

State of Vermont
Agency of Human Services

Global Commitment to Health
11-W-00194/1

Section 1115
Demonstration Year: 7
(10/1/2011 – 9/30/2012)

Quarterly Report for the period
July 1, 2012 – September 30, 2012

November 29, 2012

Background and Introduction

The Global Commitment to Health is a Demonstration Initiative operated under a Section 1115(a) waiver granted by the Centers for Medicare and Medicaid Services, within the Department of Health and Human Services.

The state of Vermont is a national leader in making affordable health care coverage available to low-income children and adults. Vermont was among the first states to expand coverage for children and pregnant women, through the implementation in 1989 of the state-funded Dr. Dynasaur program. In 1992, Dr. Dynasaur became part of the state-federal Medicaid program.

When the federal government introduced the State Children's Health Insurance Program (SCHIP) in 1997, Vermont extended coverage to uninsured and under-insured children living in households with incomes below 300 percent of the Federal Poverty Level (FPL).

In 1995, Vermont implemented an 1115(a) waiver program, the Vermont Health Access Plan (VHAP). That program's primary goal was to expand access to comprehensive health care coverage for uninsured adults with household incomes below 150 percent (later raised to 185 percent) of FPL, through enrollment in managed care. VHAP also included a prescription drug benefit for low-income Medicare beneficiaries who did not otherwise qualify for Medicaid. Both waiver populations pay a modest premium on a sliding scale based on household income.

Implemented October 1, 2005, the Global Commitment converts the Office of Vermont Health Access (OVHA), the state's Medicaid organization, to a public Managed Care Entity (MCE). AHS will pay the MCE a lump sum premium payment for the provision of all Medicaid services in the state (with the exception of the Long-Term Care Waiver, managed separately). A Global Commitment to Health Waiver Amendment, approved October 31st 2007 by CMS, allows Vermont to implement the Catamount Health Premium Subsidy Program with the corresponding commercial Catamount Health Program (implemented by state statute October 1, 2007) up to 200 percent of the Federal Poverty Level. The Catamount Plan is a health insurance product offered in cooperation with Blue Cross Blue Shield of Vermont and MVP Health Care. It provides comprehensive, quality health coverage at a reasonable cost no matter how much an individual earns. The intent of this program is to reduce the number of uninsured citizens of Vermont. Subsidies are available to those who fall at or below 300 percent of the Federal Poverty Level (FPL). On December 23, 2009 a second amendment was approved that allowed Federal participation for subsidies up to 300 percent of the Federal Poverty Level. Additionally, this amendment also allowed for the inclusion of Vermont's supplemental pharmaceutical assistance programs in the Global Commitment to Health Waiver. Renewed January 1, 2011 the current waiver continues all of these goals.

The Global Commitment provides the state with the ability to be more flexible in the way it uses its Medicaid resources. Examples of this flexibility include new payment mechanisms (e.g., case rates, capitation, combined funding streams) rather than fee-for-service, to pay for services not traditionally reimbursable through Medicaid (e.g., pediatric psychiatric consultation) and investments in programmatic innovations (e.g., the Vermont Blueprint for Health). The managed care model also requires inter-departmental collaboration and encourages consistency across programs.

One of the Terms and Conditions of the Global Commitment Waiver requires the State "to submit progress reports 60 days following the end of each quarter. ***This is the fourth quarterly report for waiver year seven, covering the period from July 1, 2012 through September 30, 2012.***

Global Commitment Amendment and Revised Cost Sharing

CMS approved an amendment to Vermont's 1115 Demonstration, effective August 1, 2012, with a June 27, 2012 reissue date. The amended 1115 Demonstration provides Vermont with the authority to: 1) Eliminate the \$75 inpatient admission co-pay; and 2) Implement nominal co-payments for the Vermont Health Access Plan (VHAP) population as long as they do not exceed the co-payments charged to the state plan populations under the Medicaid State Plan. Premiums and Co-Payments for the Demonstration Populations were removed from the body of the Demonstration document and are now included as Attachment C.

Member Services

A Member Newsletter was mailed to beneficiaries in July 2012 giving prior notification of health care benefit changes prior to the August 1 start date for changes to co-pays. The newsletter also touched on changes for prior authorizations required for out-of-network elective outpatient visits and for outpatient therapies. In addition, it contained the Reminder of Notice of Privacy Practices and member's appeal rights. There are three brief informative articles to encourage beneficiaries to take charge of their health and their children's health by seeing their providers for preventive care via well visits for screenings, immunizations, dental cleanings and exams, plus a healthy eating tip and link to more "Eat for Health" information on the Department of Health web site and the "No Child Left Inside" project that helps families find outdoor activities.

Enrollment Information and Counts

Please note the table below provides point in time enrollment counts for the Global Commitment to Health Waiver. Due to the nature of the Medicaid program and its beneficiaries, enrollees may become retroactively eligible; move between eligibility groups within a given quarter or after the quarter has closed. Additionally, the Global Commitment to Health Waiver involves the majority of the state's Medicaid program; as such Medicaid eligibility and enrollment in Global Commitment are synonymous, with the exception of the Long Term Care Waiver and SCHIP recipients.

Reports to populate this table are run the Monday after the last day of the quarter. Results yielding less than or equal to a 5% fluctuation quarter to quarter will be considered as illustrating normal deviations reflecting retroactive eligibility determinations and expected terminations. Results reflecting more than a 5% fluctuation between quarters will be reviewed by DVHA and AHS staff for further detail and explanation.

Enrollment counts are person counts, not member months.

Demonstration Population	Current Enrollees	Previously Reported Enrollees	Variance 06/30/12 to 09/30/12
	Last Day of Qtr 9/30/2012	Last Day of Qtr 6/30/2012	
Demonstration Population 1:	48,493	47,744	1.57%
Demonstration Population 2:	43,636	43,891	-0.58%
Demonstration Population 3:	9,601	9,576	0.26%
Demonstration Population 4:	N/A	N/A	N/A
Demonstration Population 5:	961	1003	-4.19%
Demonstration Population 6:	3,266	3,174	2.90%
Demonstration Population 7:	35,711	35,815	-0.29%
Demonstration Population 8:	9,922	10,414	-4.72%
Demonstration Population 9:	2,716	2,637	3.00%
Demonstration Population 10:	N/A	N/A	N/A
Demonstration Population 11:	12,150	11,801	2.96%

Green Mountain Care Outreach / Innovative Activities

During the third quarter, DVHA continued to maintain established outreach work, including an up-to-date web presence to promote Green Mountain Care to uninsured individuals. The Health Benefit Exchange team began aggressive work on the comprehensive outreach and education plan for the Exchange. Attachment 7 provides a brief summary of the outreach and education plan that was provided to CMS. The outreach and education plan, consistent with Exchange development, was shared with the encompassing Green Mountain Care members and may be viewed online in its entirety at: <http://dvha.vermont.gov/administration/vermont-health-connect-outreach-and-education-plan.pdf>.

Health Benefit Exchange:

During this reporting period, Vermont continued to make significant progress in Exchange development. In May, the Governor signed Act 171 into law, which clarified the definition of small employer, defined the role of brokers in the Exchange, merged the individual and small group markets, and required individuals and small groups to purchase insurance through the Exchange.

The Medicaid and Exchange Advisory Board, which formed from the merger of separate Exchange and Medicaid boards, met for the first time in July, and continued to meet on a monthly basis. Exchange staff hosted numerous public forums on the Exchange, and held focus groups to develop a name and visual identity for the Exchange. The selected name for the Exchange is Vermont Health Connect, and the tagline is “find the plan that is right for you.”

Vermont selected its benchmark plan, finalized essential health benefits, and made significant progress toward issuing an RFP for Qualified Health Plans to be offered on the Exchange. Vermont also decided to utilize federal services for risk adjustment and reinsurance. Numerous business requirements development sessions were held for both the Exchange and integrated eligibility, and progress was made a contract with an Exchange systems integrator. A decision was made to include all health care eligibility into this contract, while a separate procurement process occurs for Vermont’s integrated eligibility system. Vermont successfully hired a number of Exchange staff, and brought in additional contracted resources as necessary.

On June 28th, 2012 Vermont submitted an application for Level 2 Establishment Grant funding, and in August received a Notice of Award for \$104.2M. Vermont also made a decision to seek an additional Level 1 grant for the primary purpose of seeking funding for an In-Person Assistance Program.

Expenditure Containment Initiatives

Vermont Chronic Care Initiative for Quarter 3 of FFY 2012

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

The VCCI uses a holistic approach of evaluating both the physical and behavioral conditions, as well as the socioeconomic issues, that often are barriers to health improvement. The DVHA's VCCI emphasizes evidence-based, planned, integrated and collaborative care for beneficiaries who exhibit high-prevalence chronic disease states, high-expense utilization, high medication utilization, and/or high emergency room and inpatient utilization. Ultimately, the VCCI aims to improve health outcomes by supporting better self-care and lowering health care expenditures through appropriate utilization of health care services. By targeting predicted high cost beneficiaries, resources can be allocated where there is the greatest cost savings opportunity. The VCCI focuses on helping beneficiaries understand the health risks of their conditions; engage in changing their own behavior, and by facilitating effective communication with their primary care provider. The intention ultimately is to support the person in taking charge of his or her own health care.

The VCCI supports and aligns with other State health care reform efforts, including the Blueprint for Health advance practice medical homes and local Community Health Teams (CHTs). The VCCI has now expanded its services to include all age groups and prioritize their outreach activities to target beneficiaries with the greatest need based on the highest acuity population (defined as the top 5%) with an ability to impact their conditions and/or utilization patterns. The VCCI is expanding both our service scope as well as our partnerships. New services in FY 2012 included our Pediatric Palliative Care Program development with initial launch in early September in Chittenden County (see below). As a result, our partnerships have expanded beyond our current network of primary care providers, hospitals, community agencies and other Agency of Human Services (AHS) departments to also include Pediatric palliative care providers at FAHC and Dartmouth Hitchcock's Children's Hospitals. The VCCI supports providers, patients and families by focusing on care coordination of complex medical and psycho-social conditions, supporting development of self-management skills, health system improvements including enhanced access to evidence based resources that are also cost beneficial.

In July 2010, the VCCI added a new strategy of embedding nursing and licensed social workers primary care practices with high volume Medicaid populations; and hospitals with high volume ambulatory sensitive ED and inpatient admissions. This approach allowed the VCCI to further develop our provider network relationships and thus, facilitated direct referrals of our high risk population. This also provided an opportunity for enhanced service coordination with hospitals, providers and our Blueprint partners to facilitate and assure appropriate transitions in care and/or securing a Medical Home when one was not available.

In the last quarter of FFY 2012, the VCCI has been in the process of replicating this model in other areas throughout the state and will include opportunity for embedded staff at 2 additional hospitals and several additional high volume primary care providers. We will focus on our growing network of FQHC's throughout the state who see the majority of our Medicaid beneficiaries and which have been expanding as the private practice PCP network in some areas shrinks due to operational and financial challenges associated with independent practice. Our staffing model will expand to include a total of 27 FTE's which includes the requisite regional managers and administrative support staff required to operate and deliver clinical improvement, financial results and also assures communication among our growing partner network.

Pediatric Palliative Care:

As part of our expansion in FFY 2012, the VCCI also began the design and development of the newly legislated Pediatric Palliative Care Program (PPCP) in January. Following the December 2011 CMS approval of our GC waiver amendment.

