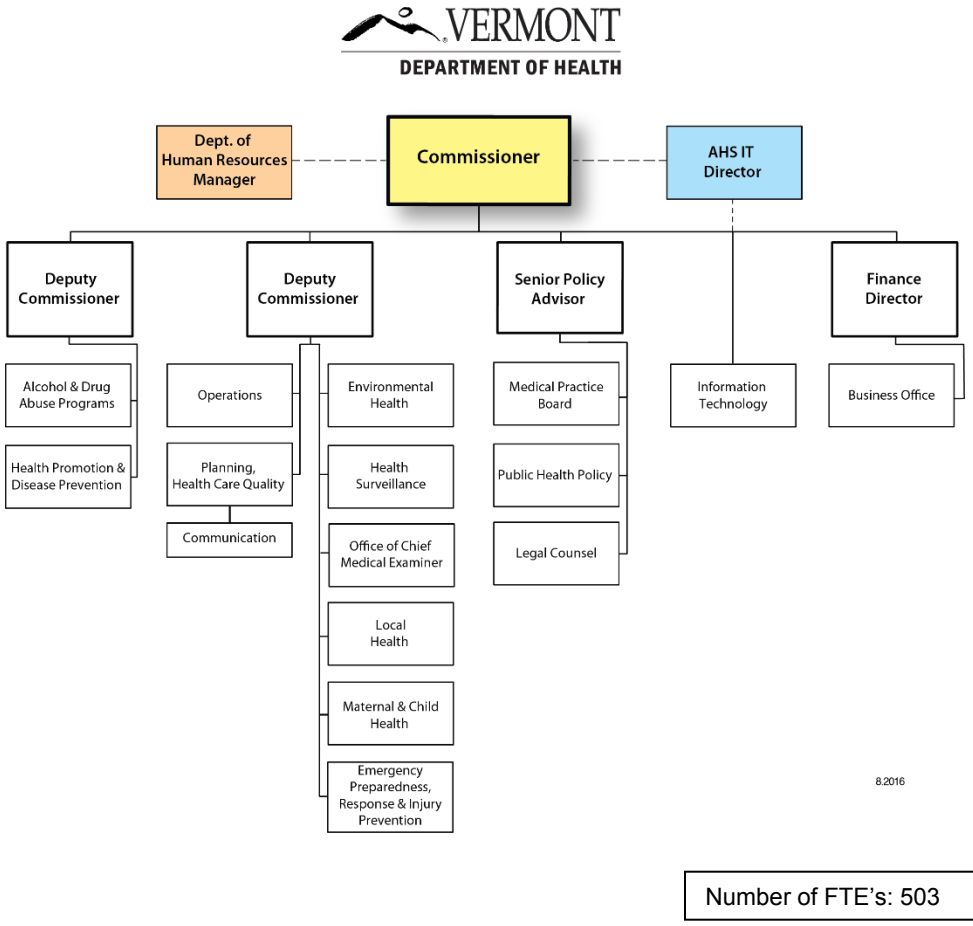
Public health is the system that works to protect and promote the health of all citizens. It is the science and art of preventing disease, prolonging healthy life and promoting physical and mental health.

On June 18, 2014, the Public Health Accreditation Board (PHAB) conferred accreditation to the Vermont Dept. of Health. PHAB standards and measures provide a means for the Department to continually assess its effectiveness in delivering the 10 essential public health services. Performance management is a core element in Departmental operations.

Mission: Protect and promote optimal health for all Vermonters
Vision: Healthy Vermonters living in healthy communities

Health Dept. Strategic Plan sets the strategic direction and priorities, based on Healthy Vermonters 2020 data, to guide the Health Department's work, quality and system improvements.

