

*State of Vermont*  
*Agency of Human Services*

**Global Commitment to Health**  
**11-W-00194/1**

**Section 1115**  
**Demonstration Year: 8**  
**(10/1/2012 – 9/30/2013)**

**Quarterly Report for the period**  
**January 1, 2013 – March 31, 2013**

**Submitted Via Email on May 30, 2013**

## **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 (CMS), within the Department of Health and Human Services (HHS).

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 1989 implementation 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 (CHIP) 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); the 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 converted the (then Office) Department of Vermont Health Access (DVHA), the state's Medicaid organization, to a public Managed Care Entity (MCE). The Agency of Human Services (AHS) pays 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 31, 2007 by CMS, allowed Vermont to implement the Catamount Health Premium Subsidy Program with the corresponding commercial Catamount Health Plan (implemented by state statute October 1, 2007) for incomes up to 200 percent of the FPL. The intent of this program is to reduce the number of uninsured citizens of Vermont. The Catamount Plan is a health insurance product offered in cooperation with Blue Cross Blue Shield of Vermont and MVP Health Care that provides comprehensive, quality health coverage at a reasonable cost regardless of how much an individual earns. Subsidies are available to those who fall at or below 300 percent of the FPL. On December 23, 2009 a second amendment was approved that allowed Federal participation for subsidies up to 300 percent of the FPL, and 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.

CMS approved an amendment to Vermont's 1115 Demonstration, effective August 1, 2012, with a June 27, 2012 reissue date which provided 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.

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 reinforces 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 second quarterly report for waiver year eight, covering the period from January 1, 2013 through March 31, 2013.***

#### Global Commitment to Health Waiver: Renewal

The Global Commitment Waiver renewal process was started in February with the commencement of the public process conducted pursuant to 42 CFR 431.408: the public comment period was from February 14 through March 22, 2013. On February 13, the draft *Global Commitment to Health Waiver Renewal Request*, the public notice, and executive summary of the draft, were posted online. Materials were available on the following websites: DVHA, the Agency of Human Services, the Agency of Administration Health Care Reform home pages. Also, the draft was distributed simultaneously to the Medicaid and Exchange Advisory Board, the committees of jurisdiction in the Vermont legislature, the DAIL Advisory Board, Department of Children and Families (DCF) District Offices, Dual Eligible Demonstration Stakeholders, DMH, VDH and other external stakeholders as well as internal management teams from across AHS.

On February 14, a public notice was published in the Burlington Free Press noticing the availability of the draft renewal request, two public hearing dates, the online website, and the deadline for submission of written comments with contact information. Additionally, all district offices of the Department for Children and Families’ Economic Services Division, the division responsible for health care eligibility had notice posted and proposal copies available, if requested. The Burlington Free Press is the state’s newspaper with the largest statewide distribution and paid subscriptions. Between February 16-20,<sup>th</sup> additional public notices were published in Vermont’s other newspapers of record, including the Valley News, The Caledonian Record, St. Albans Messenger, Addison Independent, The Bennington Banner, Newport Daily Express, The Islander, Herald of Randolph, and the News and Citizen. This distribution list represents all geographic regions of the state.

On March 1, a public notice and link to the renewal documents was included on the banner page for Vermont’s Medicaid provider network.

The State posted a comprehensive description of the draft waiver request on February 13, 2013 on the above-cited websites. The document included: program description, goals and objectives; a description of the beneficiary groups that will be impacted by the demonstration; the proposed health delivery system and benefit and cost-sharing requirements impacted by the demonstration; estimated increases or decreases in enrollment and in expenditures; the hypothesis and evaluation parameters of the proposal; and the specific waiver and expenditure authorities it is seeking. In addition to the draft posted for public comment, an Executive Summary and the PowerPoint presentation used during each public hearing was also posted to the same state websites noted above.

The State convened to two public hearing on the Global Commitment to Health 1115 Waiver renewal request.

On February 19 from 3:30 p.m.-5:30 p.m., a public hearing was held using videoconferencing at Vermont Interactive Television (VIT) sites in Bennington, Brattleboro, Johnson, Lyndonville, Middlebury, Newport, Randolph Center, Rutland, Springfield, St. Albans, White River Junction, Montpelier, and originating in Williston.

On March 11 from 11:00 a.m.-1:00 p.m., a public hearing was held during the Medicaid and Exchange Advisory Board meeting in Winooski, with teleconferencing available for individuals who could not attend in person.

On March 14, an informational presentation (with a question/answer period), was given at the Department of Disabilities, Aging, and Independent Living (DAIL) Advisory Board meeting in Berlin, Vermont.

Vermont plans to submit the renewal request to CMS in April.

**Enrollment Information and Counts**

Please note the table below provides point in time Demonstration Population counts for the Global Commitment to Health Waiver. Due to the nature of the Medicaid program beneficiaries 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 CHIP.

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.

Demonstration Population counts are person counts, not member months.

<b>Demonstration Population</b>	<b>Current Enrollees Last Day of Qtr 12/31/2012</b>	<b>Previously Reported Enrollees Last Day of Qtr 9/30/2012</b>	<b>Variance 01/31/12 to 03/31/12</b>
Demonstration Population 1:	48,745	48,613	0.27%
Demonstration Population 2:	43,853	43,351	1.16%
Demonstration Population 3:	9,775	9,623	1.58%
Demonstration Population 4:	N/A	N/A	N/A
Demonstration Population 5:	905	1,016	-10.93%
Demonstration Population 6:	3,284	3,299	-0.45%
Demonstration Population 7:	36,323	35,138	3.37%
Demonstration Population 8:	10,137	9,981	1.56%
Demonstration Population 9:	2,640	2,697	-2.11%
Demonstration Population 10:	N/A	N/A	N/A
Demonstration Population 11:	12,052	12,291	-1.94%

**Outreach/Innovation Activities**

**Member Relations**

The DVHA Provider and Member Relations Unit has mailed timely access surveys to 357 randomly selected primary care providers (PCP) with a return request for May 31, 2013. A similar network adequacy survey will be mailed to specialists after receipt of the PCP responses. A member satisfaction survey, to be mailed to a random selection of beneficiaries in the fall, will complete the collection of information about

appointment wait times, travel, distances, waiting room wait times and the overall member satisfaction with the provider network.

## **Operational/Policy Developments/Issues**

### **Health Benefit Exchange**

Vermont continued to make significant progress in development of its Health Benefits Exchange. In January, 2013 Vermont received notification from CMS of conditional approval to operate a state based exchange, indicating that we have sufficiently met required milestones in the design and development process. Vermont expanded outreach and education activities through public forums, e-newsletters, and enhanced promotion of the Vermonthealthconnect.gov website. Vermont continued the process of selecting Qualified Health Plans (QHP) for the Exchange by receiving bids from prospective health plans. Vermont and its systems integrator, CGI, continued to hire and train new staff, and CGI submitted a project management plan. Vermont worked with CGI to develop and refine business requirements, and defining system design. Vermont worked on procuring call center services by developing and beginning negotiation of an amendment to a current contract with Maximus to continue their Medicaid services and expand to provide services for individual and small employer private QHP plans. Vermont also worked in procuring a premium processing vendor, narrowing to a single candidate and conducting negotiations with that candidate. Exchange staff participated in a federal technical assistance gathering in Baltimore, and continued to work with CMS/CCIIO staff to ensure satisfactory completion of benchmark milestones.

### **Expenditure Containment Initiatives**

#### ***Vermont Chronic Care Initiative (VCCI)***

The goal of the Vermont Chronic Care Initiative (VCCI) is to improve health outcomes of Medicaid beneficiaries by 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 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 utilizing motivational interviewing and techniques to support behavioral change; 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 behavioral changes to improve their overall health, and by facilitating access to and effective communication with their primary care and specialty care providers. The intention ultimately is to empower beneficiaries to take charge of their own health and 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); and staff function as members of these local resource teams. The VCCI expanded services to include all age groups and all conditions in the population accounting for the top 5% of expenses; as well as those with ambulatory sensitive conditions which adversely impact utilization trends, such as Emergency Department (ED) and

inpatient admissions and readmissions. The VCCI expanded its service scope as well as partners who support these new focus areas (pediatrics, ob/gyn, etc...), as outlined in segments below.

The VCCI continues to expand upon the 2010 strategy to embed licensed staff within high volume Medicaid primary care sites and hospitals experiencing high volume ambulatory sensitive ED visits and inpatient admissions/readmissions. The VCCI has staff in 20 locations including embedded within two hospitals and in eight primary care provider locations. Additionally, staff have a physical presence in nine Agency of Human Service (AHS) office locations.

Unfortunately, the VCCI has not been able to secure space at the largest FQHC in Chittenden County as earlier anticipated as that facility has indicated a lack of space for dedicated external staff given its own local growth. Similarly, VCCI has been unable to co-locate in the largest hospital and tertiary care facility but still anticipates a nurse hire that will allow daily rounds and discharge coordination/transition in care for our vulnerable population to prevent readmissions. Embedding staff has helped foster relationships with providers and hospital partners, and to secure direct referral for high risk populations versus utilizing professional staff to perform outreach to eligible populations via 'cold calling'. Experience has demonstrated that direct referrals are more likely to engage with VCCI staff if they are referred by a local resource including state AHS partners in economic services, and probation and parole, as well as CHT members.