The intention of implementing this program was to address the unique needs of children who are living with a serious and potentially life threatening illness. As stated in the waiver, children who are medically eligible must be under age 21, have Vermont Medicaid, and be living with a life limiting or life threatening diagnosis from which they may not live into adulthood. Services for children who are medically eligible may include Care Coordination, Family Training, Expressive Therapy, Respite, and Counseling (including Bereavement if necessary). Program implementation involved advisory group engagement with service and design recommendations, researching similar program in other states, evaluating current comparable services available within Medicaid, and building an entirely new infrastructure to support program operations. Less than a year later in August 2012, the Pediatric Palliative Care Program (PPCP), a partnership program between AHS' VCCI and Integrated Family Services (IFS), launched in Chittenden County with local implementation by our Home Health community partners with oversight by the Medicaid Pediatric Palliative Care Nurse Case Manager. The PPCP is actively enrolling medically eligible children in Chittenden County and will launch in Washington County in October, followed by Orange, Windsor, and Windham Counties scheduled for November 2012. Progressive statewide expansion is expected to continue throughout early FY 2013.

High Risk Pregnancy

Another portion of the VCCI expansion model will include the additional specialty area of High Risk Pregnancy Case Management, which will align with ACA initiatives including high risk populations with substance abuse disorders; our Pediatric Palliative Care Program; and our Department of Health efforts for maternal child health. This will be a centrally administered service with some local support by VCCI field staff. The High Risk Pregnancy positions were approved in the last quarter of FY 2012 and are currently under recruitment.

Health Resources and Services Administration (HRSA) and VCCI in Franklin County

As outlined in earlier reports, the VCCI has received HRSA designation for our Franklin County program staff as an recognized Health Professional Shortage Areas (HPSAs). Our LICSW staff had 2 location sites with the intention of securing direct referrals for our high risk Medicaid population from our hospital partner in Franklin County. The VCCI had two locations for our staff including within the State office building where Medicaid beneficiaries are already coming for services; as well as the area hospital – Northwest Medical Center (NMC). Our location within the hospital footprint was to provide for direct referrals to the VCCI given their high rate of ambulatory sensitive admissions for substance abuse and

mental health disorders.

Due to challenges including limited available and appropriate space within the hospital and decline in appropriate referrals, we now have one location within the AHS office space. This has proved to be a very effective strategy and has resulted in far greater capacity for case load by our LICSW including direct counseling as well as case management services; and has expanded our partnership with the areas designated agency for mental health services. This agency is now routinely referring Medicaid beneficiaries with access delays for more immediate evaluation and treatment with the VCCI LICSW staff.

APS Contract

Since 2007, DVHA has contracted with APS Healthcare for assistance with providing disease management assessment and intervention services to Vermont Medicaid beneficiaries with chronic health conditions. DVHA currently is in the final year of its contract with APS and with the newest amendment had made a decision to move away from traditional telephonic disease management and instead to expand care coordination services provided by DVHA nurse case managers and social workers. DVHA has found this approach more effective with its highest cost/highest risk beneficiaries as staff are able to communicate directly at the local level with provider, partners, patients and their families. As DVHA transitions to the new approach, it required a different level of support from APS. APS presented a cost neutral proposal to provide services to DVHA that are better aligned with DVHA's current needs. Specifically, APS is providing enhanced information technology and more sophisticated decision-support tool to assist DVHA's care coordinators to outreach the most costly and complex beneficiaries based on risk and ability to positively impact results. APS continues to provide supplemental population based supports to the DVHA's care coordinators working within provider offices; as well as to support the work of the Blueprint Community Health Teams addressing NCQA priorities. APS also has evidence based treatment guidelines for our population.

APS has guaranteed a 2:1 return on investment by implementing these enhancements, which equates to roughly \$5 million dollars and will bear 100% of the investment if the agreed upon savings are not realized (i.e., full risk contract based upon agreed upon savings methodology). As a result, DVHA invoked its option to extend the contract with APS for the two additional years with a scheduled end date of June 30, 2013.

The DVHA has also contracted with the University of Vermont (UVM) for VCCI program evaluation, and for assistance with identifying and implementing quality improvement projects. A clinical performance improvement project (PIP) was developed, focusing on heart failure which is one of the eleven high cost, high risk chronic conditions that VCCI targets. The PIP was designed and is being implemented according to the CMS PIP requirements related to quality outcomes. The PIP topic addresses the appropriate treatment of heart failure (HF), a progressive chronic condition. HF patients are managed through both APS and DVHA's VCCI. An important component of outpatient management of HF is appropriate use of evidence-based pharmaceutical treatments. The study design and analysis of the baseline data were completed and submitted for validation to the external quality review organization hired by AHS. DVHA received a validation score of 100%. Interventions are being developed and implemented for Year 2 of the PIP.

Highlights of the Vermont Chronic Care Initiative (Quarter 4 of FFY 2012)

- VCCI expanded staffing as authorized by legislature with 2 new staff hired; and 2 offers extended including the second regional manager. Five nursing positions remain under recruitment including both high risk pregnancy positions.

- VCCI nursing positions were reclassified given challenges with recruitment of skilled nursing staff and market demands and associated salaries.
- Agreement received from two additional hospital partners for VCCI staff with on –site presence; details to be determined in October/November. Two additional provider practice sites identified for ‘embedded’ nursing model including a commitment from a large FQHC (10 providers) in Chittenden County; and potential site in Springfield.
- The VCCI is currently implementing a PIP for the MCE with dissemination of a second population based report to providers for Heart Failure patients not receiving evidenced based care. Both a health ‘registry’ outlining gaps in treatment; as well as ‘health briefs’ demonstration overall utilization for select patients were disseminated to primary care and cardiology providers; practice level meetings were held and patients assigned for follow up with VCCI staff.
- Received administrative support to cover scales for beneficiaries dx with heart failure to support self - monitoring of daily weights.
- Received administrative support to cover transportation for beneficiaries attending evidence based self-management training courses.
- Completed the CAD ‘registry’ outlining gaps in care for high risk practice sites. Depression registry is scheduled for November.
- Expanded access to timely hospital ED and inpatient data from hospital partners. Six hospitals provide data either via secure data feeds (FTP site); access to the hospital data via direct query; or faxed admission/discharge reports. Early access to utilization history supports timely engagement with patients and transitions in care between hospital inpatient and outpatient settings. As of the 4th quarter, VCCI receives electronic/secure FTP data from 3 sites; faxed data from 2 sites and on line reporting from one site.
- HRSA LICSW in Franklin County has amended her location from 2 part time sites to one site with improved referrals, direct counseling time and case management hours resulting.
- The Pediatric Palliative Care Program (PPCP) was launched in August in Chittenden County and various provider outreach and education sessions have been implemented including with pediatric providers and partner home health agencies. An ELNEC training was hosted in September by the Assembly of Home Health Agencies in collaboration with DVHA/VCCI with over 75 professionals in attendance.
- The APS data indicates that from July 1, 2012 through September 30, 2012 VCCI maintained an average monthly caseload of 627 beneficiaries with a year to date total of 1,775 unique members served. Unique members are beneficiaries who have been assigned to VCCI staff and have had a Social Needs, Behavioral Risk or Transitions of Care Assessment completed.

Integrated Treatment for Opioid Dependence: Hub and Spoke Initiative

Background

The Agency of Human Services (AHS) is collaborating with community providers to create a coordinated, systemic response to the complex issues of opioid addictions in Vermont, referred to as the *Hub and Spoke* initiative. This initiative is focused on beneficiaries receiving Medication Assisted Therapy (MAT) for opioid addiction. MAT is the use of medications, in combination with counseling and behavioral therapies, to provide a whole patient approach to the treatment of substance use disorders. Overall health care costs

are approximately three times higher among MAT patients than within the general Medicaid population, not only from costs directly associated with MAT, but also due to high rates of co-occurring mental health and other health issues, and high use of emergency rooms, pharmacy benefits, and other health care services.

The *Hub and Spoke* initiative creates a framework for integrating treatment services for opioid addiction into Vermont's state-led *Blueprint for Health (Blueprint)* model, which includes patient-centered medical homes, multi-disciplinary Community Health Teams (CHTs), and payment reforms. Initially focused on primary care, its goals include improving individual and overall population health and improving control over health care costs by promoting health maintenance, prevention, and care management and coordination.

The two primary medications used to treat opioid dependence are methadone and buprenorphine, with the majority of MAT patients receiving office-based opioid treatment (OBOT) with buprenorphine prescribed by specially licensed physicians in a medical office setting. These physicians generally are not well-integrated with behavioral and social support resources. In contrast, methadone is a highly regulated treatment provided only in specialty opioid treatment programs (OTPs) that provide comprehensive addictions treatment but are not well integrated into the larger health and mental health care systems. To address this service fragmentation, Vermont is developing a state plan amendment to provide Health Home services to the MAT population under section 2703 of the Affordable Care Act. Health Home services include comprehensive care management, care coordination, health promotion, comprehensive transitional care, individual and family support, and referral to community and social support services. State-supported nurses and licensed clinicians will provide the health home services and ongoing support to both OTP and OBOT providers.

The comprehensive *Hub and Spoke* initiative builds on the strengths of the specialty OTPs, the physicians who prescribe buprenorphine in office-based (OBOT) settings, and the local *Blueprint* patient-centered medical home and Community Health Team (CHT) infrastructure. Each MAT patient will have an established physician-led medical home, a single MAT prescriber, a pharmacy home, access to existing *Blueprint* CHTs, and access to *Hub* or *Spoke* nurses and clinicians for health home services.

The five planned regional *Hubs* build upon the existing methadone OTPs and also will provide buprenorphine treatment to a subset of clinically complex buprenorphine patients. Working in partnership with primary care providers and *Blueprint* CHTs, *Hubs* will replace episodic care based exclusively on addictions illness with comprehensive health care and continuity of services.

Spokes include a physician prescribing buprenorphine in an OBOT and the collaborating health and addictions professionals who monitor adherence to treatment, coordinate access to recovery supports and community services, and provide counseling, contingency management, care coordination and case management services. Support will be provided by the nurses and licensed addictions/mental health clinicians, who will be added to the existing *Blueprint* CHTs.

Highlights during This Quarter

- Planning Guidance was sent to all buprenorphine providers and the entities that manage the local *Blueprint* CHTs to assist with *Spoke* network development and staffing estimates.
- Two *Hub and Spoke* learning collaboratives with multidisciplinary provider teams were established; they are provided through a partnership of the *Blueprint*, the Vermont Department of Health, and the Dartmouth Psychiatric Research Center.

- The two western Vermont regional *Hubs* began developing their infrastructure for implementation in 2013.
- An RFP for the remaining regional *Hubs* was developed, and bidder proposals are under review.
- The first draft of the Health Home SPA proposal was completed.

DVHA's Substance Abuse Unit

DVHA established a Substance Abuse Unit in August 2012 to consolidate its substance abuse services into a single, unified structure and point of contact for prescribers, pharmacists, and beneficiaries. This unit is intended to provide seamless and integrated care to beneficiaries receiving Medication Assisted Therapy (MAT) and/or those participating in the *Team Care* program or who have a *Pharmacy Home*. The Substance Abuse Unit coordinates with the *Hub and Spoke* initiative, the Vermont Chronic Care Initiative (VCCI) and the DVHA Pharmacy Unit to provide beneficiary oversight and outreach.

Team Care (formerly called the lock-in program) designates one prescribing physician and one pharmacy (the *Pharmacy Home*) to improve coordination of care and decrease over-utilization and misuse of services by participants. Beneficiaries who exceed certain thresholds for opiates and other controlled substances or who utilize multiple prescribers and pharmacies to obtain controlled substance prescriptions are identified for *Team Care*. All beneficiaries receiving MAT with buprenorphine/Suboxone[®] have a *Pharmacy Home* that dispenses all their prescriptions. In addition to overseeing these programs, the Substance Abuse Unit coordinates and facilitates prescriber reconsideration requests and appeals when prior authorizations for controlled substances are denied.