Six major goals:
1. Effective and integrated public health programs
2. Communities with the capacity to respond to public health needs
3. Internal systems that provide consistent and responsive support
4. A competent and valued workforce that is supported in promoting and protecting the public's health
5. A public health system that is understood and valued by Vermonters
6. Health equity for all Vermonters



Number of FTE's: 503

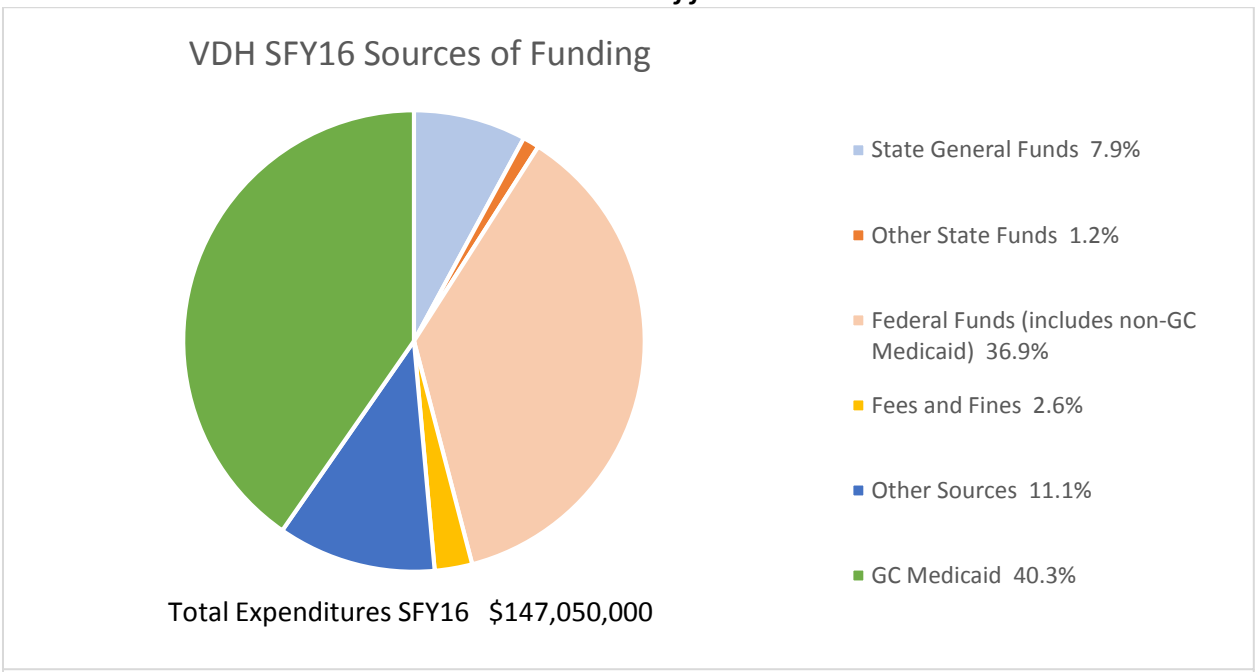
Budget

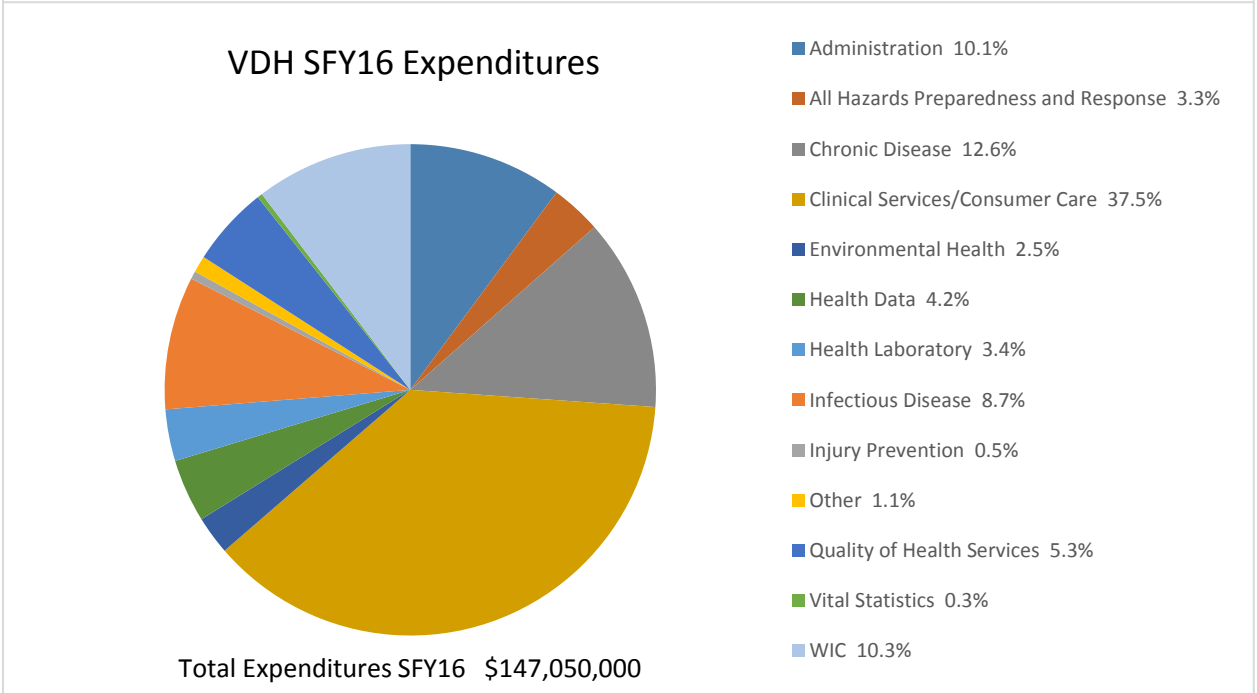
The Health Dept. has a budget of about $150 million. Federal grant programs provide 36% of total funds and federal Medicaid (Global Commitment) accounts for another 40% of funds. Only 8% of the Department's budget is state General Fund. This relatively small share of the budget has disproportionate importance, since state funding is usually applied as match or maintenance of effort to secure federal funds.