An additional challenge has been the ability to recruit nurses with the applicable background and experience at the pay rate available in state government. Despite these challenges, the VCCI did add new RN case management staff in the second quarter in the Burlington and Bennington locations; and added two RNs in Rutland on April 7<sup>th</sup> to replace staff lost to attrition - including one internal to state government and one externally and at a higher salary. Lastly, the VCCI successfully added an administrative assistant to support the Director and field based teams. The VCCI continues to recruit for a long standing vacancy in rural St. Johnsbury as well as a position in Barre vacated by a nurse who returned to a previous employer at a higher wage – after only two weeks of employment. The VCCI anticipates filling remaining vacancies, including the two high risk pregnancy nurse case management positions in the 3<sup>rd</sup> quarter of the FFY as a result of more aggressive recruitment efforts, which will bring the VCCI to a full staffing complement of 27 licensed and non-licensed staff members.

#### *Pediatric Palliative Care:*

The VCCI added a Pediatric Palliative Care Program (PPCP) in September of 2012 and has subsequently expanded to include a statewide presence with multiple referring providers, direct service/home health agency partners and internal partners engaged in the Children with Special Health Needs (CSHN) program in the Vermont Department of Health (VDH). Over 20 children have been enrolled to date; and unfortunately, the program also lost its first child in February. Some operational challenges remain as we integrate internally to assure alignment with partners within the Licensing and Protection Division of the Department of Aging and Independent Living (DAIL) which is responsible for audits of home health agencies. A meeting with DVHA/VCCI and partners in DAIL and Home Health is scheduled in May to assure operational integration meets auditing standards. Another area which likely will remain a challenge is the restricted capacity statewide to deliver Expressive Therapy services. Home Health agencies are in the process of recruiting, hiring and/or contracting with this new group of professional staff to meet the needs of this unique newly covered service. The premise of implementing the PPCP is to address the unique needs of children who are living with a serious and potentially life threatening illness. Covered services for medically eligible children may include Care Coordination, Family Training, Expressive Therapy, Respite, and Bereavement Counseling.

New VCCI partners supporting PPCP include AHS/Integrated Family Services (IFS), Department for Children and Families/Children's Integrated Services (CIS) and Vermont Department of Health (VDH)/Children with Special Health Needs (CSHN). To further support integration with CSHN, the PPCP nurse case manager has space one day per week available within the CSHN offices to facilitate collaboration and planning.

An extensive network of pediatric palliative care providers at Fletcher Allen Health Care (FAHC) and Dartmouth Hitchcock's Children's Hospitals, as well as primary care pediatric practitioners and pediatric oncologists are new provider partners. Home Health agencies (hospice and palliative care units), the Vermont Ethics Network and the Vermont Family Network are also collaborating service providers and partners.

In February, the VCCI was invited to provide testimony to the House Health and Human Services committee, to provide a status report on the program development and implementation, which was met with very favorable results from committee members.

### High Risk Pregnancy

VCCI continues to make progress toward the launch of a High Risk Pregnancy Case Management program. This new service for vulnerable pregnant women and their unborn child has been delayed by inability to successfully recruit nurses with the skill and passion to help develop and implement this vision. As a result, the VCCI is beginning a pilot in Franklin County - using the skill available in a current staff member with extensive experience in labor and delivery - concurrent with aggressive staff recruitment. This program will align with the ACA health home effort underway to support individuals with substance abuse disorders, the Pediatric Palliative Care Program (PPCP) and the VDH programs and services available for maternal/child health. The high risk pregnancy case management program will be centrally administered and will focus on the system of care; and coordination of services for the identified population. VCCI field staff may provide supplemental local support for the OB/GYN provider practice and pregnant woman based on needs.

### APS Contract

Per earlier reports, since 2007 the DVHA has contracted with APS Healthcare for assistance with providing disease management assessment and intervention services to Vermont Medicaid beneficiaries with chronic health conditions. In SFY 2012, DVHA and APS migrated away from the original model of support for those with chronic conditions, to a full risk based contract focused on the top 5% of the population accounting for highest service utilization without regard for age or diagnosis – as long as the condition and utilization patterns were 'impactable'. DVHA has found this approach, with its highest cost/highest risk beneficiaries, more effective because VCCI staff are able to communicate directly at the local level with provider, partners, patients and their families.

As DVHA transitioned to the new approach, it required a different level of support from APS to better align with current needs and healthcare goals. APS now provides enhanced information technology and more sophisticated decision-support tools to assist VCCI (DVHA and APS staff) to outreach the most costly and complex beneficiaries. APS continues to provide supplemental population based expertise supporting all the work of the Blueprint Community Health Teams (CHT) addressing NCQA priorities.

In the amended contract, APS guarantee a 2:1 return on investment (ROI) by implementing these enhancements in SFY 2012 and SFY 2013. These results were exceeded by the VCCI team in 2012 with a demonstrated ROI of roughly \$11.5 million which included the DVHA employed staff

expenses.

The current contract with APS is due to expire in June 2013; however, the DVHA sought (and secured) administrative approval to extend the current contract term for an additional year with a one year option to renew. This was necessitated by the DVHA's desire to assure that VCCI integrates with the newly procured Service Orientated Architecture (SOA) infrastructure which cannot, as a stand-alone solution, meet the operational needs of the VCCI. As the SOA needs to first become operational to support the Health Benefits Exchange (HBE), it was not anticipated that the VCCI RFP process, contracting and interface build would be ready and able to support VCCI operation at the end of the current contract term with the vendor. A new contract will be negotiated with APS for SFY 2014.

#### University of Vermont (UVM) Contract

The DVHA has contracted with the University of Vermont (UVM) for evaluation of the VCCI program, 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 high cost, high risk chronic conditions that VCCI targets. The PIP was designed and implemented according to the CMS PIP requirements for quality outcomes. The PIP addresses the appropriate treatment of heart failure (HF), a progressive chronic condition. HF patients are managed through both APS and 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 (EQRO) 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 2 of FFY 2013)

- Achieved \$11.5 million in savings for FY 2012.
- Completed the Heart Failure (HF) PIP and met goals as established. Efforts will continue with this population given the need to continue to monitor and improve adherence to evidence based care.
- Hired 4 nurses for Chittenden, Bennington Counties and Rutland Counties, and an administrative assistant. During the same period, the VCCI also lost two nurses in the Rutland County office. The replacement nurses will begin in April. The VCCI has been challenged in its hiring efforts due to the shortage of nurses in general and qualified nurse case managers in particular. This has been further hampered by the current salary structure for nurses in DVHA and the challenge of hiring new staff at a competitive rate while simultaneously trying to maintain internal equability, and not risk losing seasoned professionals who can secure higher salaries in the private sector. Aggressive recruitment continues for five vacancies – Barre, St. Johnsbury, Burlington; as well as two high risk pregnancy positions.
- APS has had a vacancy in the key Clinical Specialist Liaison position since 12/31/12 due in part to concerns regarding the impending contract end date of 6/30/13. APS is submitting a plan to assure coverage of this key staff person and seeking recruitment support from external sources/firms.
- A Market Factor analysis for nursing positions was completed and submitted to the Secretary of Administration in January 2012 to foster both recruitment as well as retention of VCCI nursing positions and remains under review.

- Requested that APS provide data on the utilization impact resulting from a gap in evidence based pharmacy for asthma and HF in order to assess cost benefit of reducing and/or eliminating co-payments for evidence based medications that are more costly than non-evidence based medications.
- Completed an Asthma registry outlining gaps in pharmacy treatment for patients with this diagnosis. A Diabetes registry is planned for May 2013.
- Expanded FTP sites and/or excel tools with partner hospitals for data sharing on emergency department and inpatient admission to support early notification of patterns of utilization, case assignment and transitions in care. Five hospitals are currently providing data and a sixth is exploring this opportunity to jointly address high utilization of ED; and prevention of ambulatory sensitive admissions and readmissions.
- Pilot testing a new hospital liaison role for embedded staff in Rutland Hospital to facilitate communication with ED and inpatient case managers; and coordinate patient needs.
- The Pediatric Palliative Care Program (PPCP) expanded to statewide coverage and has 20 children enrolled.
- High Risk Pregnancy ‘pilot’ program in early development for Franklin County.
- APS data indicates that VCCI maintained an average monthly caseload of 711 with 925 unique beneficiaries served. Unique beneficiaries are those who have been assigned to VCCI staff and have had a Social Needs, Behavioral Risk or Transitions of Care Assessment completed.

*Hub and Spoke Initiative: Integrated Treatment for Opioid Dependence:*

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, *Blueprint*’s 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.

Five regional *Hubs* are planned that build upon the existing methadone OTPs and also provide buprenorphine treatment to a subset of clinically complex buprenorphine patients, as well as serve the regional consultants and subject matter experts an opiod dependence and treatment. *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 is provided to *Spoke* providers and their Medicaid MAT patients by nurses and licensed addictions/mental health clinicians, added to the existing *Blueprint* CHTs. Similar to all CHT staff, *Spoke* staff are provided free of cost to MAT patients. Staff are embedded directly in the prescribing practices to allow more direct access to mental health and addiction services, promote continuity of care, and support the provision of multidisciplinary team care.

