2012 Report of the Health Care Oversight Committee
January 2013

In Accordance with 2 V.S.A. § 852

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Senator Ann Cummings
Senator Sally Fox
Senator Jane Kitchel
Senator Kevin Mullin

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Table of Contents

I. Statutory Authority and Responsibilities of the Health Care Oversight Committee

During the 1995 session of the Vermont General Assembly, the Legislature authorized the creation of the Vermont Health Access Plan (VHAP), taking one of the first steps in health care reform by offering health care coverage to uninsured low-income Vermonters (1995 Acts and Resolves No. 14). At the same time, the Health Access Oversight Committee was created to monitor the development, implementation, and ongoing operation of VHAP and to ensure improved access to health care. In 2006, the General Assembly broadened the Committee's jurisdiction to include the Medicaid program and all waiver programs that may affect the administration and beneficiaries of these programs.

In 2011, the General Assembly again expanded the Committee's jurisdiction, this time to encompass all health care and human services programs in the state, including programs and initiatives related to mental health, substance abuse, and health care reform. The General Assembly also renamed the Committee the Health Care Oversight Committee (HCOC). The changes took effect on July 1, 2012. (See Appendix 1 to view the statutory authority for the HCOC.)

II. Summary of Committee Activities

The Committee met once in June 2012 as the Health Access Oversight Committee, and five more times in the summer and fall of 2012 as the Health Care Oversight Committee, hearing from individuals and organizations representing a broad spectrum of perspectives and interests. The Committee developed recommendations on following topics as provided in this report:

- Choices for Care
- Health information technology
- Adverse event reporting
- Eligibility for public benefits
- Adult Protective Services
- Medicare Savings Program
- 3SquaresVT
- State-funded premium and cost-sharing assistance
- Accountable care organizations
- Exchange planning and implementation

The Committee also took testimony regarding the implementation of the new mental health system of care in Vermont, but chose to defer to the Mental Health Oversight Committee's recommendations on this topic. The Committee did not take testimony regarding the Blueprint for Health or substance abuse treatment sufficient to make recommendations on these topics, but recommends that the standing committees of jurisdiction pursue both of these important issues to ensure that the health care services provided in this state meet the needs of all of its residents.

(See Appendix 2 for the 2012 Witness List.)

III. Choices for Care

Choices for Care, a Section 1115 Medicaid waiver program, provides patients with a choice between receiving long-term care services in a nursing home or through home- and community-based services. Under Choices for Care, an individual must first meet certain financial eligibility criteria; the person's needs are then evaluated through a clinical assessment, and he or she is assigned to a risk group ranging from "highest needs" to "high needs" to "moderate needs." The needs determination establishes priority for services, with those in the "highest needs" category enrolled as soon as Medicaid eligibility is established. Individuals assigned to the "high needs" group are enrolled as soon as funds are available to pay for their treatment option. To the extent funds are available, "moderate needs" individuals receive preventive services, such as adult day care, homemaker, and case management services.

The legislation establishing the Choices for Care program requires "[a]ny savings realized due to the implementation of the long-term care Medicaid 1115 waiver [to] be retained by the department and reinvested into providing home- and community-based services under the waiver."[1] The Committee spent a considerable amount of time looking at what was intended by the word "savings," how to determine the amount realized as a result of the waiver, how to distinguish savings realized as a result of the waiver from unspent appropriations, and what it means to "reinvest" in services "under the waiver." The Department of Disabilities, Aging, and Independent Living (DAIL) presented several reinvestment plans to the Committee over the course of the summer and fall in response to concerns the Committee raised. One particular area of concern for the Committee related to DAIL's allocation of approximately $1.6 million to a caseload reserve fund. In addition to discussion about Choices for Care reinvestment, the Committee expressed interest in obtaining more detailed information about the moderate needs group and had concerns about reports of wait lists for that group while DAIL finished FY2012 almost $8 million under budget.

[1] 2005 Acts and Resolves No. 56, Sec. 1(g)(1), as amended by 2007 Acts and Resolves No. 65, Sec. 112a; 2008 Acts and Resolves No. 192, Sec. 5.207; and 2012 Acts and Resolves No. 139, Sec. 51(q).