Federal funding comes in the form of over 70 separate grants from Health & Human Services, Environmental Protection Agency and Dept. of Agriculture. These grants range in size from under $100,000 to nearly $8 million annually. Approximately 48% of Department salary and fringe costs are federally funded.

The Health Department budget has grown at an average annual rate of 8% over the past five fiscal years, primarily due to increased spending on substance abuse treatment services. Overall Health Department budget for substance abuse treatment services has increased at a 14% average annual rate. The budget for medication assisted treatment in specialized hubs has increased from $4.8 million in FY '13 to $18.2 million in FY '17, which has resulted in improved access to services and reduced waiting lists. This trend will continue in FY '18 as we budget an additional $2 million for a 400 client expansion of hub services at a new location in St. Albans.

Sources & Uses of funds – FY 2016 actuals





Health for All, by All *(Achieving Health Equity)*

Eliminating health disparities and creating health equity

Vermont is consistently ranked as one of the healthiest states in the nation, however, health is not equally shared among all. Too many Vermonters, especially younger, less educated, minority and lower income citizens, experience real differences in years of healthy life when compared to the general population. Our goal is to eliminate health disparities for vulnerable populations as defined by race/ethnicity, socio-economic status, geography, gender, age, disability status, risk status related to sex and gender, and among other populations identified to be at-risk for health disparities. Staff target policies and programs and promote a focus on health equity with community partners/organizations. Recently it has been important, for instance, to change perceptions of refugees as a public health threat due to infectious disease concerns through education and community engagement.

See: **The Health Disparities of Vermonters** (2010) http://www.healthvermont.gov/research/healthdisparities.aspx.

Engaging Other Sectors in Creating a Culture of Health

Where it is recognized that where we live, work and play, the opportunities we have and the choices we make are as important, if not more so, than what happens in the doctor's office. *Opportunity:* Vermont has a number of initiatives at the state and local level to strategically harness the power of governmental and non-governmental partners in change:

Health in All Policies Task Force

Seeks to ensure that decision-makers are informed about the health consequences of various policy, program and budgetary options during the decision making process. The State is a significant employer and can set policies that result in wellness for state workers and model policies for the private sector. Vermont already has many examples of a Health in All Policies approach, such as healthy nutritional procurement guidelines. The challenge and opportunity now is to maximize the impact through system wide changes supported by a cabinet-level Task Force empowered to utilize the authority and tools of government.

Health Impact Assessments

A tool to evaluate the potential negative and positive health impacts of projects or policies and to identify opportunities to minimize any potential negative impacts.

Expenditure Analysis

A detailed database of state spending that includes population-based spending on health as a whole, rather than simply as individual health care-related expenditures.