Highlights of the Hub and Spoke Initiative (Quarter 2 of FFY 2013)

- The Northwest regional *Hub* and *Spoke* model was implemented January 1, 2013, covering Chittenden, Addison, Franklin and Grand Isle counties.
- Although a proposed Rutland county *Hub* serving southwestern Vermont was delayed, *Spoke* implementation in Rutland and Bennington counties proceeded as planned on January 1, 2013.
- Negotiations continued with potential *Hub* providers in the remaining regions of the state. Planning continued for scheduled implementations from July 2013 through January 2014.
- The Health Home State Plan Amendment for the Northwest region was submitted to CMS.
- *Hub* Health Home services are provided through a performance-based contract with an OTP. MOUs and contracts between the participating buprenorphine providers and the *Blueprint* area administrative entities govern *Spoke* staffing agreements.
- With only a few exceptions, all buprenorphine prescribers in these regions agreed to participate, including FQHCs, all *Blueprint* patient-centered medical homes, OB/GYN providers, specialty psychiatry practices, and primary care practices that do not participate in the *Blueprint*.
- Based on current Medicaid beneficiaries receiving buprenorphine MAT in the four northwestern counties and two southwestern counties, full *Spoke* staffing is 21 FTEs.
- 470 beneficiaries are receiving MAT through the *Hub* serving Chittenden, Addison, Franklin and Grand Isle counties.
- The number of Medicaid buprenorphine patients, *Spoke* providers, and staff are:

Region	Medicaid Beneficiaries Receiving MAT	# Buprenorphine Providers	# Participating Buprenorphine Providers	Spoke FTE Staff
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Chittenden, Addison, Franklin, Grand Isle	650	29	26	13
Rutland, Bennington	400	9	7	8

Manage Substance Abuse Services

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 provides 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<sup>®</sup> 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.

Buprenorphine Program

The DVHA, in collaboration with the Vermont Department of Health’s Alcohol and Drug Abuse Programs (ADAP), maintains a Capitated Program for the Treatment of Opiate Dependency (CPTOD). The CPTOD provides an enhanced remuneration for physicians in a step-wise manner depending on the number of beneficiaries treated by a physician enrolled in the program. The Capitated Payment Methodology is depicted in (Figure 1) below:

(Figure 1)

Complexity Level	Complexity Assessment	Rated Capitation Payment	Final Capitated Rate (depends on the number of patients per level, per provider)	
III.	Induction	\$366.42	+ <u>BONUS</u> =	
II.	Stabilization/Transfer	\$248.14		
I.	Maintenance Only	\$106.34		

The total for the two quarters (October 2012- March, 2013) is \$ (Figure 2).

(Figure 2)

Buprenorphine Program Payment Summary FFY 2012	
FIRST QUARTER	
Oct-12	\$23,454.82
Nov-12	\$24,081.24
Dec-12	\$16,365
<b>1<sup>st</sup> Quarter Total</b>	<b>\$63,901.36</b>
SECOND QUARTER	
Jan – 2013	\$9,818.74
Feb – 2013	\$8,341.92
March- 2013	\$13,541.08
<b>2<sup>nd</sup> Quarter Total</b>	<b>\$31,541.08</b>
<b>Grand Total</b>	<b>\$95,442.44</b>

The Buprenorphine Practice guidelines are also reviewed and updated every two years. DVHA has revised the guidelines and they were submitted and approved by the Managed Care Medical Committee (MCMC) in November 2012.

#### 340B Drug Discount Program

The 340B Drug Pricing Program resulted from enactment of the Veterans Health Care Act of 1992, which is codified as Section 340B of the Public Health Service Act. The 340B Drug Pricing Program is a federal program managed by the Health Resources and Services Administration (HRSA) Office of Pharmacy Affairs (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).

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

- Northeastern Vermont Regional Hospital
- 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. In 2012, all of Fletcher Allen's outpatient pharmacies also enrolled. 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 DVHA is confident that 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.

DVHA's 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.

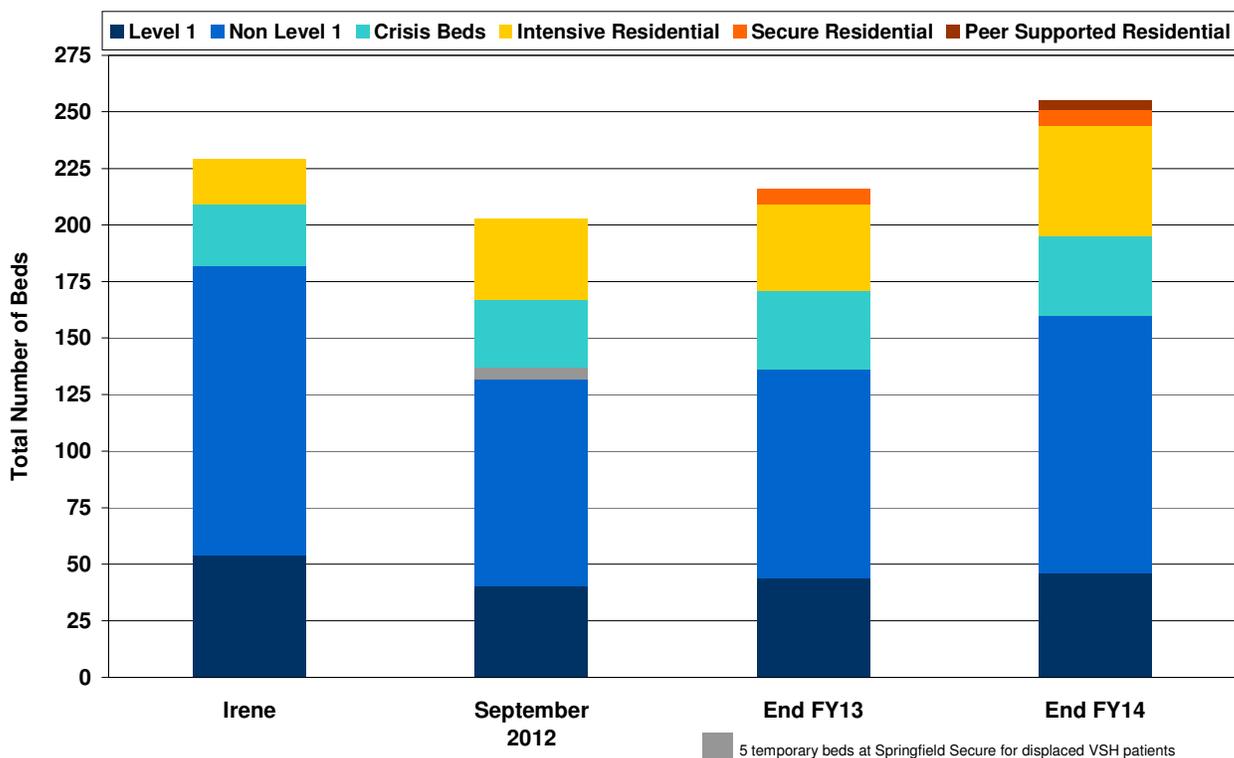
Because of federal laws prohibiting "duplicate discounts" on Medicaid drug pricing related to the interaction of 340B and manufacturer rebate programs, Medicaid participation in 340B has been limited both in Vermont and nationally. Vermont has put in place an innovative, first in the nation methodology 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. For the reporting period, Vermont has realized approximately \$296,306.28 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.

## Mental Health System of Care

### *State Hospital Inpatient Replacement Planning*

As referenced in earlier reports, an additional 28 psychiatric inpatient beds to serve Level I patients, individuals who would otherwise have been treated at the former state-run psychiatric hospital, were authorized via legislation while a new 25 bed hospital is under construction. During this reporting period, an interim psychiatric hospital (8 beds) in Morrisville opened in early January and began serving individuals requiring psychiatric inpatient care services. Facility renovations at the Brattleboro Retreat (14 beds) and Rutland Regional Medical Center (6 beds) are nearly complete and will be put online in the next quarter. These "designated" local hospitals, through renovation and program re-design, will serve individuals closer to their home communities and in substantially improved treatment settings when compared to the former state treatment facility. An overview of inpatient psychiatric beds in the system of care Pre-Irene and projected through the end of FY 14 was outlined in the Department's January 15, 2013 Act 79 report and follows below.

## Vermont Department of Mental Health Psychiatric Beds in System of Care



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, continues in earnest to triage and manage the inpatient needs and system movement. Staffed by department care management personnel, 24/7 admissions personnel of the former state hospital, and an electronic bedboard of inpatient and crisis bed census information available to service providers, the care management system has been taking shape over several months. Community and inpatient treatment providers have access to these centralized resources to assist with systemic issues or barriers that might arise as an individual moves through the continuum of care. The centralized department function supports timely access to the most acute levels of care and movement to lesser levels of care as quickly as clinically appropriate for individuals, consistent with the statutory directives outlined in Act 79.