Cost savings associated with the Substance Abuse Unit are expected through improved coordination of care and through reductions in over-utilization, misuse of medications, duplicative pharmacy payments, non-emergency health care services, unnecessary emergency room use, and inpatient detoxification.

340B DRUG DISCOUNT PROGRAM

Background

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

Organizations that qualify under the 340B drug pricing program are referred to as “covered entities”. Only federally designated Covered Entities are eligible to purchase at 340B pricing and only patients of record of those Covered Entities may have prescriptions filled by a 340B pharmacy.

Covered entities include:

- Certain nonprofit disproportionate share hospitals (DSH), critical access hospitals (CAH), and sole community hospitals owned by or under contract with state or local government, as well as certain physician practices owned by those hospitals, including Rural Health Clinics
- Federally qualified health centers (FQHCs) and FQHC "look-alikes"
- State operated AIDS drug assistance programs (ADAPs)
- The Ryan White CARE Act Title 1, Title 11, and Title III programs
- Tuberculosis clinics
- Black lung clinics
- Family planning clinics
- Sexually transmitted disease clinics
- Hemophilia treatment centers
- Public housing primary care clinics
- Homeless clinics
- Urban Indian clinics
- Native Hawaiian health centers

Covered entities can utilize contract pharmacy services under a “ship to-bill to” arrangement where the covered entity retains legal title of the drugs purchased under 340B and has their drugs shipped to the contract pharmacy. The covered entity retains legal title to all drugs purchased under 340B and must pay for all 340B drugs. The contract pharmacy is subject to audits to identify and prevent diversion and/or duplicate discounts (accessing the 340B discount and Medicaid rebate on the same drug).

340B PROGRAM IN VERMONT

A legislative report entitled “Expanding Use of 340B Programs” was published January 1, 2005, and its principal recommendation was that in order to maximize 340B participation, Vermont should expand access to 340B through its FQHCs. Vermont has made substantial progress in expanding 340B availability

since 2005, including applying for and receiving federal approval that enables the statewide 340B network infrastructure operated by five of the state's FQHCs.

In 2010, the Department of Vermont Health Access (DVHA) aggressively pursued enrollment of 340B covered entities made newly eligible by the Affordable Care Act and as a result of the Challenges for Change legislation passed in Vermont that year. As of October 1, 2011, all but two Vermont hospitals and some of their owned practices are eligible for participation in 340B as covered entities. DVHA expanded its 340B program to encourage enrollment of both existing and newly eligible entities within Vermont and to encourage covered entities to "carve-in" Medicaid (e.g. to include Medicaid eligibles in their 340B programs). There is no state or federal requirement for covered entities to include Medicaid, but if they do, the 340b acquisition cost of the drugs must be passed on to Medicaid, unlike commercial insurance plans to whom they do not have to pass along the discount. 340B acquisition cost is defined as the price at which the covered entity has paid the wholesaler or manufacturer for the drug, including any and all discounts that may have resulted in the sub-ceiling price.

In Vermont, the following entities participate in 340B, although not all of the following yet participate in Medicaid's 340B initiative:

- The Vermont Department of Health, for the AIDS Medication Assistance Program, STD drugs programs, and the TB program, all of which are specifically allowed under federal law.
- Planned Parenthood of Northern New England's Vermont clinics
- All of Vermont's FQHCs, operating 41 health center sites statewide
- Central Vermont Medical Center
- Copley Hospital
- Fletcher Allen Health Care
- Gifford Hospital
- Grace Cottage Hospital
- North Country Hospital
- Northern Vermont Regional Medical Center
- Porter Hospital
- Rutland Regional Medical Center
- Springfield Hospital

Through a great deal of public engagement of various 340B stakeholders including pharmacies and covered entities in Vermont, in 2011 the Department of Vermont Health Access applied for, and on January 10, 2012 received, federal approval for a Medicaid pricing 340B methodology.

Effective January 1, 2011, the dispensing fee for all fills and refills for prescriptions that are eligible for 340B pricing under the rules of the 340B Program is:

- a.) \$18.00, subject to a minimum dispensing fee of \$15.00 and a demonstration that dispensing fee payments in excess of \$15.00 do not exceed 10% of the difference between: 1.) The sum of 340B acquisition costs and the minimum dispensing fees and 2.) Total payments that would have been made in accordance with the methodology described in this section for non-340B prescriptions less estimated pharmacy rebates, in aggregate within each reporting period.
- b.) \$60.00, subject to a minimum dispensing fee of \$30.00 and a demonstration that dispensing fee payments in excess of \$30.00 do not exceed 10% of the difference between: 1.) The sum of 340B acquisition costs and the minimum dispensing fees and 2.) Total payments that would have been made in

accordance with the methodology described in this section for non-340B compounded prescriptions less estimated pharmacy rebates, in aggregate within each reporting period.

Claims are paid at the regular rates and a monthly true-up process calculates the 340B acquisition cost, dispensing fees, savings, and what is owed back to the state with payments due 30 days after the invoices are mailed. Currently, Community Health Pharmacy and its five FQHCs continue to participate. In addition, Northern Tiers Health Center with the in-house Notch Pharmacy, Central Vermont Medical Center, and Fletcher Allen Health Care have all been enrolled with Medicaid since January 2011. Grace Cottage has recently enrolled and several other covered entities are in the process of enrolling. DVHA continues to encourage Medicaid enrollment with the goal of enrolling all eligible and HRSA-enrolled covered entities in Vermont.

During its review of Vermont's 340B State Plan Amendment, CMS raised several areas of concern. These included assuring beneficiary protections related to safeguards for overprescribing, and assuring that our reimbursement structure does not exceed ingredient costs plus a reasonable cost of pharmacy dispensing, and the structure of the incentive payments to covered entities.

Safeguards for Overprescribing

While we are confident that our prescribers, covered entities, and pharmacies will continue to operate in an ethical and medically-appropriate fashion, the Department of Vermont Health Access (DVHA) has many controls and processes in place to monitor and prevent overprescribing. These include both the features of our Program Integrity monitoring, and the Drug Utilization Review programs that are vetted through the state's Drug Utilization Review Board.

The goal of the DVHA's Drug Utilization Review (DUR) programs is to promote appropriate prescribing and use of medications. We identify prescribing, dispensing, and consumption patterns which are clinically and therapeutically inappropriate and do not meet the established clinical practice guidelines. A variety of interventions are then employed to correct these situations. DVHA's DUR programs take a multilevel approach to identifying, filtering, and communicating important information pertaining to the prescribing and/or consumption of medications. It is an approach that analyzes patterns of utilization at a patient-specific level, as well as the unique prescribing habits and the pharmaceutical care provided by the physician. The criteria, research and compilation of data, and recommended actions are reviewed and approved by consensus of Vermont's DUR board.

In addition, DVHA's Program Integrity Unit (PIU) performs data-mining activities through a state contract with a nationally respected firm, which is designed to identify potential overpayments and problem claims in all spending categories, including pharmacy claims. For example, the PIU recently evaluated a 3-year period, with over \$400 million of paid pharmacy claims analyzed, the report found potential unreasonable quantities with potential overpayments of only \$245,012. A review of pharmacy prescription records and clinical records from selected prescribers indicates that most of prescriptions under review were dispensed as written, with prescribers selecting high doses for clinical reasons.

Our Drug Utilization Review and Program Integrity Unit's programs continue to develop and run data-mining queries to detect improper prescribing, dispensing, and reimbursement. Specifically, we are developing a plan to support the oversight of the 340B program in Vermont. This plan includes the review and analysis of all 340B drug claims on a regular basis to determine several factors, including proper payment and reconciliation of the 340B claims, avoidance of duplicate discounts from manufacturers, and evaluating whether any differences in prescribing patterns are detected. The Program Integrity Unit will

employ various techniques to conduct these analyses. Findings will be discussed, as deemed necessary and appropriate, with various other departments and agencies including, but not limited to the Pharmacy Unit, Clinical Utilization Review Board (CURB), Drug Utilization Review Board (DURB), and the Clinical Unit. If problems are detected and substantiated, Program Integrity unit may refer the provider(s) over to the Attorney General's Medicaid Fraud and Residential Abuse unit (MFRAU), the Vermont Medical Practice Board, and/or the Secretary of State's Office of Professional Regulations (OPR). Any Program Integrity investigation may also run parallel or in conjunction with any other investigation initiated by MFRAU, Vermont Medical Practice Board and/or OPR. Standard Program Integrity guidelines and protocols will be utilized to ensure appropriate outcomes are met. DVHA is confident that appropriate controls and monitoring of the 340B program will assure its integrity.

340B Reimbursement and Calculation of Incentive Payment

Determination of Dispensing Fee and Savings Sharing Amounts

The Department of Vermont Health Access (DVHA) identified the following goals in establishing its proposed 340B reimbursement methodology:

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

Vermont researched available resources regarding pharmacy dispensing costs, which included consultation with local pharmacists. Vermont determined that a reasonable estimate of pharmacy dispensing costs falls in the range of \$12.00 to \$15.00 per prescription. The DVHA also determined that pharmacies' additional costs associated with 340B program management would equal \$3.00 per prescription. Therefore, Vermont determined that a reasonable 340B dispensing fee would range from \$15.00 to \$18.00 per prescription.

Vermont's proposed reimbursement methodology establishes a flat rate payment at the low end of this range (\$15.00) and presents the opportunity, subject to demonstrated Medicaid program savings, for pharmacies to be reimbursed at the high end of this range (\$18.00). We believe the proposed approach represents an innovative payment strategy that reasonably reimburses pharmacies, encourages pharmacy participation and promotes program savings.

Summary

Because of federal laws prohibiting "duplicate discounts" on Medicaid drug pricing related to the interaction of 340B and manufacturer rebate programs, Medicaid participation in 340B has been limited both in Vermont and nationally. Vermont has put in place an innovative, first in the nation methodology to maximize Medicaid participation in 340B pricing for Medicaid beneficiaries served by eligible prescribers at 340B enrolled covered entities. This methodology can enable substantial expansion participation in 340B. Using the Global Commitment authority, DVHA provides incentive payments to providers for their 340B participation that recognizes the additional administrative burden of the program. Because of the beneficial 340B pricing, both Vermont and CMS benefit from higher 340B covered entity-employed prescriber and Medicaid beneficiary participation in the program. **CY 2012, Vermont has realized**

approximately \$425,000 in savings through Medicaid participation of a relatively small number of eligible covered entities. DVHA is focused on outreach and education of all Vermont covered entities to encourage enrollment in the 340B discount program.

Catamount Health

In September MVP Health Care announced they were ending participation in Vermont's Catamount program effective December 31, 2012. MVP Health Care informed all subscribers, subsidized and direct pay, with the help of the state of Vermont in a letter dated September 20, 2012. Subscribers and state of Vermont Catamount Assistance beneficiaries will not be harmed by MVP's exit from the Catamount program. They will continue to have Catamount coverage and receive the state subsidies they have been receiving. The State will make sure that the transition process to Blue Cross Blue Shield of Vermont for approximately 315 subsidized MVP recipients and approximately 210 MVP recipients goes smoothly.