The 3-4-50 Initiative

Intended to create an epiphany about the causes and impact of chronic diseases as well as the steps that can be taken by various sectors to prevent it. Three behaviors (tobacco use, physical inactivity and poor diet) lead to four chronic diseases (cancer, cardiovascular disease and stroke, diabetes, and lung disease) that result in more than 50% of deaths in Vermont. The goal is to raise awareness among decision makers in various sectors (education and early childcare, municipalities, business, health care, state leaders) and provide concrete steps that each sector can take to reduce the behaviors that lead to chronic disease. *Opportunities:* Northwestern Medical Center provided an example of how a hospital can use funds to support change at a community level. This model could be utilized in other hospital service areas.

Health System Transformation *(Effective and Integrated Programs)*

Articulate and promote the role of public health approaches and strategies in Vermont's health systems reform planning and implementation. Public health is a critical partner in addressing the contributors to health outcomes. The Health Department has critical resources to offer in two domains: evidence-based prevention strategies and population health data.

Successes

- Adoption of the State Health Improvement Plan (SHIP) to set statewide goals, priorities, and measures; to inform statewide payment reforms; and guide regional priority setting
- Inclusion of primary prevention and population health strategies in health payment and care model reforms (e.g., Blueprint for Health, Regional/Community Collaboratives, and the Vermont Health Care Innovation Project)
- Community partnerships with hospitals to develop Community Health Needs Assessments and promote integration of population health interventions into their Improvement Plans

Opportunities

- Applying for the 1115 SUD (Substance Use Disorder) waiver to support the substance abuse system of care
- Participating in the AHS-led Medicaid Pathway initiative
- Including oral health in the Blueprint for Health initiative and other quality improvement/pay for performance movement in healthcare

Integrate Substance Abuse Treatment into the Larger Health Care System

Primary focus for the past two years has been: public education and social marketing campaigns, prevention and community action, Screening, Brief Intervention and Referral to Treatment (SBIRT) Initiative with primary care and hospital providers; increased access to treatment (Hub & Spoke Initiative), recovery supports, distribution of naloxone rescue kits to reverse opioid overdoses, and the Vermont Prescription Monitoring System (VPMS). The Health Department's division of Alcohol & Drug Abuse Programs (ADAP) continues to work with a wide range of partners to forge an integrated system for decreasing addiction and improving health outcomes. Despite major increases in resources there is still a serious challenge in meeting the demand for opioid treatment.

The Board of Medical Practice has contributed to the effort to reduce the harms caused by opioids through discipline of unprofessional conduct relating to opioids, establishment of policies for prescribing opioids and treating addiction, and many educational programs. The Health Dept. and Dept. of Corrections are collaborating on addressing addiction and accessing care.

Successes:

- Fewer people are waiting for treatment due to expanded Care Alliance (Hub and Spoke)
- Increases in the number of primary care physicians who can now prescribe buprenorphine
- Blueprint funded masters-prepared clinicians and nurse-care managers in the enhanced health home model
- Increased access to substance abuse screening services through the AHS Substance Abuse and Treatment Coordination initiative and the SBIRT initiative
- Expansion to 12 Recovery Centers around the state

Opportunities:

- Inequities and inconsistencies exist across regions of the state regarding availability and type of prevention, treatment and recovery services offered. Prevention services are highly dependent on time limited federal grants.
- The 1115 Substance Use Disorder (SUD) Waiver is needed to continue to fund the substance abuse system of care with Medicaid dollars.

Support women and children throughout the lifecycle

The Maternal and Child Health division operates a number of programs and engages in multiple statewide initiatives. These will remain stable. Two with great opportunity for expansion are:

Early Childhood Systems

Home visiting is one of the most effective programs in the state and needs to be expanded statewide. This requires a new financial model that is a mix of Medicaid and federal grant dollars to both expand the client reach and support the infrastructure needed to run the program. Some models have been explored and more work is needed to provide home visiting to every pregnant woman who needs it. *Opportunities:* Expansion of evidence-based home visiting statewide, including universal (light-touch) home visiting for all new families; work connecting refugees and immigrants to services and assisting the system of care in best meeting the needs of families from diverse backgrounds.

Maternal Depression

Increase capacity of health care and mental health providers to educate, screen, diagnose, and treat maternal depression. *Opportunity:* In May 2016, CMS issued guidance that state Medicaid agencies may allow screenings to be claimed as a service for the child as part of the EPSDT benefit, as well as diagnostic and treatment services directed at treating the health and well-being of the child. What is needed now is for Vermont Medicaid to be willing to do this.