### Community System Development

Act 79 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. Each new initiative carries reporting requirements to inform the Department of Mental Health (DMH) regarding overall contribution to the system of care and impacts to persons served. A full report of Act 79 funded initiatives and early outcomes were submitted to the Vermont Legislature on January 15, 2013. The report provided an overview of the significant program development areas and preliminary data collection and outcomes findings. Brief excerpts from the report's executive summary follow:

- Peer support programs have expanded to include the development of a 24/7 warm line, outreach services, and crisis beds. Peers are also working within some designated agencies

to provide supports to patients awaiting psychiatric hospitalization in emergency rooms of general hospitals and to individuals seen by crisis services.

- Crisis services acts as the gatekeeper for crisis beds and hospital beds for psychiatric care throughout the state. A statewide inter-disciplinary training program between police and mobile crisis responders is about to enter the second phase of its development.
- A variety of housing options has expanded, particularly for individuals most vulnerable upon discharge from the hospital. These options include transitional beds through intensive residential recovery programs, of which 18 more beds will come on line by March 2012. Supportive housing units have also developed to assist people in individual apartments with on-site supports. Specific wraparound programs have increased for high-needs mental health clients, with an eye on investment in recovery.
- Crisis bed programs have grown from 27 beds to 35 beds and are an excellent resource for hospital step-down and hospital diversion at a daily average of 50-75% lower cost than hospitals. It is expected that we will see a significant increase in usage as these beds expand from a regional to a statewide resource.

Following passage of Act 79 during the last legislative session, DMH launched the Dashboard Project. Based on traditional formatting of electronic dashboards, the DMH was looking for a means to track and report defined outcome measures in a user friendly format. Some elements that have been included are occupancy rates of both crisis and inpatient beds; forensic screenings and their outcomes; statewide suicide statistics; the number of consumers placed in permanent housing; and admissions to Designated Hospitals who are in the care and custody of the commissioner of mental health to mention but a few. The dashboard is a program and services evaluation tool that is of interest to the Mental Health Oversight Committee and other legislative committees of jurisdiction. It has become an important part of the DMH's ongoing effort to update lawmakers and to learn from their comments during such meetings. The Act 79 report submitted January 15 included the dashboard. The DMH is now reviewing both the outcomes to be monitored and how these data elements will be defined. The expectation is to have the dashboard updated on a monthly basis and posted on the DMH website.

The January 15, 2013 report also identified the top priorities for the department based on current system stresses identified by other providers, considers DMH evaluation of current system of care data within the report, and emphasizes the recommendations in the DMH consultant's report through the Behavioral Health Policy Collaborative. Some identified issues and recommendations for future planning were:

- High utilizers of hospital
  - DMH will initiate a process to review readmission trends in order to identify specific factors and develop a plan to reverse the increase in readmission rates
  - DMH anticipates a need for more wraparound programs; 1-2 bed supported apartments and wrap-around services are highly successful investments in the recovery of the individual. Among the individuals supported in this manner, hospitalization rates are negligible
  - A few individuals move from hospital to high-cost community-based wraparound programs and require significant supervisory resources, and yet they accept little in the way of treatment and present ongoing safety concerns. Evaluation of the

numbers in this category, as well as a public-policy discussion regarding the cost of individualized programming versus congregate housing, is planned for the coming year

- Individuals with higher acuity being treated in the community, placing high demand for services/staff in outpatient arena.
  - Funding needs to be maintained and increased needs evaluated for outpatient management programming
  - Over time, the CRT and AOP programs could blend, thus addressing the consultants' recommendation that there be an expansion in the CRT program. DMH believes it is less important what we name the program than to have sufficient service provision with appropriate funding resources
- Flow of individuals within the system of care
  - When the hospital and crisis bed inpatient system has no beds, there is a backup in emergency rooms statewide
  - The clinical care management system needs to continue its working partnership with hospitals, bridging from hospital to communities around placement options. DMH is developing training and consultation, both legal and clinical, to emergency rooms regarding the care and treatment of a person in mental health crisis.
  - Outpatient community-based services need to be available to a person seeking services immediately upon discharge from the hospital.
- Concerns around staff capacity in the outpatient arena
  - Staff capacity is an issue. Designated agencies have identified a need to increase the rate of pay as an issue in hiring
- Collaboration with Corrections
  - Bridging from Corrections to community services, particularly for clients who are categorized as seriously functionally impaired (SFI), continues to require more resources than are available within communities, particularly in the outpatient setting.
  - Training opportunities regarding working with the SFI population have been jointly sponsored over the past two years by DMH and DOC. A DOC/DMH work group will begin meeting to discuss on-going training for correctional officers and clinicians regarding the SFI population. The goals of the work group will include identification of DOC needs for augmentation of its current contract for provision of mental health services, consultation, and clear protocols with DMH for inmates needing in-patient hospital treatment
- Treatment of individuals with co-occurring issues (mental health and substance abuse)
  - Designated agencies throughout the state are working towards co-occurring treatment capability
  - Although funding streams are still separate for mental health and substance abuse services, program integration efforts are outlined below
- Needs of Refugee Resettlement programs
  - The population of refugees making their homes in Vermont is growing. Mental health needs are growing exponentially for these diverse groups

- Complete implementation of Act 79 activities and evaluate effectiveness
  - Evaluation of the effectiveness of enhanced community supports, no-refusal hospital beds, crisis bed programs, intensive residential recovery beds, and the care management/technical support system shall take place over the next year to formulate proposals for new programming
- DMH is working toward implementing a robust Information Systems program.
  - DMH is working with Vermont Information Technology Leaders, Inc., (VITL) to ensure compliance with the health information technology plan established under 18 V.S.A. § 9351. The goal at DMH is to fulfill the strategic mission through implementation of a state-of-the-art EHR that maintains interoperable connectivity to the Health Information Exchange (HIE) network to coordinate care
- Integration of health, mental health, and substance use care
  - Increasing access to mental health and substance use screening, early intervention, referral, support and treatment within the Vermont Blueprint for Health primary care practices, as well as increasing care coordination between DAs and primary care practices
  - Working with community mental health and substance abuse providers to support the inclusion of mental health and substance abuse health information into Vermont's development of a comprehensive Health Information Exchange
  - Developing capacity within specialty substance abuse and mental health settings to provide coordinated health care services for individuals who are receiving significant treatment services through a designated/preferred community provider
  - Providing leadership within Vermont's health care reform efforts to ensure that mental health and substance abuse care is accessible and integrated within the unified health system that is being developed (this includes current efforts to integrate public mental health and substance abuse services into Vermont's unified health system).

In the upcoming quarter, the DMH will continue to incrementally develop and systematically implement multiple initiatives that continue to transform the existing mental health system of care in Vermont. Data collection, reporting mechanisms, and systems of accountability will also continue to develop for both monitoring investments in inpatient and community based care and evaluation of outcomes for the populations served.

### Integrated Family Services (IFS) Initiative

The AHS continues to review opportunities to improve quality and access to care, within existing budgets, using managed care flexibilities and payment reforms available under 42 CFR 438 and the 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 the IGA partners. Programs historically evolved separate and distinct from each other with varying Medicaid waivers, procedures and rules for managing sub-specialty populations. These were the best approaches available at the time; however the artifacts of this history are multiple and fragmented funding streams, policies, and guidelines. Often the

same provider and family will be captive to varied and conflicting procedures, reporting and eligibility requirements. With the inception of the Global Commitment and other changes at the federal level these siloed structures no longer need to exist. Global Commitment has allowed for one overarching regulatory structure (42 CFR 438) and one universal early periodic screening diagnostic and treatment (EPSDT) continuum. This allows for efficient, effective, and coordination with other federal mandates such as Title V, IDEA part B and C, Title IV-E, Federal early childhood programs and others.

The IFS Initiative seeks to bring 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.*

The first IFS pilot is underway in Addison County: consolidation of over 30 state and federal funding streams into one unified whole through one master grant agreement. The state has created an annual aggregate spending cap for two providers who have agreed to provide a seamless system of care to ensure no duplication of services for children (prenatal to 22) and families. The aggregate annual budget for this pilot is approximately \$4 million with \$3 million being global commitment covered services. The pilot successes are:

- Increased ability to provide the right services to children and their families more immediately.
- Increased ability to provide services in a child's natural setting.
- Increased ability to work with a variety of providers and bring resources together to support families.
- Reduction in separate and conflicting paperwork having a positive impact on the number of hours clinicians can spend on direct services.
- A more immediate response to families who ask for help who, prior to this pilot, were "not sick enough" to meet funding criteria.
- Unified local efforts to offer a single onsite response to families combining multiple state and federal programs that would otherwise be offered at differing times and places.

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 and outreach services commensurate with their functional needs within an overall annual aggregate reimbursement cap. 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 for: 1) caseload, and 2) decreasing utilization and expenditures in intensive more restrictive settings.

This shift continues to be addressed both programmatically and financially. There is a review of the

method used to establish the PMPM to see if there is a more effective method. There are currently three other regions interested in undertaking this model. It is anticipated that soon after implementing in a few additional regions there will be statewide interest.

### **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 PMPM payments to the underlying actual Global Commitment expenditures incurred via the usual reconciliation draw process on a quarterly basis.