Mental Health System of Care

Vermont State Hospital – Replacement Planning

This fourth quarter marked the beginning of State FY 13 and the first fiscal year of additional general fund resources that became available through the abrupt closure of Vermont single state psychiatric hospital. These previously constrained general fund resources could now be used to infuse the State's global commitment funding for enhanced community-based support and treatment services. Additionally, global commitment funding could be leveraged to support the under and uninsured hospitalization needs for persons who would otherwise have been served by the former state hospital, These most acute, Level I patients as they became known, could continue to be served by enrolled Medicare and Medicaid provider hospitals. Often these "designated" local hospitals, through renovation and program re-design, could serve individuals closer to their home communities or in substantially improved treatment settings when compared to the former state treatment facility.

As referenced in earlier reports, an additional 28 inpatient beds to serve individuals who would otherwise have been treated at the former Vermont State Hospital was authorized via legislation while the new 25 bed hospital was under development. Facility renovations at the Brattleboro Retreat (14 beds), Rutland Regional Medical Center (6 beds), and an interim psychiatric hospital (8 beds) in Morrisville are all in process this quarter. An emergency Certificate of Need Application was submitted in late July for the new hospital construction as well.

A care management system, to support patient access and flow into acute care hospitalization, or diversion when clinically appropriate and step-down transition from inpatient care, is in development. This centralized departmental function will traverse the inpatient and community treatment settings to promote timely access to the most acute levels of care. Care management staff are being expanded to follow all individuals proposed for involuntary mental health inpatient services and facilitate coordination of treatment services between the community and inpatient provider. Availability of centralized resources to address systemic issues or barriers that might arise as an individual moves through the continuum of care will maximize access to available inpatient beds. Global Commitment resources are being brought to bear to support this clinical management function, as well as, implement the statutory directives outlined in Act 79.

Community System Development

Act 79 also authorized significant investments in a more robust publicly funded mental health services system for Vermont. Fiscal Year 13 funding supports the implementation of service expansion in several support and services areas that will offer a stronger continuum of care for the public mental health system.

Given the anticipated and growing demand for mental health support services in a state experiencing a smaller capacity of acute psychiatric inpatient care, access to evaluation is an essential cornerstone of mental health service. Designated Agencies (DA's) throughout the state were provided resources to develop and further enhance emergency outreach and crisis support services at the local level. Mobile response capability and improved collaborations with local law enforcement are encouraged to better meet the challenges of providing effective engagement in a rural state. In this first quarter, DA's have been building this capacity and developing protocols for this collaborative work in their local areas.

Global commitment resources in this fiscal year are targeting additional crisis beds capacity to divert unnecessary inpatient hospitalization where clinically appropriate and step-down individuals who are ready to transition from inpatient care back to community support services. Three regions of the state are developing crisis bed stabilization capabilities where limited or no capacity existed before. Act 79 also supported the investment of global commitment resources into intensive residential recovery support programs. During this quarter a new 8-bed program was established and has quickly offered some relief to the inpatient care system. An additional 8-bed program is proposed for the northern part of the state and move through a Certificate of Approval (COA) process for development during the next quarter.

The realities of a rural state, with remote or geographic distance between points of service, require that transportation also be a consideration for access of any crisis stabilization, residential, or inpatient treatment capacities established. Throughout this quarter, the flexible application of global commitment resources has supported further development of both trauma sensitive and least restrictive modes of transportation consistent with safety needs being increased throughout the state. Collaboration with law enforcement and training in alternative transport options, when clinically appropriate, have already had a positive influence on reducing the use of hard restraints for acute emergency mental health transports as the norm.

Inroads for the outpatient services population are also being made via the expansion of service planning and coordination supports beyond the severe and persistently mentally ill population. More responsive, hands-on case management support services to stabilize individuals who might otherwise further decompensate from mental health stressors or exhaust existing coping mechanisms were supported through Act 79. What has been called "non-categorical" case management is an expanded service capacity that is no longer reserved for the most incapacitated individuals served in community-based programs. Earlier supportive intervention available to individuals struggling with mental health issues will further reduce potential need for limited acute inpatient resources. A population targeted for these support services, which are at risk for higher cost public and health care resource utilization, are individuals transitioning between periods of incarceration and re-entry to the community. Individuals at risk for recidivism, law enforcement involvement and incarceration, are a continuing priority group for expanded mental health and community support services.

Act 79 also provided for new investment in housing supports and coordinated treatment supports to provide greater stabilization in the community for individual at higher risk for homelessness. The pairing of both treatment and stable housing resources increases the likelihood of individuals with mental health needs

remaining more engaged with services and less likely to destabilize requiring acute inpatient treatment. Augmenting these formal support services with peer support services is also being promoted in FY 13. Act 79 also supported investments in peer services to broaden the array and options for recovery supports to individuals with mental illness. In the first quarter, the development of a statewide peer “warmline” is in development as an alternative for individuals needing active listening and problem-solving supports on issues that did not rise to the level of mental health crisis contacts. The state’s peer community is also working collaboratively with the DMH to further develop a proposal for a peer supported residential program, also supported by Act 79, for individuals seeking an alternative course of recovery that minimizes reliance on medications.

All of the initiatives that are under way are formalizing data collection and reporting capabilities consistent with Act 79 provisions regarding: access to emergency room and inpatient services, mobile outreach supports, crisis bed and intensive residential recovery bed utilization, alternative transportation availability, housing stability, and adverse event and emergency involuntary procedures. Outcomes and cost-savings to the service system for this and the subsequent quarter will be reported back to the legislature as outlined within Act 79.

Integrated Family Services

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

Specifically, children’s Medicaid services are scattered across six IGA partners for the Medicaid program. Programs historically developed separate and distinct from each other with varying, Medicaid waivers, procedures and rules for managing sub-specialty populations. These were the best approaches available at the time; however the artifacts of this history are multiple and fragmented funding streams, policies, and guidelines for our work with children and families. Often the same provider and family will be captive to varied and conflicting procedures, reporting and eligibility requirements. With the inception of the Global Commitment and other changes at the federal level these siloed structures no longer need to exist. Global Commitment has allowed the AHS to look at one overarching regulatory structure (42 CFR 438) and one universal EPSDT screening, referral and treatment continuum. This also allows us to review for efficiency and effectiveness our coordination efforts with other federal mandates such as Title V, IDEA part B and C, Title IV-E, Federal early childhood programs and others.

AHS Integrated Family Services Initiative seeks to bring all agency children, youth and family services together in an integrated and consistent continuum of services for families. The premise being that giving families early support, education and intervention will produce more favorable health outcomes at a lower cost than the current practice of *waiting until circumstances are bad enough* to access funding which often result in treatment programs that are out of home or out of state. Several efforts are underway and include: performance based reimbursement projects, capitated annual budgets with caseload and shared savings incentives and flexible choices for self-managed services. Each of these is described in brief below.

Annual Aggregate Budgets and pmpm for Medicaid Children's MH and Family Support services.

Effective July 1, 2012, our first Integrated Family Services pilot is underway in Addison County. We have brought together over 30 state and federal funding streams into one unified whole through one master grant agreement with the state. The state has created an annual aggregate spending cap for two providers who in turn have agreed to provide a seamless system of care to ensure no duplication of services for children and families prenatal to 22. The aggregate annual budget for this pilot is approximately \$4 million with \$3 million being global commitment covered services. Very early success includes:

- Local clinicians moving from a day per week of separate and conflicting paperwork requirements to one set representing approximately 2-3 hours of paperwork time, immediate freeing up more time for direct family services
- A more immediate response to families who ask for help who prior to this grant were “not sick enough” to meet funding criteria
- Unified local efforts to offer a single on site response to families bringing together multiple state and federal programs that would otherwise be offered at differing times and places.

The financial model supporting this agreement includes a monthly pmpm rate established for the reimbursement of all Medicaid-covered sub-specialty services. Member month rates are based on agreed upon annual allocations for covered services divided by the minimum Medicaid caseload expectation. The same member month rates will be paid for minimal service packages as for intensive service packages. The goal of the funding model is to ensure that beneficiaries get a package of early periodic screening diagnostic and treatment (EPSDT) and outreach services commensurate with their functional needs within an overall annual aggregate cap on reimbursements. PMPM/Case rates are not based on any one group of services being “loaded” into a claim; they are global aggregate budget/minimum caseload. Annually, providers and the state will reconcile actual financial experience to the grant. This pilot includes two levels of incentives. One for caseload and one for decreasing utilization and expenditures in intensive more restrictive settings

Redesign of Vermont's Children's Personal Care Services. Children's Personal Care Services (CPCS) have historically been one of the few service options for families caring for a child with developmental and other disabilities. Through an expansion of specialized rehabilitation, assessment and targeted case management services each beneficiary in the CPCS program is being reassessed and children are being diverted from CPCS to rehabilitation plans that will focus on skill building and care giver support as clinically appropriate. This expansion of rehabilitation services includes a merger between the CPCS and the state's Title V (Children's with Special Health Needs) programs. In addition to eliminating duplicative infrastructure, the changes include offering eligible families the choice of self managed or agency managed allocations for PCA's services.

Performance Based Pilots. The State has engaged in two successful performance based pilot projects. One pilot, “Jump on Board for Success” or JOBS, provides mental health services for target youth in order to increase coping, daily living and anger management skills which ultimately result in increased attainment and stability of jobs, home/family and health status. The second pilot involves a package of crisis counseling, health and mental health services for runaway and homeless youth in order to stabilize crisis and health status reunify youth with their families and/or ensure a safe and stable housing situation. In both of these pilots, the state identifies expected outcomes as well as the number of FTE clinicians it wishes to ‘purchase’ and the minimum Medicaid caseload per provider to create a bundled rate based on capacity.

Participants in these programs are tracked on a number of health, mental health and social service outcomes. For the past two years, both programs have seen an increase in the number of youth served and better overall outcomes, all within existing budgeted resources.

The state will continue to track outcomes and look to apply lessons learned from these pilots to the larger system of care for children and families.

Financial/Budget Neutrality Development/Issues

Effective with the January 1, 2011 waiver renewal, AHS began paying DVHA a monthly PMPM estimate using the existing rates on file, in accordance with the new Special Terms and Conditions. This monthly payment reflects the State's monthly need for Federal funds based on estimated Global Commitment expenditures for the month. Beginning with the QE0311 filing, AHS has reconciled the Federal claims from the estimated monthly PMPM payments to the underlying actual Global Commitment expenditures incurred via the usual reconciliation draw process on a quarterly basis.

AHS worked with its actuarial consultant (Milliman) throughout QE0912, to develop actuarially sound rate ranges for the FFY13 period. AHS selected PMPM rates and sent a revised IGA for the FFY13 period to CMS on October 4, 2012. Additionally, AHS worked with CMS during September and October 2012, toward resolution of issues pertaining to approval of the FFY11 and FFY12 IGAs and selected PMPM rates.

Member Month Reporting

Demonstration project eligibility groups are not synonymous with Medicaid Eligibility Group reporting in this table. For example, an individuals in the Demonstration population 4 HCBS (home and community based services) and Demonstration Project 10 may in fact be in Medicaid Eligibility Group 1 or 2. Thus the numbers below may represent duplicated population counts.

This report is run the first Monday following the close of month for all persons eligible as of the 15th of the preceding month.