Build upon Health Dept. data for AHS and Health Reform decision-making

The Health Dept. has systems data including hospitals, provider census clinical data from various screening and disease registries, and population trend data from our surveys. Our analytic staff is recognized as the best trained in government. *Challenge:* Demands for data driven decision-making and results-based accountability are increasing pressure to collect more data. However, there is not corresponding commitment to support the needed infrastructure. *Opportunities:*

Data sharing across government Continue discussions across state government to consider utility of a statewide data warehouse and shared analytic capacities. A new "data governance board" that is in the works is an essential first step to working through the complexity involved in this type of initiative.

Integration with HIE Coordinate with Vermont Information Technology Leaders (VITL) on two needed projects:

1. Ensuring that VITL meets certain patient matching criteria for the exchange and matching of patient health data in the Health Information Exchange (HIE) to speed interoperability efforts, and allow the Health Dept. to take advantage of the HIE for sharing certain data with Health Partners (such as Vital Records Death data)
2. Implement planning to bring healthcare provider offices and hospitals into compliance with meaningful use requirements related to the state cancer registry.

Respond to Public Health Needs *(Community Capacity)*

Emergency preparedness and response is in constant demand. The Health Dept. must be ready to respond to a wide-range of emergencies and disasters using health operations center (HOC) and partnering with the health care system, Medical Reserve Corps and EMS volunteers. The Health Dept. has been a resource for technical assistance as the Agency strives to improve its overall preparedness – and our communication staff is viewed as the lead and resource for other state agencies in providing effective crisis and emergency risk communication. Recent examples of public health emergency response include: inappropriate pesticide use in Rutland, preparedness for Ebola returning travelers, response to PFOA contamination in water supplies, and a pertussis outbreak.

The Food & Lodging Program is significantly understaffed.

Is not able to conduct necessary inspections often enough to prevent illness. We will require positions to ensure an adequate level of inspection, particularly for restaurants. Staff must inspect hundreds of food and lodging establishments as a daily a responsibility but also must respond with all available resources to emergencies like foodborne outbreaks. National program standards recommend a staffing level of one FTE devoted to food for every 280-320 inspections performed. Using this standard applied to overall licensed establishment activities, the Department should have 18-20 inspectors. The program currently has 8 inspectors for roughly 6000 licenses establishments, far below the standard to support the protection of public health with a preventive approach.

Environmental health capacity is stretched

Environmental Health assesses, prevents and minimizes health risks associated with exposure to certain substances in the environment through education, technical assistance and licensing of the regulated community. Much of this work is invisible to the public, and therefore potentially undervalued, until it is essential. For example, the radiological program registers and inspects approximately 500 radiation-producing machines and 16 medical facilities: for employee and public health protection purposes and is responsible for oversight of decommissioning activities at the Vermont Yankee Nuclear Power Station. The Asbestos & Lead Program licenses more than 1200 professionals, and issues approximately 500 permits. Each year the public demands increased action and risk communication on newer and novel issues such as

blue-green algae in Lake Champlain, the presence of harmful chemicals in children's programs, potential health effects from noise, etc.

Office of the Chief Medical Examiner is at capacity

This very busy and lean operation relies on Assistant Medical Examiners in the field who are reimbursed via stipend and serve on a part-time voluntary basis. In addition to performing more than 400 autopsies a year (with a growing number of overdose deaths), the office also provides teaching opportunities, works with public safety on investigations and testifies in court. The Office is accredited but in recent years has come close to losing that accreditation due to longer turnaround times for autopsies. The Office has had a long standing request for another medical examiner to relieve the workload, increase autopsy turnaround times and decrease the amount of on call work for the two Medical Examiners.

Public Health Laboratory is ready to excel

The laboratory provides testing and analytical services to support disease prevention, surveillance and control, environmental health and protection, food safety and emergency response.
Opportunity: A new state of the art public health laboratory has been built. In order to utilize the full potential of this laboratory and its highly trained staff, two actions are needed: 1) Planning and securing funds for the replacement or purchase of equipment to meet the needs of the citizens of Vermont with regards to emerging contaminants (such as PFOA) and environmental toxins; and 2) Implementation of electronic ordering of tests and reporting of test results for our customers including medical providers, state agencies and the public.