AHS selected PMPM rates and sent an IGA for the FFY13 period to CMS on October 4, 2012. AHS continues to work with CMS toward resolution of issues pertaining to approval of the FFY11, FFY12 and FFY13 IGAs and selected PMPM rates. Vermont would bear a significant retroactive and ongoing financial risk in the event the selected PMPM rates in the IGAs and actuarial certifications for FFY11, FFY12 and FFY13 are not approved as submitted. Resolution of the remaining issues as expeditiously as possible remains a top priority for the State.

Governor Peter Shumlin released his recommended budget for State fiscal year 2014 on January 24, 2013. This budget includes the assumption that the Global Commitment waiver will continue beyond December 31, 2013, and that Federal financial participation will be available for premium assistance for the current Catamount population when the Affordable Care Act becomes fully effective on January 1, 2014.

AHS has begun to work with its actuarial consultant, Milliman, on development of the FFY14 PMPM rate ranges.

### **Member Month Reporting**

Demonstration Populations are not synonymous with Medicaid Eligibility Group reporting in this table. For example, an individual 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 15<sup>th</sup> of the preceding month. Data reported in the following table is NOT used in Budget Neutrality Calculations or Capitation 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.

Demonstration Population	Month 1 1/31/13	Month 2 2/28/13	Month 3 3/31/13	Total for Quarter Ending 2nd Qtr FFY '13	Total for Quarter Ending 1st Qtr FFY '13	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
Demonstration Population 1:	48,980	48,965	48,745	146,690	145,618	145,197	142,952	142,365	141,300
Demonstration Population 2:	43,727	48,873	43,853	136,453	130,969	131,709	132,537	132,285	132,095
Demonstration Population 3:	9,832	9,770	9,775	29,377	29,302	29,326	29,076	28,869	29,054
Demonstration Population 4:	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Demonstration Population 5:	944	920	905	2,769	3,024	2,955	3,012	2,999	3,325
Demonstration Population 6:	3,332	3,255	3,284	9,871	10,063	9,795	9,536	9,646	9,704
Demonstration Population 7:	35,512	36,264	36,323	108,099	106,273	107,004	107,528	106,610	105,833
Demonstration Population 8:	10,012	10,087	10,137	30,236	29,808	29,086	30,939	30,730	30,174
Demonstration Population 9:	2,660	2,662	2,640	7,962	8,101	7,970	7,874	7,889	7,875
Demonstration Population 10:	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Demonstration Population 11:	11,764	11,959	12,052	35,775	36,702	35,797	35,175	33,674	33,464

### Consumer Issues

The AHS and DVHA have several mechanisms whereby consumer issues are tracked and summarized. The first is through Health Access Member Services. This is a contracted function for providing information on health care programs, assisting with the eligibility process, and helping beneficiaries to understand the benefits and responsibilities of their particular program. The complaints received by Member Services are based on anecdotal weekly reports provided 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 ask for additional 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 of approximately 25,000 calls a month. Based on the low volume of complaints and grievances received in relation to the quantity of calls, it is an indicator that the system is working well.

The second mechanism to assess trends in beneficiary issues is the Managed Care Grievance and Appeal report. This report is based on data entered by grievance and appeal coordinators in various locations across the MCE. The database into which they enter information helps them track the timeframes for responding to the grievances and appeals, as well as assists DVHA and AHS in monitoring compliance and assessing if there are trends that may benefit from a performance improvement project.

The third mechanism to track consumer issues is the Office of Health Care Ombudsman (HCO) report which is a comprehensive report of all contacts with beneficiaries (see Attachment 3). These include inquiries, requests for information, and requests for assistance. The 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**

The AHS Quality Improvement Manager (QIM) worked with the EQRO to develop timelines for each of the required annual external quality review activities. All timelines included the following elements: start date, completion date, task, and responsible party. Key tasks of the Performance Improvement Validation timeline include the following: feedback/comments on PIP documents, review/revise PIP validation tool, provide feedback on draft report, and review final report. The MCE is scheduled to receive the review documents during the next quarter. Key tasks of the Performance Measure Validation timeline included the following: identify measures for validation, review and provide feedback on documentation request letter and attachments, develop schedule of on-site visit, review and provide feedback on draft performance measure validation report. The MCE is scheduled to receive the review documents during the next quarter. Key tasks of the Compliance Review timeline included the following: finalize the scope of the review, review supporting documents and data collection tool, plan on-site visit, and review draft report. The MCE is scheduled to receive the compliance review documents during the next quarter. Finally, key tasks of the Annual Technical Report timeline included the following: draft report outline and discuss overall expectations, provide feedback/comments on draft tool, and provide edits/comments to draft report. The report is scheduled to be completed during the first quarter of next year.

### **Quality Assurance Performance Improvement Committee (QAPI)**

The DVHA Quality Improvement Director, the DVHA Compliance Director and the AHS Quality Improvement Manager (QIM) met to review compliance activities of DVHA and the IGA partners. DVHA completed the annual report of the Toolkit for oversight of delegated activities and provided this to the AHS QIM. Areas of improvement were identified with one recommendation made to the AHS QIM for corrective action. Conversations around the QAPI program also included the activities related to the development of a Quality Improvement Work Plan and each IGA Partner's quality improvement program.

Several meetings were held to work on the development of the new governance structure and to identify representatives from the IGA Partners to form the Program Accountability Committee (PAC). A committee charter was developed and communicated. The PAC is charged with improving the delivery of services, consumer outcomes, and the overall health and well-being of those served by AHS. The PAC will review various types of data to help guide decisions to help AHS achieve its goals. The format of the meeting has yet to be finalized, but it is anticipated that Medicaid specific topics will be addressed during the meeting. It is hoped that the PAC will align agency-wide efforts as well as establish an Agency approach to accountability. In addition to this effort, work continued on updating the IGAs and meetings were held with the Department of Mental Health and the Department for Children and Families.

### **Quality Strategy**

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 future meetings, the AHS QIM will engage members of the PAC in a discussion re: the National Quality Strategy to determine where Global Commitment and national quality assessment and improvement efforts might align for maximum results.

### **Transportation Quality Assurance & Coordination**

The DVHA transitioned the Non-Emergency Medical Transportation (NEMT) contracts to a per-member per-month (PMPM) payment methodology, which encourages service coordination and efficiencies. After prolonged negotiations, an existing broker discontinued its participation in the NEMT program, requiring DVHA to work with bordering established brokers to provide coverage for the affected service area with no breaks in service for beneficiaries. Letters were mailed to beneficiaries notifying them of the change.

Through better case management and coordination between Provider and Member Relations and the Program Integrity unit, DVHA is progressing toward its goals to slow the growth in NEMT costs and improve service quality.

DVHA implemented several improvements to the bus pass program. DVHA has partnered with its Member Services contractor Maximus to monitor bus pass use and verify appointments prior to authorizing the services.

Transition to the PMPM model interrupted direct cost growth but administrative costs were slightly higher than expected during implementation. Stability in the system going forward should allow for additional administrative savings.

### **Demonstration Evaluation**

The AHS Quality Improvement Manager (QIM) continued to work with evaluation staff at the Pacific Health Policy Group (PHPG) to complete the demonstration evaluation. The evaluation will determine the Demonstration's progress toward accomplishing its three goals of increasing access, improving quality, and controlling costs and will include both quantitative and qualitative analyses of enrollment statistics, quality of health care measurement information, and beneficiary survey results. A draft evaluation report will accompany Vermont's waiver renewal application.

### **Reported Purposes for Capitated Revenue Expenditures**

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

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

Attachment 6 is a summary of Managed Care Entity Investments, with applicable category identified, for State Fiscal Year 2012.

### **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 Health Care Ombudsman Report

Attachment 6: DVHA Managed Care Entity Investment Summary

**State Contact(s)**

Fiscal: Jim Giffin, CFO  
VT Agency of Human Services 802-871-3005 (P)  
208 Hurricane Lane 802-871-3001 (F)  
Williston, VT 05495 [jim.giffin@state.vt.us](mailto:jim.giffin@state.vt.us)

Policy/Program: Stephanie Beck, Director  
AHS Health Care Operations, Compliance, and Improvement  
VT Agency of Human Services 802-871-3265 (P)  
208 Hurricane Lane 802-871-3001 (F)  
Williston, VT 05495 [stephanie.beck@state.vt.us](mailto:stephanie.beck@state.vt.us)

Managed Care Entity: Mark Larson, Commissioner  
Department of VT Health Access 802-879-5901 (P)  
312 Hurricane Lane, Suite 201 802-879-5952 (F)  
Williston, VT 05495 [mark.larson@state.vt.us](mailto:mark.larson@state.vt.us)

**Date Submitted to CMS: May 30, 2013**

## **ATTACHMENTS**



**State of Vermont**  
**Department of Vermont Health Access**  
 312 Hurricane Lane, Suite 201  
 Williston VT 05495-2807  
[dvha.vermont.gov](http://dvha.vermont.gov)

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

*Agency of Human Services*

**The Department of Vermont Health Access**  
**Caseload and Expenditure Report ~ All AHS Medicaid Spend**  
**All AHS YTD '13**  
 Wednesday, May 29, 2013