The Committee also heard stakeholder concerns regarding DAIL's reinvestment choices and the process for making those decisions. For example, DAIL proposed to use Choices for Care funds to cover the costs of a program known as OASIS to address the use of psychotropic drugs in nursing homes, a use the Committee found to be inconsistent with reinvesting in home- and community-based services, as the language of the Choices for Care law requires. In addition, there was confusion regarding pay increases for direct care workers and uncertainty about whether all direct care workers would receive three raises: two $0.15 per-hour increases and one $0.20 per-hour cost-of-living increase, for a total increase of $0.50 per hour.

Recommendations

The Committee recommends that the committees of jurisdiction:

1. Clarify (and codify):
    a. what is meant by "savings";
    b. how to determine the amount to be reinvested;
    c. what are permissible uses of savings, including whether to expand permissible uses to include investments in nursing homes, and whether those permissible uses of savings differ from permissible uses of unspent appropriations; and
    d. the process for determining how to reinvest the savings and unspent appropriations, including whether it should be in the Administration's sole discretion or whether there should be a role for the General Assembly.
2. Request quarterly, monthly, or other periodic reports from DAIL about the Choices for Care program, including detailed information about the moderate needs group such as regional differences in utilization and flexibility to reallocate funds to reduce or eliminate waiting lists.
3. Look at the wages paid to direct care workers in Vermont to determine whether they are receiving a livable wage.

IV. Adult Protective Services

The Committee finds that in order to monitor effectively the services provided to vulnerable adults in Vermont, the General Assembly must know what happens after DAIL receives a report of abuse, neglect, or exploitation. It needs to understand what happens when DAIL does not investigate or substantiate a report so that it can determine whether changes should be made to the statutes or to the services available to individuals in Vermont.

The Committee requested certain Adult Protective Services (APS) data from DAIL on a number of occasions, and while the Department provided some of the information, the majority of the requests were delayed or denied because the information was not available electronically through DAIL's new Harmony system. In some instances, even when DAIL provided information, it was unclear what information DAIL was providing

– for example, the Committee requested the number of unduplicated intakes, but DAIL's data report included "intake calls (could include multiple calls on the same incident and calls related to faxes/on-line reports as well)," "faxes," "online reports," and "intakes entered."[2] It was not clear from the information the Committee received which of these numbers, if any, actually represented the number of unduplicated intakes. DAIL responded to certain requests, such as the number of cases in which there was no contact with an alleged victim or the number of cases in which there was no contact with an alleged victim or reporter after the initial screening, by saying "no data field reflects this."[3] For other requests, the Department said that it could not get the information "without purchasing additional modifications" to the Harmony system or that it would be available in "Harmony Advanced Reports … in 6–9 months."[4]

The Committee believes that evaluating the requested data is essential to the General Assembly's understanding of whether DAIL is providing sufficient APS services to vulnerable adults. It does not feel that the Legislature's ability to obtain information from DAIL should be constrained by the current limits of the Harmony system or that the General Assembly should have to wait until Harmony is fully programmed to enable computer data to answer legislative requests. DAIL should not respond to the Committee's requests with what information is available through Harmony, but what services are being provided to vulnerable Vermonters, and when are they being provided. The Committee recognizes that this may require some staff time to look at files and case notes, but the Committee believes that addressing the needs of vulnerable adults is important enough to require such efforts. The Committee also feels it is important to be informed of the outcome when certain cases are not opened. For example, DAIL interprets the APS law to exclude cases of self-neglect, so reports of self-neglect are not investigated. The Committee would like to know what happens to individuals who are reportedly neglecting themselves and the services, if any, to which they are referred.