Local public health infrastructure

Essential to providing public health services across the state through our 12 district offices. The district offices work in partnership with health care providers, volunteer agencies, schools, businesses, coalitions and organizations in their communities to improve health and extend public health initiatives across the state. Local health infrastructure is essential to ensure the benefits and services of Health Dept. programs and initiatives are accessible to local residents and responsive to changes in communities across the state. Additionally, local health offices work with a variety of community partners on prevention activities and with clinical partners to improve health indicators. Two important efforts are work with hospitals to conduct community health assessments and with Unified Community Coalitions (AKA Community Partnerships) on health system reform efforts to integrate care, increase prevention activities, and improve health outcomes.

Support Systems for Public Health Action *(Internal Systems)*

Build on performance management system. Performance management has become a core element of the Health Dept., and we are recognized as a leader within Vermont, AHS, and nationally compared to other Departments and health agencies, respectively. The Health Dept. was an early adopter in results-based accountability, and has developed strong performance management and quality improvement systems that are valued by our staff, the legislature and our Agency partners. These include Public Health Stat and the online scorecards of state and regional data to promote accountability, transparency, and data-driven decision-making at population and program levels. These initiatives also provide the foundation for the inter-agency work to build AHS Health and Well-being Community Profiles. *Opportunities* exist to further align performance management and performance based budgeting across AHS and other agencies of state government. The Health Dept. has and can continue to provide technical assistance related to Act 186 legislation and Results Based Accountability.

Prepare for accreditation requirements related to Vital Records' Offices. There will be new accreditation requirements when the Health Dept. re-applies for accreditation. We would currently fail to meet a significant number of the requirements as currently written due to statutory limitations. *Opportunity:* This requirement may support the Dept.'s efforts to update the Vital Records law.

Address aging software The Health Dept.'s Information Technology Unit manages a portfolio of increasingly diverse and complex systems. *Challenge:* There are often more resources dedicated to building new systems than to maintaining existing systems for the entire lifecycle of a system. Some key software applications and databases require a replacement plan. One critical area is the Public Health Lab software system (StarLIMS) that is only 50% complete in production, after 8 years of effort. Completion remains a high priority for the Department.

Recruiting and Developing the Workforce *(Competent Workforce)*

Reductions in workforce due to governmental cut backs and competition from the marketplace remain a challenge. This is especially true with the shortage of alcohol and drug counselors available and willing to work in lesser paid positions in community settings; the loss of sanitarians needed for food safety inspections; and limited staff trained for coordinating statewide emergency responses.

Public Health workforce: continue to respond to funding opportunities to support recruitment and retention activities. Partner with institutions of higher education to attract and promote interest in public health as a career.

Health care workforce: continue partnerships with University of Vermont, AHEC, and other interested organizations to meet the demand for primary care and specialty clinicians in all disciplines. Limited state funding threatens ability to attract qualified workforce through loan repayment.

Behavioral health workforce: a shortage has been exacerbated by increased demand for treatment and an aging workforce. There is also an increasing demand for alcohol and drug counselors to work in primary care settings and hospitals that provide higher salaries than community agencies, which lose experienced staff to these other entities.

Inter-Agency and Intra-Departmental Issues

Promoting population-based prevention

The Health Dept. will continue to actively lead the development and enhancement of community-based prevention efforts to lower incidence of chronic diseases caused by tobacco use, poor nutrition and physical inactivity. The Health Promotion and Disease Prevention division) works closely with DVHA on chronic disease, oral health and tobacco use; with the Dept. of Aging and Independent Living on disability health, chronic disease and tobacco use; with the Dept. of Mental Health on Tobacco Control and Physical Activity & Nutrition and with the Dept. for Children and Families on SNAP-ed. The release of *3-4-50* is intended to further Health Dept. collaboration with both other Departments and agencies as well as with the private sector.

Health system transformation

Through participation in community health teams and community collaboratives; engagement with hospitals in community health needs assessments; development of public policies that promote primary prevention efforts: implementation of evidence-based prevention strategies; and provision of statewide and regional data to drive the planning for health system reform focused on population health improvement. The Health Dept. has also numerous authorities related to licensing health and hospital systems. For example, the Board of Medical Examiners is collaborating with the Dept. of Aging and Independent Living to revise the existing administrative rules for hospital licensing.