	SFY '13 Appropriated			SFY '13 Budget Adjustment			SFY '13 Actuals thru March 31, 2013			% of Approp.	% of BAA
	Caseload	Expenses	PMPM	Caseload	Expenses	PMPM	Caseload	Expenses	PMPM	Spent to Date	Spent to date
ABD Adult	14,445	\$ 171,838,251	\$ 991.36	14,189	\$ 168,678,573	\$ 990.65	14,262	\$ 120,360,981	\$ 937.68	70.04%	71.36%
ABD Dual	17,155	\$ 194,934,351	\$ 946.93	17,215	\$ 192,935,162	\$ 933.93	17,070	\$ 130,137,936	\$ 847.07	66.76%	67.45%
General Adult	11,686	\$ 79,100,241	\$ 564.08	11,614	\$ 73,162,753	\$ 524.96	11,386	\$ 53,540,935	\$ 522.47	67.69%	73.18%
VHAP	38,799	\$ 173,502,508	\$ 372.65	37,340	\$ 159,569,907	\$ 356.12	37,178	\$ 117,613,405	\$ 351.51	67.79%	73.71%
VHAP ESI	810	\$ 2,006,576	\$ 206.35	807	\$ 1,429,801	\$ 147.62	774	\$ 775,852	\$ 111.38	38.67%	54.26%
Catamount	11,440	\$ 62,002,768	\$ 451.65	11,582	\$ 59,153,214	\$ 425.61	11,615	\$ 39,147,193	\$ 374.50	63.14%	66.18%
ESIA	874	\$ 2,270,715	\$ 216.52	766	\$ 1,000,629	\$ 108.80	769	\$ 578,636	\$ 83.64	25.48%	57.83%
ABD Child	3,614	\$ 93,601,570	\$ 2,158.44	3,727	\$ 87,208,278	\$ 1,950.14	3,706	\$ 60,908,434	\$ 1,826.29	65.07%	69.84%
General Child	55,564	\$ 228,797,327	\$ 343.14	55,519	\$ 226,071,854	\$ 339.33	55,231	\$ 152,004,934	\$ 305.79	66.44%	67.24%
Underinsured Child	943	\$ 2,088,216	\$ 184.56	1,029	\$ 2,101,240	\$ 170.14	1,015	\$ 1,447,468	\$ 158.51	69.32%	68.89%
SCHIP	4,017	\$ 10,358,905	\$ 214.90	4,017	\$ 9,289,125	\$ 192.69	4,145	\$ 7,425,065	\$ 199.04	71.68%	79.93%
Pharmacy Only	12,698	\$ 4,777,918	\$ 31.36	12,565	\$ (440,929)	\$ (2.92)	12,553	\$ 2,437,380	\$ 21.57	51.01%	-552.78%
Choices for Care	3,758	\$ 198,654,108	\$ 4,405.70	3,859	\$ 203,142,801	\$ 4,387.16	3,915	\$ 147,443,737	\$ 4,184.23	74.22%	72.58%
<b>Total Medicaid</b>	<b>175,802</b>	<b>\$ 1,223,933,456</b>	<b>\$ 580.17</b>	<b>174,230</b>	<b>\$ 1,183,302,408</b>	<b>\$ 565.97</b>	<b>173,619</b>	<b>\$ 833,821,954</b>	<b>\$ 533.62</b>	<b>68.13%</b>	<b>70.47%</b>

**The Department of Vermont Health Access**  
**Caseload and Expenditure Report ~ DVHA Only Medicaid Spend**  
**DVHA YTD '13**  
 Wednesday, May 29, 2013

	SFY '13 Appropriated			SFY '13 Budget Adjustment			SFY '13 Actuals thru March 31, 2013			% of Approp.	% of BAA
	Caseload	Expenses	PMPM	Caseload	Expenses	PMPM	Caseload	Expenses	PMPM	Spent to Date	Spent to Date
ABD Adult	14,445	\$ 100,440,442	\$ 579.46	14,189	\$ 97,260,433	\$ 571.21	14,262	\$ 70,422,846	\$ 548.63	70.11%	72.41%
ABD Dual	17,155	\$ 48,138,865	\$ 233.84	17,215	\$ 46,097,874	\$ 223.14	17,070	\$ 33,260,575	\$ 216.49	69.09%	72.15%
General Adult	11,686	\$ 71,664,326	\$ 511.06	11,614	\$ 65,724,721	\$ 471.59	11,386	\$ 48,887,319	\$ 477.06	68.22%	74.38%
VHAP	38,799	\$ 161,957,523	\$ 347.86	37,340	\$ 148,021,635	\$ 330.34	37,178	\$ 109,708,243	\$ 327.88	67.74%	74.12%
VHAP ESI	810	\$ 2,006,576	\$ 206.35	807	\$ 1,429,801	\$ 147.62	774	\$ 774,309	\$ 111.16	38.59%	54.16%
Catamount	11,440	\$ 62,002,768	\$ 451.65	11,582	\$ 59,153,214	\$ 425.61	11,615	\$ 39,147,193	\$ 374.50	63.14%	66.18%
ESIA	874	\$ 2,270,715	\$ 216.52	766	\$ 1,000,629	\$ 108.80	769	\$ 578,636	\$ 83.64	25.48%	57.83%
ABD Child	3,614	\$ 35,654,068	\$ 822.18	3,727	\$ 29,244,275	\$ 653.96	3,706	\$ 24,878,237	\$ 745.95	69.78%	85.07%
General Child	55,564	\$ 123,109,797	\$ 184.64	55,519	\$ 120,354,228	\$ 180.65	55,231	\$ 84,148,504	\$ 169.28	68.35%	69.92%
Underinsured Child	943	\$ 677,890	\$ 59.91	1,029	\$ 690,513	\$ 55.91	1,015	\$ 550,256	\$ 60.26	81.17%	79.69%
SCHIP	4,017	\$ 7,598,806	\$ 157.64	4,017	\$ 6,528,240	\$ 135.42	4,145	\$ 5,474,987	\$ 146.76	72.05%	83.87%
Pharmacy Only	12,698	\$ 4,777,918	\$ 31.36	12,565	\$ (440,929)	\$ (2.92)	12,553	\$ 2,437,380	\$ 21.57	51.01%	-552.78%
Choices for Care	3,758	\$ 198,654,108	\$ 4,405.70	3,859	\$ 203,142,801	\$ 4,387.16	3,915	\$ 147,443,737	\$ 4,184.23	74.22%	72.58%
<b>Total Medicaid</b>	<b>175,802</b>	<b>\$ 818,953,805</b>	<b>\$ 388.20</b>	<b>174,230</b>	<b>\$ 778,207,433</b>	<b>\$ 372.21</b>	<b>173,619</b>	<b>\$ 567,712,220</b>	<b>\$ 363.32</b>	<b>69.32%</b>	<b>72.95%</b>

## Glossary of Terms

**PMPM** – Per Member Per Month

**MEG** – Medicaid Eligibility Group

**ABD Adult** – Beneficiaries over age 18; categorized as aged, blind, disabled, and/or medically needy

**ABD Child** – Beneficiaries age 18 or under; categorized as blind, disabled, and/or medically needy

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

**General Adult** – Beneficiaries over age 18; pregnant women or parents/caretaker relatives of minor children receiving cash assistance and those receiving transitional Medicaid after the receipt of cash assistance

**General Child** – Beneficiaries age 18 or under, and below the protected income level, categorized as those eligible for cash assistance including Reach Up (Title V) and foster care payments (Title IV-E)

**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

**Underinsured Child** – Beneficiaries age 18 or under with household income 225-300% FPL with other insurance

**CHIP** – Beneficiaries under 18 with household income 225-300% FPL with no other insurance

**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

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

**Choices for Care** - Vermont's Long Term Care Medicaid Program; for Vermonters in nursing homes, home-based settings, enhanced residential care (ERC), and program for all-inclusive care for the elderly (PACE)