Data reported in the following table is NOT used in Budget Neutrality Calculations or Capitation

Demonstation Population	Month 1	Month 2	Month 3	Total for Quarter Ending 4th Qtr FFY '12	Total for Quarter Ending 3rd Qtr FFY '12	Total for Quarter Ending 2nd Qtr FFY '12	Total for Quarter Ending 1st Qtr FFY '12	Total for Quarter Ending 4th Qtr FFY '11	Total for Quarter Ending 3rd Qtr FFY '11
	7/31/2012	8/31/2012	9/30/2012						
Demonstration Population 1:	48,282	48,422	48,493	145,197	142,952	142,365	141,300	139,591	138,493
Demonstration Population 2:	44,097	43,976	43,636	131,709	132,537	132,285	132,095	130,715	130,868
Demonstration Population 3:	9,855	9,870	9,601	29,326	29,076	28,869	29,054	29,396	29,431
Demonstration Population 4:	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Demonstration Population 5:	994	1,000	961	306,232	3,012	2,999	3,325	3,246	3,310
Demonstration Population 6:	3,268	3,261	3,266	467,267	9,536	9,646	9,704	9,888	9,795
Demonstration Population 7:	35,593	35,700	35,711	802,825	107,528	106,610	105,833	105,932	108,184
Demonstration Population 8:	9,484	9,680	9,922	1,576,324	30,939	30,730	30,174	23,287	24,639
Demonstration Population 9:	2,584	2,670	2,716	3,152,648	7,874	7,889	7,875	7,512	7,634
Demonstration Population 10:	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Demonstration Population 11:	11,811	11,836	12,150	35,797	35,175	33,674	33,464	33,207	32,732

Payments as information will change at the end of quarter; information in this table cannot be summed across the quarters. All payments are adjusted at the end of the year to reconcile expected population movement between eligibility groups.

Consumer Issues

The AHS and DVHA have several mechanisms whereby consumer issues are tracked and summarized. The first is through the Managed Care Entity, Health Access Member Services. This is a contracted function for providing information on health care programs, assisting with the eligibility process, and helping beneficiaries to understand the benefits and responsibilities of their particular programs. The complaints received by Member Services are based on anecdotal weekly reports that the contractor provides to DVHA (see Attachment 2). Member services works to resolve the issues raised by beneficiaries, and their data helps DVHA look for any significant trends. The weekly reports are seen by several management staff at DVHA and staff asks for further information on complaints that may appear to need follow-up to ensure that the issue is addressed. When a caller is dissatisfied with the resolution that Member Services offers, the member services representative explains the option of filing a grievance and assists the caller with that process. It is noteworthy that Member Services receives an average approximately 25,000 calls a month. We believe that the low volume of complaints and grievances is an indicator that our system is working well.

The second mechanism to assess trends in consumer issues is the Managed Care Entity Grievance and Appeal report. This report is based on data entered by grievance and appeal coordinators in various locations throughout the Managed Care Entity (Due to staff resources (leave) this quarter data could not be compiled to meet report filing deadlines. Info will be present next quarter for both quarters.). The unified Managed Care Entity database in which they enter information helps them track the timeframes for responding to the grievances and appeals, as well as assists DVHA and AHS in monitoring compliance and assessing if there are trends that may benefit from a performance improvement project.

The third mechanism to track consumer issues is the report for the Office of Health Care Ombudsman (HCO) is a comprehensive report of all contacts with beneficiaries (see Attachment 3). These include inquiries, requests for information, and requests for assistance. HCO's role is to assist individuals to navigate health care insurance systems, and help to resolve eligibility and coverage problems. The data is not broken down into requests for assistance as opposed to complaints.

Quality Assurance/Monitoring Activity

External Quality Review Organization

During this quarter, the Managed Care Entity's (MCE) Performance Improvement Project (PIP) work group submitted the initial PIP summary form to the External Quality Review Organization (EQRO) for review. The PIP validation evaluated the technical methods of the PIP (i.e., the study design, implementation/evaluation and outcomes) associated with the Re-measurement 1 data reported. The EQRO conducted their validation consistent with the CMS protocol, *Validating Performance Improvement Projects: A Protocol for Use in Conducting Medicaid External Quality Review Activities*, final protocol, Version 1.0, May 1, 2002. The PIP received an overall *Met* validation status when originally submitted and DVHA had the opportunity to incorporate HSAG's recommendations from the PIP Validation Tool, and resubmit the PIP, at which time the plan improved its overall evaluation element score and maintained the

Met validation status. DVHA identified a data collection issue when it was collecting interim data for analysis. The plan realized that the data reported in its resubmitted PIP were inaccurate. After discussing the identified issue with AHS, AHS determined that DVHA would be allowed to resubmit a second revised PIP to HSAG for validation. Overall, 96 percent of all applicable evaluation elements received a score of *Met*. DVHA progressed to reporting Re-measurement 1 data. With the progression, the overall evaluation elements score declined when compared to the 2010–2011 validation due to the lack of statistically significant improvement.

Also during this quarter, the MCE submitted Performance Measure (PM) source code and supporting documentation to help inform the EQRO PM Validation activities. After reviewing the documents, the EQRO conducted an on-site review of the MCE. During their visit, the EQRO completed the following: opening meeting, evaluation of system compliance, review of ISCAT and supporting documentation, overview of data integration and control procedures, primary source verification, and a closing conference. During their review, the EQRO validated a set of 9 performance measures calculated by the MCE as outlined in the CMS publication, *Validating Performance Measures: A Protocol for Use in Conducting External Quality Review Activities*, final protocol, Version 1.0, May 1, 2002. The performance measures were reported and validated for the measurement period of calendar year 2011 (i.e., January 1, 2011 through December 31, 2011). All 9 measures were assigned a validation finding of fully compliant with AHS specifications.

Finally, during this quarter, the MCE submitted documents demonstrating its ability to comply with Federal Medicaid Managed Care Access standards. After reviewing the document, the EQRO conducted an on-site review of the MCE. During the visit, the EQRO conducted the following activities: opening conference, review of documents, interviews with key staff, and a closing conference. The EQRO followed the guidelines in the February 11, 2003, CMS protocol, *Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs): A Protocol for Determining Compliance with Medicaid Managed Care Proposed Regulations* at 42 CFR Parts 400, 430, et al, for the pre-on-site and on-site review activities. The MCE received an overall compliance score of 100 percent.

During the next quarter, the AHS Quality Improvement Manager will work the EQRO to develop the Annual Technical Report. This document combines the results of all three external quality review activities and identifies strengths and challenges associated with the three activities as well as making recommendations to improve the timeliness, access, and quality of services provided by the MCE. It is anticipated that this document will be produced by the EQRO by the end of next quarter.

Quality Assurance Performance Improvement Committee (QAPI)

The Quality Assurance and Performance Improvement (QAPI) Committee held its quarterly meeting and continued ongoing communication between meetings. The Committee reviewed the compliance activities of the MCE in the areas of confidentiality and the ongoing work around the Quality Plan and the Quality Work Plan. The annual AHS confidentiality report was reviewed by all members and this report was brought back to each IGA partner's leadership team for an internal review. No recommendations were made and each member will report back any follow-up from this report. The Committee continued its work on the MCE Quality Work Plan and incorporating the quality initiatives from each of the represented IGA partners.

During this quarter DVHA developed a new position for a Managed Care Compliance Director prompting the review of the current reporting structure and the role of the QAPI Committee. The Committee reviewed its current structure and purpose, and identified the need to focus more on quality improvement

and assessment, utilization management, and program integrity which would align with the changes being made throughout the MCE. New staff were being hired to focus on these activities resulting in the change in membership of the Committee. As part of the restructuring, the DVHA Quality Improvement Director and the AHS Quality Manager will meet with the IGA partners individually throughout the next quarter. The meetings will focus on identifying any changes in compliance activities, ongoing performance improvement efforts, and how activities can be aligned throughout the MCE.

The 2012 external quality review (EQR) audit was conducted at the beginning of this period and the results were presented to the Committee. The audit focused on three compliance standards: Practice Guidelines, Quality Assessment & Performance Improvement Program, and Health Information Systems. The MCE was found to be in 100% compliance with the standards. The QAPI Committee Chair met with the AHS Quality Improvement Manager to review the compliance activities and the results of the EQR audit. Conversations around the QAPI program centered on the activities related to the Quality Work Plan and the upcoming meetings with the IGA partners. No recommendations were made to the AHS Quality Manager for corrective action.

Quality Strategy

During this quarter, no issues with the Quality Strategy were identified by members of the QAPI committee. As a result, no action was taken on the strategy during this quarter.

Demonstration Evaluation

During this quarter, the AHS Quality Improvement Manager continued to work with the Pacific Health Policy Group (PHPG) project manager to modify the current evaluation work plan to be in sync with the new waiver extension time period.

Reported Purposes for Capitated Revenue Expenditures

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

- Reduce the rate of uninsured and/or underinsured in Vermont;
- Increase the access of quality health care to uninsured, underinsured, and Medicaid beneficiaries;
- Provide public health approaches to improve the health outcomes and the quality of life for Medicaid-eligible individuals in Vermont; and
- Encourage the formation and maintenance of public-private partnerships in health care.

Please see Attachment 5 for a summary of Managed Care Entity Investments, with applicable category identified, for State fiscal year 2011.

Enclosures/Attachments

Identify by title any attachments along with a brief description of what information the document contains.

Attachment 1: Catamount Health Enrollment and Expenditure Report

Attachment 2: Budget Neutrality Workbook

Attachment 3: Complaints Received by Health Access Member Services

Attachment 4: Medicaid Managed Care Entity Grievance and Appeal Reports

Attachment 5: Office of VT Health Access Ombudsman Report

Attachment 6: DVHA Managed Care Entity Investment Summary

Attachment 7: Health Benefit Exchange Outreach and Education Plan Summary

State Contact(s)

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Date Submitted to CMS: November 29, 2012

ATTACHMENTS

ATTACHMENTS

The Department of Vermont Health Access
Caseload and Expenditure Report ~ All AHS Medicaid Spend
All AHS YTD September 30, 2012

MEG	Avg. Mo. Enrollment	YTD '12 Expenditures
VHAP	37,346	\$ 40,915,242
VHAP ESI	823	\$ 265,503
Catamount	11,162	\$ 10,094,394
ESIA	707	\$ 159,002
Total Medicaid	50,038	\$ 51,434,140.17

Glossary of Terms

VHAP – Beneficiaries over age 18 without children who have a household income below 150% FPL or beneficiaries 18 and older with children who have a household income below 185% FPL

VHAP ESI – Adults who are eligible for the Vermont Health Access Plan (VHAP) and who have access to an approved cost-effective, employer-sponsored insurance plan

ESIA – Adults who are uninsured and not eligible for VHAP and who have access to an approved cost-effective employer-sponsored insurance plan

Catamount – Beneficiaries over age 18 with income under 300% who are ineligible for existing state-sponsored coverage programs and do not have access to insurance through their employer