In DAIL's January 2010 Adult Protective Services Annual Report, DAIL reported that the APS unit "received 2,452 unduplicated reports … from 2,957 reporters" during state fiscal year 2009.[5] The report explained that 697 of the reports did not meet the statutory definition of abuse, neglect, or exploitation, including 314 cases in which APS determined that the individual did not meet the statutory definition of a vulnerable adult. APS recommended substantiation of 165 allegations against 82 perpetrators and referred 175 cases of self-neglect by an individual over the age of 60 to the Area Agencies on Aging.[6] The 2010 APS report included a table showing the number of allegations and investigations by type of abuse (physical abuse, emotional abuse, sexual abuse/sexual exploitation, neglect, financial exploitation, and self-neglect), the number of cases referred for investigation by law enforcement or regulatory review and the agencies to which such referrals were made, the number of cases with social or protective service

[2] *APS Reporting Numbers SFY 2013* chart from DAIL, distributed at 9/20/12 HCOC meeting.
[3] *HARMONY and the Legislative Oversight Committee Request for Information – Re: September Reporting Format*, memorandum from Suzanne Leavitt, Dep. Comm'r, DAIL, distributed at 9/20/12 HCOC meeting.
[4] *Id.*
[5] *Adult Protective Services Annual Report – January 2010*, Division of Licensing and Protection, Department of Disabilities, Aging, and Independent Living, p. 4.
[6] *Id.*

referrals and the public and private entities to which such referrals were made, the alleged perpetrator's relationship to the alleged victim (including resident-on-resident abuse), the alleged victim's living arrangement, and several other factors.[7] This report predates DAIL's adoption of the Harmony information system, which leads the Committee to believe that DAIL is capable of collecting and analyzing data beyond that available through Harmony.

Recommendations

The Committee recommends that the standing committees of jurisdiction reiterate their requests to DAIL for APS information. The Committee also recommends that:

1. the committees require DAIL to report requested APS data to the committees of jurisdiction during the legislative session and to the Health Care Oversight Committee during the legislative interim;
2. the committees direct DAIL to provide the information using the language requested by the General Assembly;
3. DAIL collect manually any information that it cannot get from Harmony and consider using random case sampling to provide detailed information;
4. DAIL consider conducting its own supervisory-level audit to review outcomes and other information not available through Harmony;
5. that DAIL provide information from July 2012 forward to allow the General Assembly to review the data over time.

(See Appendix 3 for a list of data that the Committee believes are important for the standing committees to receive.)

V. Health Information Technology

The Committee heard testimony from the Department of Vermont Health Access (DVHA), Vermont Information Technology Leaders, Inc. (VITL), and others about the development and implementation of health information technology (HIT) in Vermont. The Committee received information about the use of HIT in the Blueprint for Health and ways in which technology can assist health care professionals to deliver high-quality care to patients. The Committee also heard testimony about the use of HIT to facilitate the evaluation of health care data at the local and statewide level. Witnesses explained to the Committee that the term "HIT" encompasses a number of different initiatives, including electronic health records (EHR), the statewide Health Information Exchange (HIE), the Vermont Health Benefit Exchange, and the Medicaid Management Information System (MMIS). Members of the Committee expressed concerns about the pace of HIT implementation and whether the state was on track with where it needs to be, particularly with respect to the operation of the Health Benefit Exchange and to public benefit delivery and determinations across the Agency of Human Services (AHS).

[7] *Id. at pp. 8–15.*

Recommendation

The Committee recommends that the standing committees of jurisdiction continue to monitor HIT implementation and benefit delays. The Committee encourages the standing committees to meet with VITL's newly appointed President and Chief Executive Officer, John Evans, to hear his vision for the organization and to express the General Assembly's concerns about the pace of EHR adoption and HIE development. In addition, the Committee recommends that the standing committees receive frequent updates from AHS regarding its HIT initiatives, including the Health Benefit Exchange and the anticipated replacement for the MMIS, and with respect to its delivery of timely and accurate benefits and benefit determinations.