1115 Substance Abuse Disorder Waiver Application

Use of Medicaid to support the substance abuse system of care. This involves transforming the system of care to meet the waiver standards.

Substance Abuse Treatment Coordination (SATC)

Establishes policy and protocols for intervening earlier, assuring that people served by AHS have access to screening services, and staff are trained and supported to offer screening and referral. ADAP's work involves strong collaboration with the mental health system, the corrections system, the judiciary, law enforcement and public safety.

ADAP/DCF Collaboration
To improve access to substance abuse treatment for families involved with child welfare. ADAP and Dept. for Children and Families developed a substance use treatment triage tool to prioritize families involved with child welfare, which is being implemented through the DCF/Lund screener program.

Licensing of Alcohol and Drug Counselors
Has shifted from the AHS/ Dept. of Health to the Agency of Administration's Office of Professional Regulation.

Payment Reform – Medicaid Pathway
ADAP is participating in the AHS Medicaid Pathway initiative.

Overdose Prevention (naloxone)
The Health Dept. is continuing efforts to distribute naloxone statewide and to work with first responders, providers and families.

Opioid Dashboard
Developed to track key indicators and trends to inform action
www.healthvermont.gov/adap/dashboard/opioids.aspx

Integrating Family Services (IFS)
The division of Maternal and Child Health is actively engaged in ensuring a statewide system of services, which reflect principles of comprehensive, community-based, coordinated, family-centered care. They work to ensure inclusion of efforts directed at health promotion, prevention and early intervention to intensive treatment and long-term supports. ADAP participates in the AHS Integrating Family Services framework with the goal of increasing access to treatment. The local IFS projects have integrated screening of families for risk related to substance abuse into the local services system of care.

Building capacity around child behavioral / mental health epidemiology
The departments of Health and Mental Health co-host a CDC maternal and child health epidemiologist. Her work to date has addressed: adverse family/childhood experiences, attention deficit/hyperactivity disorder (ADHD), youth and lifespan suicide prevention, maternal depression, tobacco cessation among pregnant women, substance use among youth and women of reproductive age, and long-acting reversible contraceptives.

Inter-Agency Items
Health in All Policies Task Force
Key initiatives include: Healthy Food Procurement Guidelines for all State Agencies, Worksite Wellness; a catalogue of best practices here and elsewhere to be amplified; and guidance on assessing health impacts of policies, budgets and programs throughout state government.

Governor's Climate Cabinet
Provides an opportunity ensure that governmental initiatives give due consideration to six priority human health concerns that could be worsened by climate change in Vermont: hot weather, extreme storms, tick and mosquito-borne diseases, air quality, food and waterborne illnesses, and blue-green algae.

Housing
A transitional housing subsidy program for people living with HIV (PLWH)

Agriculture
Nutrition in schools, WIC access at farmers' markets, mosquito surveillance

Education
Multiple school health policies and programs

Key Dates and Decision Points
Most of the Health Dept.'s deadlines and decision points are in line with AHS planning, legislative reporting requirements and grant deliverables. One critical date is submission of the 1115 SUD Waiver in March 2017.

Legislation (Technical/Housekeeping)
Key initiatives: The Dept. of Health is in the process of reviewing and amending the body of the Dept.'s regulations.

Successes: The Dept. of Health has completed 26 rulemakings and is in-process on 15 rulemakings. The Dept. anticipates that it has 27 rulemakings still to complete. Of those, 13 will be repealed by operation of law and an additional five will be repealed through the APA process. A remaining nine will be revised and re-promulgated.

Opportunities: Modernizing and reviewing regulations presents constant opportunity to provide greater clarity, consistency, transparency, and efficiency for the Dept. and members of the public.