Global Commitment Expenditure Tracking

Quarterly	POA: WY1	POA: WY2	POA: WY3	POA: WY4	POA: WY5	POA: WY6	POA: WY7	POA: WY8	POA: WY9	Net Program POA	Net Program Expenditures as reported on 64	non-MCO Admin Expenses	Total columns JK for Budget Neutrality calculation	Cumulative Waiver Cap per 1/1/11 STCs	Variance to Cap under/over
0E															
1205	\$ 178,493,793									\$ 178,493,793					
0306	\$ 189,414,365	\$ 14,472,838								\$ 203,887,203					
0606	\$ 209,647,618	\$ (14,172,165)								\$ 195,475,453					
0906	\$ 194,437,742	\$ 133,350								\$ 194,571,092					
WY1 SUM	\$ 771,933,518	\$ 434,023								\$ 786,780,147				\$ 841,266,663	\$ 54,486,516
1206	\$ 203,444,640	\$ 8,903								\$ 203,453,543					
0307	\$ 203,904,330	\$ 8,894,097								\$ 212,698,427					
0607	\$ 188,486,403	\$ 814,587	\$ (68,409)							\$ 187,204,582					
0907	\$ 225,219,267	\$ -	\$ -							\$ 225,219,267					
WY2 SUM	\$ 818,326,640	\$ 9,717,587	\$ (68,409)							\$ 809,348,797					
Cumulative										\$ 1,596,128,945				\$ 1,684,861,317	\$ 88,732,372
1207	\$ 213,871,059	\$ -	\$ 1,010,348							\$ 214,881,406					
0308	\$ 162,921,830	\$ -	\$ -							\$ 162,921,830					
0608	\$ 196,466,768	\$ 14,717	\$ 840,276,433							\$ 228,593,470					
0908	\$ 228,593,470	\$ -	\$ -							\$ 228,593,470					
WY3 SUM	\$ 801,853,126	\$ 14,717	\$ 1,010,348	\$ 840,276,433						\$ 881,729,256					
Cumulative										\$ 2,484,316,097				\$ 2,604,109,308	\$ 119,793,211
1208	\$ 228,768,784	\$ -	\$ -							\$ 228,768,784					
0309	\$ 225,691,560	\$ (16,984,221)	\$ 338,998,635	\$ (4,144,041)						\$ 243,562,303					
0609	\$ 204,169,638	\$ -	\$ 686,851	\$ 5,522,763						\$ 210,379,252					
0909	\$ 235,585,193	\$ -	\$ 30,199	\$ 34,064,109						\$ 269,679,461					
WY4 SUM	\$ 894,215,505	\$ (16,984,221)	\$ 339,715,685	\$ 35,442,831						\$ 935,368,819					
Cumulative										\$ 3,425,180,534				\$ 3,606,430,571	\$ 181,250,037
1210	\$ 241,939,196	\$ 5,192,468	\$ -							\$ 247,131,664					
0310	\$ 246,257,198	\$ 531,141	\$ 4,400,168							\$ 251,188,504					
0610	\$ 253,045,787	\$ 248,301	\$ 5,260,537							\$ 258,554,625					
0910	\$ 252,294,668	\$ (115,983)	\$ (261,429)	\$ 3,348,303						\$ 255,265,556					
WY5 SUM	\$ 983,536,849	\$ -	\$ (115,983)	\$ 5,710,484	\$ 13,009,005					\$ 1,012,990,839					
Cumulative										\$ 4,444,120,378				\$ 4,700,022,174	\$ 255,901,796
1211	\$ 253,147,037	\$ -	\$ -							\$ 257,140,611					
0311	\$ 277,708,048	\$ -	\$ (121,416)							\$ 277,586,627					
0611	\$ 243,508,248	\$ -	\$ 5,528,143							\$ 249,036,391					
WY6 SUM	\$ 1,040,463,890	\$ -	\$ 6,444,984	\$ 5,406,727						\$ 1,045,342,616					
Cumulative										\$ 5,493,929				\$ 5,865,213,737	\$ 370,796,215
1212	\$ 253,147,037	\$ (531,744)	\$ 49,079							\$ 252,615,293					
0312	\$ 267,978,672	\$ 3,742	\$ 6,383,928							\$ 268,001,493					
0612	\$ 302,958,610	\$ -	\$ 7,750,984							\$ 309,352,538					
0912	\$ 262,406,131	\$ -	\$ -							\$ 270,157,125					
WY7 SUM	\$ 1,086,490,450	\$ -	\$ (528,002)	\$ 14,194,000						\$ 1,100,684,450					
Cumulative										\$ 6,600,715,694				\$ 7,113,290,903	\$ 512,575,209
1213	\$ -	\$ -	\$ -							\$ -					
0313	\$ -	\$ -	\$ -							\$ -					
0613	\$ -	\$ -	\$ -							\$ -					
WY8 SUM	\$ -	\$ -	\$ -							\$ -					
Cumulative										\$ -				\$ 8,450,684,436	\$ 1,849,958,792
1213	\$ -	\$ -	\$ -							\$ -					
WY9 SUM	\$ -	\$ -	\$ -							\$ -				\$ 8,955,686,798	\$ 2,355,171,104
Cumulative	\$ 6,407,479,978	\$ 10,166,327	\$ (16,042,281)	\$ 79,876,130	\$ 41,153,315	\$ 19,453,990	\$ 4,878,725	\$ 14,194,000	\$ -	\$ 6,561,160,184	\$ 39,555,510			\$ 8,955,686,798	\$ 2,355,171,104

**Complaints Received by Green Mountain Care Member Services
July 1, 2012 – September 30, 2012**

Eligibility forms, notices, or process	39
ESD Call-center complaints (IVR, rudeness, hold times)	3
Use of social security number as identifiers	1
General premium complaints	5
Catamount Health Assistance Program premiums, process, ads, plans	2
Coverage rules	2
Member services	3
Eligibility rules	9
Eligibility local office	1
Prescription drug plan complaint	1
Copays/service limit	0
Pharmacy coverage	1
Provider issues (perceived rudeness, refusal to provide service, prices) (variety of provider types)	3
Provider enrollment issues	0
Chiropractic coverage change	0
Shortage of enrolled dentists	1
Green Mountain Care Website	1
DVHA	2
Total	74

**Grievance and Appeal Quarterly Report
Medicaid MCE All Departments Combined Data
July 1, 2012 – September 30, 2012**

The MCE is composed of various administrative areas within the Agency of Human Services (AHS). These include: the Department of Vermont Health Access (DVHA), the Department for Children and Families (DCF), the Department of Mental Health (DMH), the Department of Disabilities, Aging and Independent Living (DAIL), and the Department of Health (VDH). Also included in the MCE are the Designated Agencies (DA) and Specialized Service Agencies (SSA) that provide service authorizations for DMH and DAIL. Each entity should have at least one assigned grievance and appeal coordinator who enters data into the MCE database. This report is based on data compiled on October 1, 2012, from the centralized database for grievances and appeals that were filed from July 1, 2012 through September 30, 2012.

Grievances: A grievance is an expression of dissatisfaction about any matter that is not an action taken by the MCE.

During this quarter, there were 24 grievances filed with the MCE; nine were addressed during the quarter and none were withdrawn. Grievances must be addressed within 90 days of filing, so having pending cases at the end of the quarter is to be expected. Acknowledgement letters of the receipt of a grievance must be sent within five days; the average was four days. Of the grievances filed, 79% were filed by beneficiaries, 17% were filed by a representative of the beneficiary and 4% were filed by other. Of the 24 grievances filed, DMH had 79%, DVHA had 17% and VDH had 4%. There were no grievances filed for the DAIL, or DCF during this quarter.

There were six cases that were pending from all previous quarters, with two of them being resolved this quarter.

There were no Grievance Reviews filed this quarter. There are no Grievance Reviews filed in previous quarters that have not been addressed yet.

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

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

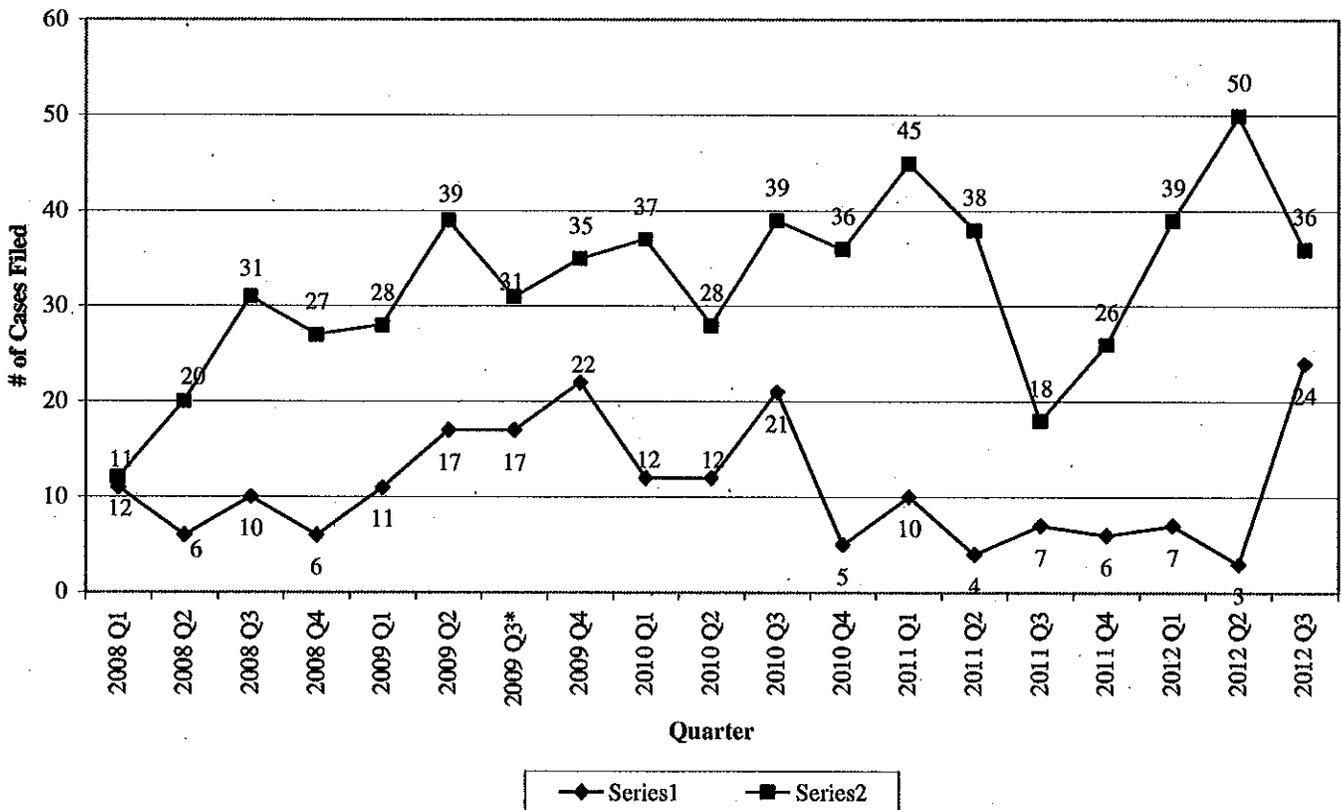
During this quarter, there were 36 appeals filed with the MCE; 10 requested an expedited decision with three of them meeting criteria. Of these 36 appeals, 19 were resolved (53% of filed appeals), five were withdrawn (14%), and 12 were still pending (33%). In 8 cases (42% of those resolved), the original decision was upheld by the person hearing the appeal, eight cases (42% of those resolved) were reversed, and three were approved by the applicable department/DA/SSA before the appeal meeting (16% of those resolved).

Of the 19 appeals that were resolved this quarter, 100% were resolved within the statutory time frame of 45 days; 84% were resolved within 30 days. The average number of days it took to resolve these cases was 15 days. Acknowledgement letters of the receipt of an appeal must be sent within five days; the average was two days.

Of the 36 appeals filed, 20 were filed by beneficiaries (55%), 12 were filed by a representative of the beneficiary (34%) and 4 were filed by the provider (11%). Of the 36 appeals filed, DVHA had 67%, DAIL had 25%, and DMH had 8%.

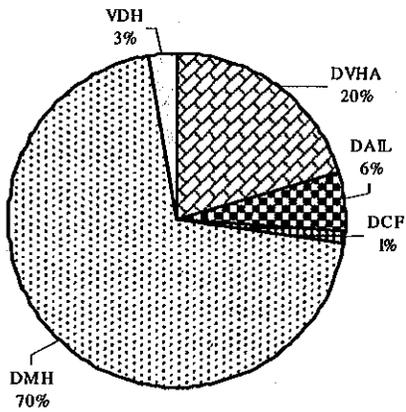
Beneficiaries can file an appeal and a fair hearing at the same time, and they can file a fair hearing if their appeal is not decided in their favor. There were no fair hearing filed this quarter.