VI. Public Benefits

Medicare Savings Program and Benefit Cliffs

The Committee heard testimony regarding the continuing problem of benefit cliffs, in which eligibility for public benefits abruptly ends when a beneficiary reaches a particular income threshold. Specifically, the Committee heard about the impact of a federal cost of living increase (COLA) on individuals eligible for the Medicare Savings Program (MSP). Because the percentage of the COLA exceeded the increase in the Federal Poverty Level (FPL), it pushed certain individuals just over the income limit to continue to receive benefits under the Qualified Medicare Beneficiary (QMB), Specified Low-Income Medicare Beneficiary (SLMB), and Qualifying Individual (QI) programs. As the Committee heard from the Department for Children and Families (DCF), Vermont's current Medicaid eligibility computer system is unable to implement a disregard for the small group of individuals affected. The Committee sent a letter to Vermont's Congressional Delegation, urging them to introduce legislation providing an express income disregard for an increase in income attributable solely to the 2012 COLA. The Committee also asked the Delegation to consider pursuing legislation that would provide for a permanent COLA income disregard for all individuals on public assistance programs.

Benefit cliffs are a problem across all public assistance programs, not just the MSP. Some members of the Committee have heard from constituents who describe situations in which a COLA or a raise has rendered them ineligible for rental assistance, child care subsidies, or other benefits.

3SquaresVT

The Committee asked the Department for Children and Families (DCF) to address federal sanctions imposed on the state as the result of excessive payment error rates in the 3SquaresVT program (formerly known as Food Stamps). In particular, the Committee

asked Deputy Commissioner Richard Giddings for a detailed explanation of the status of DCF's remediation efforts, a written remediation plan, and the Deputy Commissioner's assessment of the likelihood that the payment error rates for federal fiscal year (FFY) 2012 will have improved sufficiently to avoid additional penalties. The Committee also asked how the Department will invest $170,593.50 to improve the administration of 3SquaresVT as required by the U.S. Department of Agriculture. In response to the Committee's questions, Deputy Commissioner Giddings testified that the root causes of the high payment error rates were workload, work flow, training, and procedural issues. He said that DCF is adding staff as it becomes economically feasible and is addressing its work flow and procedural issues through what it calls "Process Modernization." Process Modernization is an approach in which staff are assigned to a single task for the entire day and all applicants are seen on the same day they come into the office, reducing the volume of work by reducing the need for follow-up calls and appointments. A new 3SquaresVT trainer was hired to conduct training programs for newer employees and workers with high error rates, and supervisors will conduct periodic review of error-prone cases. DCF is also using a performance tracking system to track worker errors and report performance issues to managers and supervisors.

The State of Vermont's settlement agreement with the U.S. Department of Agriculture over the error rates included imposing a $341,187 sanction on the State, of which one-half was required to be invested in activities to address the error rate and the other half would be held in reserve in the event that the State had not sufficiently improved its error rate by the end of FFY 2012 (September 30, 2012) . DCF plans to hire a contractor to conduct intensive "SNAP-IT" training for all of DCF's eligibility workers, supervisors, regional managers, and quality control staff. Deputy Commissioner Giddings reported that Vermont's error rate through June 2012 was down to 7.47 percent from the FFY 2011 level of 8.53 percent, but the state must reduce the rate to below six percent in order to avoid further sanctions.

Recommendations

The Committee recommends that the standing committees of jurisdiction pursue legislative remedies to reduce or eliminate benefit cliffs. The Committee received a preliminary response from Senator Sanders's office on the MSP COLA issue and recommends that the standing committees follow up to see what can be done to help Vermonter's receiving QMB, SLMB, and QI benefits. The Committee also recommends that the standing committees monitor the 3SquaresVT error rates to determine whether additional systemic changes are needed to ensure that Vermont avoids further federal sanctions and that eligible Vermonters receive the supplemental nutrition assistance they need.