Upcoming initiatives include:

- Restructuring the ADAP Chapter into a system of care
- Restructuring the Food and Lodging Chapter to reflect modern practices
- Modernize lead laws and make consistent with federal statutes
- Patient's Privilege Amendment to make clear that the Board of Medical Practice has access to hospital-employed physicians
- Grant municipalities the authority to regulate tobacco point-of-sale
- Vital Records Modernization

External Groups and Organizations
Other State Agencies
Agency of Agriculture Food and Markets, Agency of Natural Resources/Dept. of Environmental Conservation, Buildings & General Services, Dept. for Children and Families, Dept. of Corrections, Dept. of Education, Dept. of Mental Health, Dept. of Aging and Independent Living, Dept. of Public Safety (including Vermont Emergency Management), Judiciary, Secretary of State's Office (VSARA)

Health and Social Service Providers
Health care providers and allied health personnel, including but not limited to: dentists, nurses, physicians, physician assistants, mental health and substance abuse providers, veterinarians; home health agencies and providers; hospitals; social workers.

Primary Care and Public Health
Vermont Child Health Improvement Program, the Vermont Chapters of the American Academy of Pediatrics and the Academy of Family Physicians, Planned Parenthood, ObGyn physicians, and primary care internal medicine providers

ADAP Specific
Vermont Alcohol and Drug Abuse Council advises Governor, Controlled Substances and Pain Management Council, VT Recovery Network, Prevention Works, Vermont Association of Mental Health and Addiction Recovery, VAATP, SBIRT Health Disparities Work Group, Chittenden County Opioid Alliance

Community, Consumer, Trade and Stakeholder Groups

Community groups and municipalities; University of Vermont and other Vermont institutions of higher education; VAHHS; Vermont State Dental Society, Vermont League of Towns and Cities, advisory groups including but not limited to the Lead Poisoning Prevention Committee, AIDS Medication Assistance Program formulary group, Diabetes Coordinating Council, Tobacco Evaluation Review Board; Vermont chapters of the American Heart Association, American Cancer Society and American Lung Association; Bi-state Primary Care Association; Vermont Association of Addiction Treatment Providers; Vermont Council for Mental Health and Developmental Disabilities; Vermont Recovery Network; Vermont Alcohol and Drug Abuse Council; Vermont Pharmacists Association; Municipal Officers Associations, Funeral Directors Association, Coalition of Clinics for the Uninsured.

Media

Television, radio, print and online media.

National Organizations

Association of State and Territorial Health Officials (ASTHO); National Association of County and City Health Officials (NACCHO); National Association of Medical Examiners (NAME); Council of State and Territorial Epidemiologists (CSTE); Association of Maternal and Child Health Programs (AMCHP); Association of Public Health Laboratories (APHL); National Association of State Alcohol and Drug Addiction Directors (NASADAD); National Association of Chronic Disease Directors (NACDD); Association of Immunization Manager (AIM); National Association for Public Health and Information Systems (NAPHIS); National Public Health Information Coalition (NPHIC).

Legislators

State and federal congressional delegation and their staff.

Funding Sources

Particularly federal agencies such as Centers for Disease Control and Prevention (CDC), HRSA, and SAMHSA. In addition, there are many foundations (e.g., Komen Foundation, American Legacy Foundation, and Robert Wood Johnson Foundation) that provide funding to the Health Dept.

General Information

The Health Dept. performance management framework is integrated with the State Health Assessment, State Health Improvement Plan, outcomes-based legislation (Act 186), and core Dept.al operations. It functions at the program, organization, and system level to ensure the Health Dept. is using performance data to improve the public's health.

State Health Improvement Plan

Identifies three priorities: reducing prevalence of chronic disease, reducing prevalence of substance abuse and mental illness, and improving childhood immunizations (http://healthvermont.gov/hv2020/documents/ship_full.pdf) ; evidence based prevention strategies (http://healthvermont.gov/hv2020/documents/ship_appendix_a_strategies.pdf); and a plan of action (http://healthvermont.gov/hv2020/documents/ship_appendix_b_interventions.pdf).

Healthy Vermonters 2020

The State Health Assessment Plan that documents the health status of Vermonters at the start of the decade, and the population health indicators and goals that will guide the work of public health through 2020. http://healthvermont.gov/hv2020/index.aspx

Performance Dashboard

Built on the concepts of *Results Based Accountability,*™ is made up of the scorecards to track progress with:

Population Indicators

(such as smoking prevalence) for which the Health Dept., with state government and community partners, share responsibility for making change.

Performance Measures

(such as the percentage of smokers registered with the Vermont Quit Network), for which our programs are responsible for the performance of interventions - the things that, over time, will improve health - as reflected in the population indicators (such as reduced smoking prevalence).