Medicaid MCE Grievances & Appeals

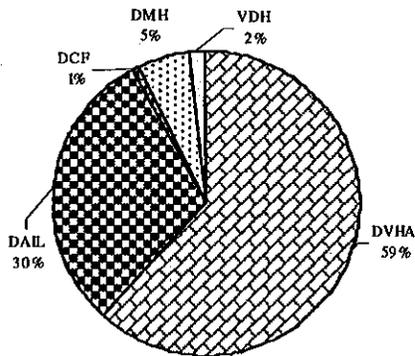


MCE Grievance & Appeals by Department From January 1, 2008 through September 30, 2012

Grievances



Appeals



OFFICE OF HEALTH CARE OMBUDSMAN

264 NORTH WINOOSKI AVE.
P.O. BOX 1367
BURLINGTON, VERMONT 05402
(800) 917-7787 (VOICE AND TTY)
FAX (802) 863-7152
(802) 863-2316

QUARTERLY REPORT
July 1, 2012 – September 30, 2012
to the
DEPARTMENT OF FINANCIAL REGULATION
and the
DEPARTMENT OF VERMONT HEALTH ACCESS
submitted by
Trinka Kerr, Vermont Health Care Ombudsman
October 18, 2012

I. Overview

This is the Office of Health Care Ombudsman's (HCO) report to the Department of Financial Regulation (DFR) and the Department of Vermont Health Access (DVHA) for the quarter July 1, 2012 through September 30, 2012. In addition to operating a hotline to provide individual consumer assistance, the HCO also does policy work and represents the public in Green Mountain Care Board (GMCB) activities and rate review proceedings.

There are five parts to this report: this narrative section, which includes a table of all calls the HCO hotline received, broken out by month and year, and four data reports. One data report has the HCO statistics for all of the calls. The other three data reports are based on the insurance status of the client at the time the case was initiated, i.e. the client was a commercial plan beneficiary, a DVHA program beneficiary or uninsured. Note that the most accurate information related to eligibility for state programs is in the All Calls data report, because callers who had questions about the DVHA programs fell into all three insurance status categories. Also, often we get a caller's insurance status only if it is relevant to the caller's issue.

The HCO database allows us to track more than one issue per case, so that we can see the total number of calls that involved a particular issue. In each section of this narrative we note whether we are referring to data on primary issues, or both primary and secondary issues. One call can involve multiple secondary issues.

A. Total call volume increased 7.25% compared to last quarter.

All Calls

The HCO received 769 calls this quarter, compared to 717 in the April through June 2012 quarter, a 7.25% increase. Call volume was 8.2% lower than the same quarter in 2011, when we received 838 calls. Call volume in August and September 2011 was the highest volume ever for those months, largely due to Tropical Storm Irene. Luckily this year there were no such disasters so call volume remained high but at a more typical level for the third quarter.

[See the table at the end of this narrative for further detail related to total call volume.]

DVHA Beneficiary Calls

We received 369 calls (47.33% of all calls) from individuals on state programs this quarter, compared to 345 calls (48.11% of all calls) last quarter. This is a continuation of a recent trend of a somewhat higher call volume from DVHA beneficiaries. In the past, these calls more typically made up 35-40% of all calls.

B. The top ten issues generating calls were:

This section includes **both primary and secondary issues.**

All Calls

1. Affordability 120 (compared to 91 last quarter, a 15.6% increase)
2. Information about applying for DVHA programs 106 (77 last quarter, a 13.78% increase)
3. Complaints about Providers 100 (83 last quarter, a 13% increase)
4. Eligibility for VHAP 82 (66 last quarter, a 10.66% increase)
5. Communication Problems with DCF 69 (45 last quarter, a 8.97% increase)
6. Access to Prescription Drugs 67 (58 last quarter, a 8.7% increase)
7. Eligibility for Medicaid 65 (60 last quarter, a 8.45% increase)
8. Eligibility for Premium Assistance 57 (42 last quarter, a 46.15% increase)
9. Community Education on Medicare 43 (19 last quarter, a 126.31% increase)
10. Access to Dental Care, Dentists, Dentures, Orthodontics 40 (37 last quarter, a 8.1% increase)

DVHA Beneficiary Calls

1. Complaints about Providers 49 (48 last quarter, a 2.08% increase)
2. Affordability 42 (35 last quarter, a 20% increase)
3. Communication Problems with DCF 40 (28 last quarter, a 42.85% increase)
4. Access to Dental Care, Dentists, Dentures, Orthodontics 34 (23 last quarter, a 42.82% increase)
5. Information about applying for DVHA programs 32 (32 last quarter, no change in %)
6. Eligibility for Medicaid 31 (26 last quarter, a 19.23% increase)
7. Eligibility for VHAP 29 (28 last quarter, 3.57% increase)
Access to Prescription Drugs 29 (29 last quarter, no change in %)
8. Fair Hearings 28 (22 last quarter, a 27.27% increase)
9. Community education on Medicare 23 (8, a 187.5% increase)
Transportation 23 (24 last quarter, a 4.16% decrease)
10. Eligibility for Premium Assistance 19 (14 last quarter, a 35.71% increase)

C. The affordability of health care continues to be a barrier to health care for all consumer groups.

This quarter we had 120 calls in which the consumer identified affordability as a barrier to the access to health care. This is the top reason HCO consumers call us. It means that 15.6% of all

callers said that difficulty paying for care was making it hard for them to get care. This was a 32% increase over last quarter, when we had 91 such calls. However, the percentage of all of the HCO's callers who identified affordability as an important issue remained between 15-16% last quarter and this quarter.

The inability to access care due to cost is an issue for consumers whether they are uninsured or insured, and whether they are insured through state programs or commercial insurance. Not surprisingly, the largest percentage of affordability calls, 34.74%, came from the uninsured.

The problem of affordability has been an increasingly common complaint since the HCO started tracking this issue in late 2009. The issue is becoming a problem for more and more consumers. In the third quarter of 2011, affordability was identified as an issue in 100 calls, which was 11.93% of the consumers who called the HCO that quarter, as compared to 15-16% in the last two quarters.

Who had issues with Affordability broke down as follows, based on the caller's insurance status:

- DVHA programs: 42 calls; 8 calls as a primary issue, 34 as a secondary;
- Commercially insured: 19 calls; 2 calls as a primary issue, 17 as a secondary;
- Uninsured: 33 calls; 2 calls as a primary issue, 31 as a secondary; and
- In the remaining calls we did not get the caller's insurance status.

D. The number of complaints about providers remains high, and is highest among DVHA beneficiaries.

The HCO received 100 calls this quarter from consumers complaining of problems with their providers, compared to 83 last quarters, a 20.48% increase. The number of complaints from DVHA program beneficiaries remained consistent, 49 this quarter compared to 48 last quarter. Callers on commercial plans had 13 complaints about providers. The uninsured had 5. In the remaining calls we did not get the caller's insurance status.

E. Complaints about the Department for Children and Families (DCF) are increasing, especially for DVHA beneficiaries.

Complaints regarding DCF ranks as the fifth highest problem among all consumers this quarter. Of all the calls that the HCO received this quarter, 69 callers identified this as an issue. This is an 8.97% increase from last quarter. It is the third highest problem for beneficiaries on a DVHA program. We received 40 calls from DVHA beneficiaries with DCF complaints, a 42.85% increase over last quarter. These numbers reflect a significant increase over such calls in both the first and second quarters of 2012.

These calls cover a broad range of issues, but many result from communication problems. Often they involve difficulties understanding DCF written notices, understanding conversations with and directions from DCF staff, or confusion about the premium payment process. These problems frequently cause lapses in coverage. In particular, callers express a significant amount of frustration with DCF staff's inability to explain the Medicaid Spend Down process. Callers do

not understand what steps they must take. Another frequent complaint is that notices are incomprehensible because they are so long and contain apparently contradictory information. Some callers, many with disabilities, are unable to get assistance from DCF staff with applications.

We also get calls on a variety of other issues including wrongful terminations, problems getting continuing benefits pending appeal, lack of proper notice before benefit changes, and miscalculation of income causing ineligibility for programs. We also continue to get calls from frustrated self-employed individuals who have very little available income, yet do not qualify for state programs because of the way the State calculates income from self-employment.

These are the same types of problems we always see regarding eligibility determinations. What's notable is the uptick in the number of these types of calls. We will continue to monitor this to see if it is a real trend.

F. Access to dental care is a growing problem, but mainly for DVHA beneficiaries.

The HCO received 40 calls this quarter, including both primary and secondary issue codes, regarding access to dental care, dentists, dentures, and orthodontists. Last quarter we received 37 such calls.

Of the 29 dental care calls coded as primary issues, 24 (83%) were from DVHA beneficiaries. Last quarter 17 of the 24 primary issue dental calls, 71%, were from DVHA beneficiaries.

G. Calls from Medicare beneficiaries are increasing.

More than a third of the HCO's calls came from Medicare beneficiaries this quarter: 275 callers were on Medicare, which was 36% of all calls. This compares to 206 calls and 29% last quarter. Many of these callers also have other coverage. This is a continuing trend, which is probably due in part to the aging of the state's population.

H. The following information is included in this quarterly report:

- A table showing monthly totals for All Calls at the end of this narrative, and
- Four data reports based on type of insurance coverage:
 - All calls/all coverages: 769 calls;
 - DVHA beneficiaries: 364 calls or 47.33% of total calls;
 - Commercial plan beneficiaries: 124 calls or 16.12%; and
 - Uninsured Vermonters: 95 callers or 12.35%.