VII. Health Care Reform

Vermont Health Benefit Exchange

State and federal law require Vermont's Health Benefit Exchange to begin enrolling qualified individuals and qualified employers in qualified health benefit plans by October 1, 2013 for coverage beginning January 1, 2014. In September 2012, the Green Mountain Care Board (GMCB) accepted DVHA's recommendations to make BlueCross BlueShield of Vermont's small group plan the "benchmark" plan for all insurers offering health insurance plans through the Exchange, the Children's Health Insurance Program (CHIP) benefit package the benchmark for pediatric dental coverage, and the federal employees' FEDVIP benefit package the benchmark for pediatric vision coverage. The GMCB also accepted DVHA's recommendation that each health insurance issuer offering plans in the Exchange be required to offer six standardized plans, with the option of offering additional "choice" plans within defined parameters. The GMCB did not, however, choose to require inclusion of adult dental benefits in Exchange plans. DVHA had initially recommended to the GMCB that it require plans to offer habilitative services on par with rehabilitative services, but further guidance from the federal government clarified that the state would not have a role in determining the scope of habilitative services; instead, each health insurance issuer will choose which habilitative services it will cover under its plans.

DVHA and the Director of Health Care Reform are analyzing the cost to the state of offering state premium and cost-sharing assistance to individuals with incomes below 350 percent of FPL. They are in discussions with the Centers for Medicare and Medicaid Services (CMS) to explore the possibility of additional federal funding for premium and cost-sharing assistance as part of Vermont's renewed Global Commitment to Health waiver. Vermont's current Global Commitment waiver expires December 31, 2013.

Accountable Care Organizations

Fletcher Allen Health Care (FAHC) and Dartmouth-Hitchcock Health recently formed a statewide accountable care organization (ACO) called OneCare Vermont. The ACO's provider network includes all but one of Vermont's 14 hospitals, as well as two federally qualified health centers, several rural health clinics, and hundreds of primary and specialty care physicians. OneCare applied in September to participate in the federal Medicare Shared Savings Program. If CMS approves OneCare's application, it will attribute participants to the ACO based on the number of Medicare beneficiaries receiving at least 50 percent of their care from a OneCare network provider. CMS has estimated that approximately 42,000 beneficiaries would be included in OneCare's population. The Medicare Shared Savings Program is a three-year, upside-only program; if the program continues beyond the initial three years, CMS and OneCare will share both the upside and downside risk. From the outset, 90 percent of OneCare's share of the

savings will be distributed to its network providers. OneCare will retain the remaining 10 percent of savings for administrative costs; provided, however, that if administrative costs total less than the full 10 percent, OneCare will also distribute the remainder to the network providers.

The Committee expressed concerns about OneCare Vermont, including its apparent lack of state regulation, its for-profit organizational status, and its potential impact on the Dual Eligibles project. In response to some of the Committee's concerns, FAHC's Senior Vice-President and OneCare CEO Todd Moore said that while OneCare itself is not regulated by the state, it is working closely with the GMC Board to ensure that OneCare's efforts are consistent with Vermont's health care reform goals. Mr. Moore also explained that OneCare could not form as a nonprofit corporation because Vermont's nonprofit corporation laws conflict with CMS's governance requirements for the Medicare Shared Savings Program, but clarified that since OneCare is owned by two nonprofit hospitals — FAHC and Dartmouth-Hitchcock — it is essentially nonprofit because the hospitals are bound by their nonprofit missions.

CO-OP Plan

The Vermont Health CO-OP, which hopes to offer health insurance plans on the Vermont Health Benefit Exchange, was organized under the federal Consumer Oriented and Operated Plan (CO-OP) program. Its application for licensure is currently pending with the Department of Financial Regulation. The Committee heard brief testimony about the Vermont Health CO-OP but was unable to fully assess its potential impact on Vermont's Exchange market.

Recommendations

The Committee recommends that the standing committees of jurisdiction continue to monitor development of the Vermont Health Benefit Exchange, including consideration of state premium and cost-sharing assistance and the possibility of a federal match. The Committee also recommends that the standing committees request updates from the Administration regarding negotiations for a renewed Global Commitment waiver. In addition, the Committee recommends that the standing committees seek a deeper understanding of the role of ACOs in Vermont's health care reform efforts, including the state's role in regulating ACOs and the impact of OneCare Vermont on the Dual Eligibles project. Finally, the Committee recommends that the standing committees explore the potential impact of the Vermont Health CO-OP on Vermont's Exchange market.

VIII. Adverse Event Reporting

The Committee identified the need for a clearer understanding of and cohesive policy for the reporting of adverse events by the departments and licensees of the Agency of Human Services (AHS). Some members felt that legislators should be briefed when adverse

events occur in order to avoid learning about such events from the media. The Committee requested that AHS coordinate and create an agency-wide policy on adverse event reporting. Secretary Doug Racine responded that most information delivered to AHS regarding critical incidents is protected health information under the federal Health Insurance Portability and Accountability Act (HIPAA) and AHS cannot disclose it in any way that would or could lead to the identification of an individual patient. AHS may be able to release some aggregate de-identified data, but Secretary Racine felt that the extent to which the Agency releases this information publicly should be a policy discussion between the commissioners, stakeholders, and the General Assembly.

Recommendation

The Committee recommends that the standing committees of jurisdiction engage with AHS and stakeholders to determine the appropriate release of adverse event information, including the extent to which members of the General Assembly should be briefed when adverse events occur.

2012 Report of the Health Care Oversight Committee to the Vermont General Assembly and the Governor of the State of Vermont

/s/ Senator Claire Ayer
Senator Claire Ayer, Chair

/s/ Representative Ann D. Pugh,
Representative Ann Pugh, Vice Chair

/s/ Senator Ann E. Cummings
Senator Ann Cummings

/s/ Representative Francis M. McFaun
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/s/ Senator Sally Fox
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/s/ Representative Anne O'Brien
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/s/ Senator Jane Kitchel
Senator Jane Kitchel

/s/ Representative Christopher Pearson
Representative Christopher Pearson

/s/ Senator Kevin J. Mullin
Senator Kevin Mullin

/s/ Representative George W. Till
Representative George Till

Appendix 1.
Health Care Oversight Committee Charge
2 V.S.A. §§ 851–853

§ 851. CREATION OF COMMITTEE

(a) A legislative health care oversight committee is created. The committee shall be appointed biennially and consist of ten members: five members of the house appointed by the speaker, not all from the same political party, and five members of the senate appointed by the senate committee on committees, not all from the same political party. The house appointees shall include one member from the house committee on human services, one member from the house committee on health care, one member from the house committee on appropriations, and two at-large members. The senate appointees shall include one member from the senate committee on health and welfare, one member from the senate committee on finance, one member from the senate committee on appropriations, and two at-large members.

(b) The committee may adopt rules of procedure to carry out its duties.

§ 852. FUNCTIONS AND DUTIES

(a) The health care oversight committee shall monitor, oversee, and provide a continuing review of health care and human services programs in Vermont when the general assembly is not in session, including programs and initiatives related to mental health, substance abuse treatment, and health care reform.

(b) In conducting its oversight and in order to fulfill its duties, the committee may consult with consumers, providers, advocates, administrative agencies and departments, and other interested parties.

(c) The committee shall work with, assist, and advise other committees of the general assembly, members of the executive branch, and the public on matters relating to health care and human services programs. Annually, no later than January 15, the committee shall report its recommendations to the governor and the committees of jurisdiction.

§ 853. MEETINGS AND STAFF SUPPORT

(a) The committee may meet during a session of the general assembly at the call of the chair or by a majority of the members of the committee. The committee may meet during adjournment subject to the approval of the speaker of the house and the president pro tempore of the senate.

(b) For attendance at meetings which are held when the general assembly is not in session, the members of the committee shall be entitled to the same per diem compensation and reimbursement for necessary expenses as those provided to members of standing committees under section 406 of this title.

(c) The staff of the legislative council and the joint fiscal office shall provide professional and administrative support to the committee. The department of financial regulation, the agency of human services, and other agencies of the state shall provide information, assistance, and support upon request of the committee.