II. Green Mountain Care Board and Rate Review Activities

Pursuant to Act 48 of 2011 and Act 171 of 2012, the Green Mountain Care Board (GMCB) consults with the HCO about various health care reform issues. In addition, the HCO represents the public in rate review proceedings. HCO activities for the past quarter included:

- GMCB meetings

- Attended ten GMCB meetings
- Attended two monthly meetings with the GMCB executive director and general counsel
- Reviewed the recording of one joint GMCB advisory board/payment reform committee meeting describing the state's Health Care Innovation Plan;
- Rate review and CON regulations (Rate review rule 2.000, draft CON rule):
 - Exchanged information with other consumer groups about the section on opportunities for public participation in the draft rate review regulations
 - Participated in public hearing about the rate review regulations
 - Submitted formal written comments on proposed GMCB regulations.
 - Reviewed draft CON regulation and submitted comments
- Rate review filings
 - Monitored and reviewed rate review filings on the DFR and GMCB websites;
 - Entered appearances and filed memoranda in ten rate review cases before the GMCB
 - Participated in two contested hearings on rate review cases
- National conference calls/state training
 - Community Catalyst call regarding MLR
 - Vermont Ethics Network conference *When Less is Better: Ethical Issues in the Use of Health Care Resources*
- Green Mountain Care Board public participation process
 - Met with the Stakeholder Engagement Coordinator for the GMCB to discuss ideas for improving public participation and sent written comments on the new public comments section of the GMCB web site to the Coordinator
 - Coordinated with consumer groups interested in commenting on the Exchange benefits package
 - Met twice with the VPIRG consumer protection advocate to review the process for commenting on rate review cases and ways to increase public participation
- Reviewed the DFR website with DFR staff and made suggestions about changes that would make the consumer information on the site more complete and user-friendly for consumers.
- Participated in a work group developing the Consumer Protection Report required by Act 171 with DFR, DVHA and Agency of Administration Office of Health Care Reform
- Tracked consumer complaints to the HCO hotline about premium rates and assisted one consumer in filing a comment about a rate increase to the Green Mountain Care Board:
 - 1 complaint about rate increases
 - 3 complaints about premium rates being too high

III. Hotline call volume by type of insurance:

The HCO received 769 total calls this quarter. Callers had the following insurance status:

- **DVHA programs** (Medicaid, VHAP, VHAP Pharmacy, Premium Assistance, VScript, VPharm, or both Medicaid and Medicare aka dual eligibles) insured 47% (364 calls), compared to 48% (345) last quarter;
- **Medicare** (Medicare only, Medicare and a Medicare Supplemental Plan aka Medigap, Medicare and Medicaid aka dual eligibles, Medicare and Medicare Savings Program aka

Buy-In program, Medicare and Part D, or Medicare and VPharm) insured **36%** (275), compared to 29% (206) last quarter;

- **8% of all callers** (92) had **Medicare only**;
 - **20%** (152) had both **Medicare coverage and coverage through a state program** such as Medicaid, a Medicare Savings Program aka a Buy-In program, or VPharm;
 - **1%** (7) had a **Medicare Supplemental plan**;
 - **3%** (24) had **Medicare and Part D**; and
 - The remaining could have had Medicare along with a retiree plan, but our data is not clear on this.
- **Commercial carriers** (employer sponsored insurance, individual or small group plans, and Catamount Health plans) insured **16%** (124), compared to 17% (122) last quarter; and
 - **12%** (95) identified themselves as **Uninsured**, compared to 8% (58) last quarter.
 - In the remainder of calls the insurance status was either unknown or not relevant.

IV. Disposition of cases

All Calls

We closed 760 cases this quarter, compared to 708 last quarter.

- 42% (322 cases) were resolved by brief analysis and advice;
- 20% (154) were resolved by brief analysis and referral;
- 29% (220) were resolved by direct intervention, including calling an insurance company, calling providers, writing letters, gathering supporting medical documentation, etc. (these numbers include complex interventions);
- 13% (120) of the cases were complex interventions, which involves complex analysis and more than two hours of an advocate's time;
- 3% (24) of the cases involved appeals; and
- 1% (11) of the cases were resolved in the initial call.
- In the remaining calls clients either withdrew or resolved the issue on their own.

DVHA Beneficiary Calls

We closed 337 DVHA cases this quarter, compared to 337 last quarter:

- 37% (136 calls) were resolved by brief analysis and advice ;
- 24% (88 calls) were resolved by brief analysis and referral;
- 35% (119 calls) were resolved by direct intervention on the caller's behalf, including advocacy with DVHA and providers, writing letters, and gathering medical information (these numbers include complex interventions);
- 16% (58 calls) were considered complex intervention, which involves complex analysis and more than two hours of an advocate's time;
- 2% (8) involved appeals (Fair Hearings); and
- 2% of calls (7) from DVHA beneficiaries were resolved in the initial call.
- In the remaining calls clients either withdrew or resolved the issue on their own.

V. Case outcomes

All Calls

The HCO got 45 people onto insurance and prevented 19 insurance terminations or reductions. We helped 7 people obtain reimbursements and helped 2 people get claims paid. We assisted 3 people with applications and provided billing assistance to 7 people. We estimated the eligibility for other programs for 24 individuals. We obtained patient assistance for 2 people. We obtained coverage for services for 5 people. As a result of our intervention, 7 claims were paid or written off. We provided 506 individuals with advice and education. We obtained other access or eligibility outcomes for 44 more people, many who will be approved for medical services and state insurance. We encourage clients to call us back if they are subsequently denied insurance or a medical service. In total, this quarter the HCO saved consumers \$ 29,493.70.

An example of a great outcome involved a husband and wife who moved to Vermont and applied for individual insurance. Vermont carriers refused to sell them an individual plan because the husband's employer offered insurance to its employees. However, the employer's out of state insurance carrier did not offer coverage to Vermont residents. Thus, the couple was unable to get insurance and was uninsured. After struggling for more than two months to resolve this conundrum on their own, the couple contacted the HCO for help. By that time, they were dangerously close to being uninsured for more than 62 days, making them vulnerable to pre-existing condition exclusions if they were able to get insurance. The HCO immediately contacted DFR. DFR made a determination that the couple was eligible to purchase individual insurance in Vermont and worked with a Vermont carrier to make it happen. By coordinating with DFR, the HCO was able to resolve the problem within two weeks, enabling the couple to get insurance and avoid any pre-existing condition exclusions.

DVHA Beneficiary Calls

We prevented 17 terminations or reductions in coverage for DVHA beneficiaries, and got 10 more people onto different DVHA programs. We assisted 2 individuals with applications or reviews. We estimated the eligibility for other programs for 6 DVHA beneficiaries. We got 5 claims paid or written off, and obtained reimbursement for 2 people. We obtained coverage for services for 10 individuals. We provided 256 DVHA beneficiaries with advice or education. We obtained other access or eligibility outcomes for 24 more people.

VI. Issues

The HCO database allows us to track more than one issue per case, so we can see the total number of calls that involved a particular problem. For example, although 138 cases had Access as the primary issue, there were actually a total of 253 calls in which we spent a significant amount of time assisting consumers in obtaining access to health care. See the breakouts of the issue numbers in the individual data reports for a more detailed look at how many callers had questions about issues other than the primary reason for their call.

The information in this section is for All Calls. See the DVHA data report for a similar breakdown for the DVHA beneficiaries who called us.

- 27.05% (208) of our total calls were regarding Access to Care;

- **14.56%** (112) were regarding **Billing/Coverage**;
- **.26%** (2) were questions regarding **Buying Insurance**;
- **10.14%** (78) were **Consumer Education**;
- **28.48%** (219) were regarding **Eligibility** for state programs, Medicare and Catamount Health plans; and
- **19.51%** (150) were categorized as **Other**, which includes Medicare Part D, communication problems with providers or plans, accessing medical records, changing providers or plans, enrollment problems, confidentiality issues, and now complaints about rates.

A. Access to Care (27.05% of all calls)

We received 208 calls from individuals for whom the primary issue was difficulty getting specific health care, an increase from last quarter's 186 calls. The top seven Access to Care issues, out of over 35 codes were, in descending order:

- 35 calls were for problems obtaining Prescription Drugs, not including Medicare Part D, compared to 31 last quarter;
- 29 Dental, Dentists, Dentures or Orthodontic care, compared to 24;
- 18 Transportation to medical appointments, compared to 22;
- 18 Durable Medical Equipment (DME), Supplies and Wheelchairs, compared to 18;
- 16 Primary Care Doctor, compared to 3;
- 14 Affordability of health care, compared to 12; and
- 10 Pain Management, compared to 11;
- 10 Specialty Care, compared to 10; and
- 9 Mental Health, compared to 9 (not including Substance Abuse).

B. Billing/Coverage (14.92%)

We received 112 calls related to primary issues with billing, compared to 107 last quarter. The top five billing related issues were:

- 17 Hospital billing, compared to 13 last quarter;
- 16 Claim denials by insurers, compared to 19;
- 8 Balance billing, Medicaid (new code starting this quarter);
- 7 Copayments, compared to 0;
- 7 Out of state billing for state programs, compared to 10;
- 6 Medicaid and VHAP billing; compared to 10; and
- 6 Medicare billing, compared to 8.

C. Consumer Education (10.14%)

We received 78 calls in which consumer education was the primary issue, compared to 74 last quarter. The top five consumer education issues were:

- 30 Information about applying for DVHA programs, compared to 35 last quarter;
- 12 Medicare, compared to 4;
- 7 General questions about insurance, compared to 9;

- 7 HIPAA, compared to 2;
- 6 Catamount programs, compared to 8;
- 4 Debt collection, compared to 3; and
- 4 Fair Hearings, compared to 4.

D. Eligibility (28.48%)

We received 219 calls from individuals for whom eligibility for state programs was the primary issue, as compared to 193 last quarter. The top five issues in this category were:

- 43 Medicaid, compared to 38 last quarter;
- 39 VHAP, compared to 34 ;
- 36 Catamount and Premium Assistance, compared to 26; and
- 23 Medicaid Spend Down, compared to 17; and
- 11 Long Term Care Medicaid, compared to 4.

E. Other (19.51%)

We received 150 calls in this category for which the primary issue was categorized as Other, compared to 156 last quarter. The top four issues in this category were:

- 39 Communication/Complaints: Providers, compared to 41 last quarter;
- 11 Problems with DCF, compared to 5;
- 9 Provider Error/Medical Malpractice, compared to 10; and
- 8 DCF ID card problems, compared to 5.

VII. Table of All Calls by Month and Year

All Cases	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
January	241	252	178	313	280	309	240	218	329	282
February	187	188	160	209	172	232	255	228	246	233
March	177	257	188	192	219	229	256	250	281	262
April	161	203	173	192	190	235	213	222	249	252
May	234	210	200	235	195	207	213	205	253	242
June	252	176	191	236	254	245	276	250	286	223
July	221	208	190	183	211	205	225	271	239	255
August	189	236	214	216	250	152	173	234	276	263
September	222	191	172	181	167	147	218	310	323	251
October	241	172	191	225	229	237	216	300	254	
November	227	146	168	216	195	192	170	300	251	
December	226	170	175	185	198	214	161	289	222	
Total	2578	2409	2200	2583	2560	2604	2616	3077	3209	2263

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

SFY12 Final MCO Investments

8/21/12

MCO Investment Expenditures

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

Document: Outreach and Education plan

Relevant Blueprint Item(s): 2.3

Summary: Vermont has done extensive work to develop an outreach and education plan, and to ensure we are well positioned to inform the Vermonters about the Exchange. This document provides an overview of our outreach and education plan.

Detail: A strong outreach and education effort ahead of the Vermont Health Benefit Exchange launch and throughout its operations will help determine its success. Communicating about the Exchange will require a coordinated effort among State agencies, community organizations, insurance carriers, corporate partners, providers and many others. Our outreach and education plan will guide all activities intended to reach Vermonters and educate them about the Exchange.

The outreach and education plan, available on CALT, is guided by a defined set of target audiences, including primary and secondary audiences, and core strategies that will always serve as a guidepost of all tactics. The target audiences detailed in the plan address the populations identified in 45 CFR 155.130:

- Educated health care consumers who are enrollees in QHPs;
- Individuals and entities with experience in facilitating enrollment in health coverage;
- Advocates for enrolling hard to reach populations, which include individuals with mental health or substance abuse disorders;
- Small businesses and self-employed individuals;
- State Medicaid and CHIP agencies;
- Public health experts;
- Health care providers;
- Large employers;
- Health insurance issuers; and
- Agents and brokers.

The plan does not address Federally-recognized Tribes, as there are none in the State of Vermont. The plan does add sub-populations to the primary audiences list including young adults (18-34), as they make up the largest portion of the uninsured population in Vermont, and Catamount Health beneficiaries, as they are currently in a State program that will transition them to the Exchange in 2014. Additionally, the underinsured population is a priority for the State.

The plan explores a variety of tactics for reaching these populations with the goal of engaging them and driving them to the Exchange website or a Navigator where they can learn more about the Exchange and get assistance enrolling. The plan includes the following components:

- Materials development
- Earned media
- Paid media (advertising)
- Social media
- Stakeholder engagement
- Partnerships and grassroots engagement
- State employee communications