Appendix 2.
2012 Witness List

John Barbour, Executive Director, Champlain Valley Agency on Aging
Hunt Blair, Deputy Commissioner, Department of Vermont Health Access (DVHA)
Michael Burts, Consumer (regarding Choices for Care)
Myscha Butt, Vermont Homecare United
Jennifer Carbee, Legislative Counsel, Office of Legislative Council
David Cochran, M.D., (Former) President and CEO, Vermont Information Technology Leaders (VITL)
Willow Emerson,
Patrick Flood, Commissioner, Department of Mental Health
Camille George, Deputy Commissioner, Department of Disabilities, Aging & Independent Living (DAIL)
Richard Giddings, Deputy Commissioner, Department for Children and Families (DCF)
Tracy Gilman, Stowe
Bard Hill, Director, Information and Data Unit, DAIL
Hans Kastensmith, Principal, Capitol Health Associates
Trinka Kerr, Vermont Health Care Ombudsman
Mark Larson, Commissioner, DVHA
Suzanne Leavitt, Director of Licensing and Protection, DAIL
Robin Lunge, Director of Health Care Reform, Agency of Administration
Veda Lyon, Adult Protective Services Program Chief, DAIL
Georgia Maheras, Executive Director, GMCB
Steve Maier, Health Care Reform Manager, DVHA
Jackie Majoros, State Long-Term Care Ombudsman, Vermont Legal Aid
Katie McLinn, Legislative Counsel, Office of Legislative Council
Todd Moore, Senior Vice-President, Accountable Care and Revenue Strategy, FAHC
Mary Moulton, Deputy Commissioner, Department of Mental Health
Jill Olson, Vice President for Policy and Operations, Vermont Association of Hospitals and Health Systems
Laura Pelosi, Executive Director, Vermont Health Care Association
Doug Racine, Secretary, Agency of Human Services
Laural Ruggles, Project Manager, Northeastern Vermont Regional Hospital
Robert Simpson, CEO, Brattleboro Retreat
Michael Sirotkin, Lobbyist, on behalf of the Community of Vermont Elders
Rick Smith, Director, Quality Control and Fraud Unit, DCF
Jeb Spaulding, Secretary, Agency of Administration
Anya Rader Wallack, Chair, GMCB
Norman Ward, M.D., Executive Medical Director, Accountable Care, FAHC
Cheryl Webber, Vermont Homecare United
Tammy Wehmeyer, DAIL
Susan Wehry, Commissioner, DAIL
David Yacovone, Commissioner, DCF

Appendix 3.
APS Data Request to DAIL (Revised)

1. Number of unduplicated intakes received during the previous month
2. Of the unduplicated intakes received during the previous month, the number that were assigned for investigation
3. Total number of cases currently open and under investigation
4. Length of time (range) between report and first contact with alleged victim
5. Method of first contact with alleged victim
6. Length of time (range) between report and first contact with reporter
7. Number of cases not investigated because alleged victim not a "vulnerable adult"
8. Number of cases not investigated because allegation not of "abuse, neglect, or exploitation"
9. Number of cases not investigated because report based on self-neglect
10. Number of cases not investigated because report based on "resident-on-resident" abuse
11. Of cases not investigated because alleged victim not a "vulnerable adult," the number that involved a resident of a facility or of a psychiatric hospital
12. Of cases not investigated because alleged victim not a "vulnerable adult," the number involving a person receiving personal care services
13. Of cases not investigated, services to which reporter/alleged victim was referred
14. Other reasons cases not investigated (e.g., no allegation of mistreatment) and number of reports in each category
15. Number of cases where no face-to-face contact with alleged victim or reporter after initial screening
16. Number of substantiations
17. Number of pending substantiations
18. Number of unsubstantiations
19. Number of completed investigations
20. Length of time (range) between report and decision about whether to investigate
21. Length of time (range) between DAIL receiving report and investigator contacting alleged victim
22. Length of time (range) between DAIL receiving report and completing investigation
23. Number of permanent FTEs and vacancies
24. Number of temporary FTEs and vacancies
25. Position titles for all employees and vacant positions
26. Employee caseloads
27. Number of cases resulting in coordinated written treatment plan
28. Number of opened cases and cases not opened that resulted in protective Number of cases resulting in a plan of care
29. Number of individuals put on abuse and neglect registry
30. Number of referrals to law enforcement
31. Number of times a penalty was imposed
32. Number of actions for intermediate sanctions
33. For cases that were investigated, the outcome of each case, including services for which victim and/or perpetrator referred