Global Commitment Expenditure Tracking

QE	Quarterly Expenditures										Net Program PQA	Net Program Expenditures as reported on 64	non-MCO Admin Expenses	Total columns J:K for Budget Neutrality calculation	Cumulative Waiver Cap per 1/1/11 STCs	Variance to Cap under/(over)
	PQA: WY1	PQA: WY2	PQA: WY3	PQA: WY4	PQA: WY5	PQA: WY6	PQA: WY7	PQA: WY8	PQA: WY9							
1205	\$ 178,493,793										\$ 178,493,793					
0306	\$ 189,414,365	\$ 14,472,838									\$ 14,472,838	\$ 203,887,203				
0606	\$ 209,647,618	\$ (14,172,165)									\$ (14,172,165)	\$ 195,475,453				
0906	\$ 194,437,742	\$ 133,350									\$ 133,350	\$ 194,571,092				
WY1 SUM	\$ 771,993,518	\$ 434,023									\$ 434,023	\$ 782,159,845	\$ 4,620,302	\$ 786,780,147	\$ 841,266,663	\$ 54,486,516
1206	\$ 203,444,640	\$ 8,903									\$ 8,903	\$ 203,453,543				
0307	\$ 203,804,330	\$ 8,894,097									\$ 8,894,097	\$ 212,698,427				
0607	\$ 186,458,403	\$ 814,587	\$ (68,408)								\$ 746,179	\$ 187,204,582				
0907	\$ 225,219,267	\$ -	\$ -								\$ -	\$ 225,219,267				
WY2 SUM	\$ 818,926,640	\$ 9,717,587	\$ (68,408)								\$ 9,649,179	\$ 802,884,359	\$ 6,464,439	\$ 809,348,797	\$ 1,684,861,317	\$ 88,732,372
Cumulative																
1207	\$ 213,871,059	\$ -	\$ 1,010,348								\$ 1,010,348	\$ 214,881,406				
0308	\$ 162,921,830	\$ -	\$ -								\$ -	\$ 162,921,830				
0608	\$ 196,466,768	\$ 14,717	\$ -	\$ 40,276,433							\$ 40,291,150	\$ 236,757,918				
0908	\$ 228,593,470	\$ -	\$ -	\$ -							\$ -	\$ 228,593,470				
WY3 SUM	\$ 801,853,126	\$ 14,717	\$ 1,010,348	\$ 40,276,433							\$ 41,301,498	\$ 881,729,256	\$ 6,457,896	\$ 888,187,152	\$ 2,604,109,308	\$ 119,793,211
Cumulative																
1208	\$ 228,768,784	\$ -	\$ -								\$ -	\$ 228,768,784				
0309	\$ 225,691,930	\$ (16,984,221)	\$ 38,998,635	\$ (4,144,041)							\$ 17,870,373	\$ 243,562,303				
0609	\$ 204,169,638	\$ -	\$ 686,851	\$ 5,522,763							\$ 6,209,614	\$ 210,379,252				
0909	\$ 235,585,153	\$ -	\$ 30,199	\$ 34,064,109							\$ 34,094,308	\$ 269,679,461				
WY4 SUM	\$ 894,215,505	\$ -	\$ (16,984,221)	\$ 39,715,685	\$ 35,442,831						\$ 58,174,295	\$ 935,368,819	\$ 5,495,618	\$ 940,864,437	\$ 3,606,430,571	\$ 181,250,037
Cumulative																
1209	\$ 241,939,196	\$ -	\$ -	\$ 5,192,468							\$ 5,192,468	\$ 247,131,664				
0310	\$ 246,257,198	\$ -	\$ -	\$ 531,141	\$ 4,400,166						\$ 4,931,306	\$ 251,188,504				
0610	\$ 253,045,787	\$ -	\$ -	\$ 248,301	\$ 5,260,537						\$ 5,508,838	\$ 258,554,625				
0910	\$ 252,294,668	\$ -	\$ (115,989)	\$ (261,426)	\$ 3,348,303						\$ 2,970,888	\$ 255,265,556				
WY5 SUM	\$ 993,536,849	\$ -	\$ -	\$ (115,989)	\$ 5,710,484	\$ 13,009,006					\$ 18,603,501	\$ 1,012,990,839	\$ 5,949,605	\$ 1,018,940,444	\$ 4,700,022,174	\$ 255,901,196
Cumulative																
1210	\$ 262,106,988	\$ -	\$ -	\$ -	\$ 6,444,984						\$ 6,444,984	\$ 268,551,972				
0311	\$ 257,140,611	\$ -	\$ -	\$ -	\$ -						\$ -	\$ 257,140,611				
0611	\$ 277,708,043	\$ -	\$ -	\$ -	\$ -	\$ (121,416)					\$ (121,416)	\$ 277,586,627				
0911	\$ 243,508,248	\$ -	\$ -	\$ -	\$ -	\$ 5,528,143					\$ 5,528,143	\$ 249,036,391				
WY6 SUM	\$ 1,040,463,890	\$ -	\$ -	\$ -	\$ -	\$ 6,444,984	\$ 5,406,727				\$ 11,851,711	\$ 1,045,342,616	\$ 6,071,553	\$ 1,051,414,168	\$ 5,865,213,737	\$ 369,678,591
Cumulative																
1211	\$ 253,147,037	\$ -	\$ -	\$ -	\$ -	\$ (531,744)					\$ (531,744)	\$ 252,615,293				
0312	\$ 267,978,672	\$ -	\$ -	\$ -	\$ 3,742	\$ 49,079					\$ 52,821	\$ 268,031,493				
0612	\$ 302,958,610	\$ -	\$ -	\$ -	\$ -	\$ 6,393,928					\$ 6,393,928	\$ 309,352,538				
0912	\$ 262,406,131	\$ -	\$ -	\$ -	\$ -	\$ 7,750,994					\$ 7,750,994	\$ 270,157,125				
WY7 SUM	\$ 1,086,490,450	\$ -	\$ -	\$ -	\$ -	\$ (528,002)	\$ 14,194,000				\$ 13,665,998	\$ 1,104,712,237	\$ 5,751,066	\$ 1,110,463,303	\$ 7,113,290,903	\$ 507,292,454
Cumulative																
1212	\$ 282,701,072	\$ -	\$ -	\$ -	\$ -	\$ 3,036,447					\$ 3,036,447	\$ 285,737,519				
0313	\$ 285,985,057	\$ -	\$ -	\$ -	\$ -	\$ 991,340					\$ 991,340	\$ 286,976,397				
0613	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -					\$ -	\$ -				
0913	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -					\$ -	\$ -				
WY8 SUM	\$ 568,686,129	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 4,027,787	\$ -			\$ 4,027,787	\$ 568,686,129	\$ 2,582,972	\$ 571,269,101	\$ 8,450,684,486	\$ 1,273,416,936
Cumulative																
1213	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -			\$ -	\$ -				
WY9 SUM	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Cumulative	\$ 6,976,166,107	\$ 10,166,327	\$ (16,042,281)	\$ 79,876,130	\$ 41,153,315	\$ 19,453,990	\$ 4,878,725	\$ 18,221,787	\$ -	\$ -	\$ -	\$ 7,133,874,100	\$ 43,393,451	\$ 7,177,267,550	\$ 8,955,886,798	\$ 1,778,619,248

**Complaints Received by Health Access Member Services**  
**January 1, 2013 – March 31, 2013**

Eligibility forms, notices, or process	28
ESD Call-center complaints (IVR, rudeness, hold times)	3
Use of social security number as identifiers	1
General premium complaints	2
Catamount Health Assistance Program premiums, process, ads, plans	10
Coverage rules	2
Member services	2
Eligibility rules	2
Eligibility local office	1
Prescription drug plan complaint	0
Copays/service limit	0
Pharmacy coverage	1
Provider issues (perceived rudeness, refusal to provide service, prices) (variety of provider types) Provider enrollment issues	7
Chiropractic coverage change	0
Shortage of enrolled dentists	0
Green Mountain Care Website	2
DVHA	0
<hr/> Total	<hr/> 62



**Grievance and Appeal Quarterly Report  
Medicaid MCE All Departments Combined Data  
January 1, 2013 – March 31, 2013**

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 January 2, 2013, from the centralized database for grievances and appeals that were filed from January 1, 2013 through March 31, 2013.

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 16 grievances filed with the MCE; eight 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 two days. Of the grievances filed, 72% were filed by beneficiaries, 21% were filed by a representative of the beneficiary and 7% were filed by other. Of the 16 grievances filed, DMH had 79%, DAIL had 14% and DVHA had 7%. There were no grievances filed for the DCF, or VDH during this quarter.

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

There was one Grievance Review filed this quarter that was still pending at the end of the quarter.

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

These actions are:

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

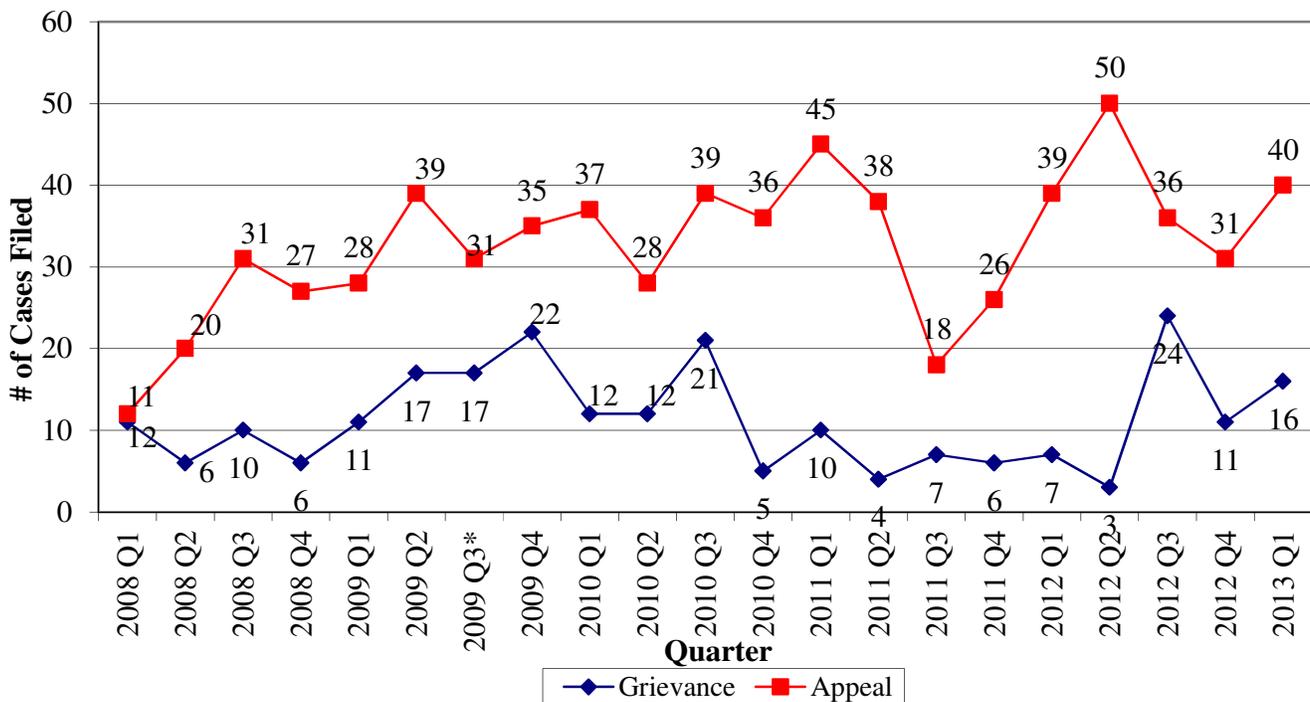
During this quarter, there were 40 appeals filed with the MCE; 13 requested an expedited decision with eight of them meeting criteria. Of these 40 appeals, 26 were resolved (65% of filed appeals), 12 were still pending (30%), and 1 was filed too late (5%). In nine cases (35% of those resolved), the original decision was upheld by the person hearing the appeal, ten cases (38% of those resolved) were reversed, one had a modified approval (4%), and six were approved by the applicable department/DA/SSA before the appeal meeting (23% of those resolved).

Of the 26 appeals that were resolved this quarter, 96% were resolved within the statutory time frame of 45 days, with one (4%) being extended by the beneficiary; 92% were resolved within 30 days. The average number of days it took to resolve these cases was 12 days. Acknowledgement letters of the receipt of an appeal must be sent within five days; the average was three days.

Of the 40 appeals filed, 22 were filed by beneficiaries (55%), 14 were filed by a representative of the beneficiary (35%) and 4 were filed by the provider (10%). Of the 40 appeals filed, DVHA had 73%, DAIL had 22%, and VDH had 5%.

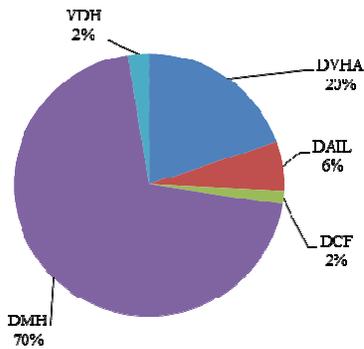
Beneficiaries can file an appeal and a fair hearing at the same time, and they can file a fair hearing if their appeal is not decided in their favor. There were two fair hearings filed this quarter.

### Medicaid MCE Grievances & Appeals

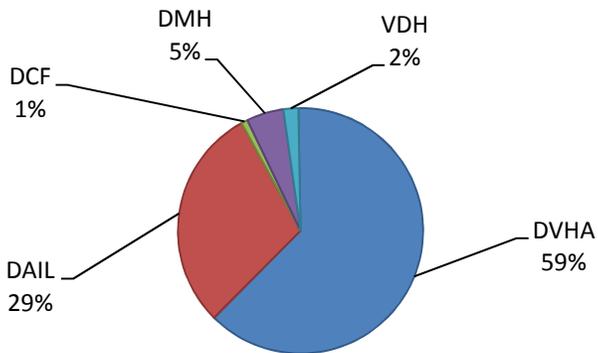


### MCE Grievance & Appeals by Department From January 1, 2008 through March 31, 2013

#### Grievances



#### Appeals



# VERMONT LEGAL AID, INC.

## 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

January 1, 2013 – March 31, 2013

to the

DEPARTMENT OF FINANCIAL REGULATION

and the

DEPARTMENT OF VERMONT HEALTH ACCESS

submitted by

Trinka Kerr, Vermont Health Care Ombudsman

April 16, 2013

## 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 January 1, 2013, through March 31, 2013. 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. We don't necessarily get a caller's insurance status in every case. In the interests of efficiency, sometimes we don't ask if it is not relevant to the caller's issue.

Note that the most accurate information about 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.

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 was about the same as last quarter, but eligibility errors by DCF tripled which caused a small spike in calls in February.**

### All Calls

The HCO received 835 calls this quarter, compared to 842 in the previous quarter. This first quarter 2013 call volume was about an 8% increase over the first quarter of 2012, when we received 778 calls. In 2011 we received 856 calls in the first quarter.

January and March 2013 were about the same as last year, but February's call volume increased by 21% over last year, from 233 to 283. This was the busiest February ever, in part because we saw a higher error rate in eligibility processing by the Economic Services Division of the Department for Children and Families (DCF). Mistakes by DCF more than tripled, from 11 to 35.

Part of this increase was due to one specific systems glitch. Benefit closure notices for non-payment of premium were generated on Friday February 15<sup>th</sup>, which was also the due date for premium payment and the day that most DVHA beneficiaries have their premiums electronically transferred from their bank accounts. Our understanding is that the closure notices went out then because it was the beginning of a holiday weekend (Presidents' Day) which meant that no mail would go out until Tuesday February 19<sup>th</sup>. Pursuant to state regulations, closure notices must be mailed eleven days prior to termination. If these notices were mailed on the 19<sup>th</sup>, beneficiaries would not have received the requisite ten days notice because February is a short month. So, the notices were generated on the 15<sup>th</sup> to ensure the requisite ten days of advance notice. However, this meant that termination notices went out before the system recorded the payments that came in on the 15<sup>th</sup>. Thus, many people got closure notices for non-payment even though they had paid their premiums.

These benefit closure notices generated hundreds of calls to Green Mountain Care Member Services and overwhelmed their phone lines. DVHA beneficiaries who received the notices of termination began calling the HCO when they couldn't get through to Member Services, or because they were still concerned about losing their insurance after speaking to Member Services.

*Recommendation to DVHA and DCF:* Although this specific timing issue will not occur very often, every February DVHA should ensure closure notices for non-payment of premium are not sent out the same day as the due date for premium payment. This will be especially important after DVHA begins operating Vermont's health benefits exchange, Vermont Health Connect, and processing premium payments for many more individuals.

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

### **B. The top issues generating calls were:**

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

### All Calls (835)

1. Affordability 135 (compared to 149 last quarter)
2. Information about applying for DVHA programs 112 (136 last quarter)
3. Access to Prescription Drugs 94 (82 last quarter)

4. Complaints about Providers 89 (97 last quarter)
5. Eligibility for VHAP 82 (82 last quarter)
6. Communication Problems with DCF 69 (73 last quarter)
7. Eligibility for Medicaid 68 (77 last quarter)
8. Eligibility for Premium Assistance 50 (55 last quarter)
9. Consumer Education about Medicare 42 (72 last quarter)
10. Hospital Billing 36 (36 last quarter, no change)
11. DCF Mistake 35 (11 last quarter)
12. Consumer Education about Fair Hearings 35 (33 last quarter)

#### DVHA Beneficiary Calls (440)

1. Affordability 57 (62 last quarter)
2. Complaints about Providers 55 (47 last quarter)
3. Information about applying for DVHA programs 52 (41 last quarter)
4. Access to Prescription Drugs 40 (43 last quarter)  
Eligibility for VHAP 40 (34 last quarter)
5. Eligibility for Medicaid 38 (25 last quarter)
6. Communication Problems with DCF 33 (40 last quarter)
7. Fair Hearings 26 (27 last quarter)
8. Transportation 24 (24 last quarter)
9. DCF Mistake 24 (7 last quarter)
10. Access to a Primary Care Doctor 23 (10 last quarter)

#### **C. Lack of affordability remains the largest barrier to consumer access to health care, even for the insured, and especially for DVHA beneficiaries.**

Lack of affordability continued to be the most-identified barrier to access to health care. The HCO had 135 calls, about 16% of all calls, in which the consumer said that cost was making it difficult for them to get care. Of these 135 calls, 57 or 45% were from DVHA beneficiaries. The inability to access care due to the cost of a service, or the cost of insurance, is an issue for consumers across all groups, those insured by state programs, federal programs, private companies, and the uninsured.

Callers for whom affordability was a barrier to access broke down as follows, based on the caller's insurance status:

- DVHA programs: 57 calls; 4 calls as a primary issue, 53 as a secondary;
- Commercially insured: 28 calls; 6 calls as a primary issue, 22 as a secondary;
- Uninsured: 32 calls; 3 calls as a primary issue, 29 as a secondary; and
- In 8 calls we did not get the caller's insurance status.

*The most frequently cited affordability issues for DVHA beneficiaries, in descending order were:*

- *Eligibility for insurance*, usually due to income changes, problems with eligibility determinations or difficulties affording CHAP cost-sharing or premiums. Often they called us because they had a gap in coverage due to changes in their insurance status. Problems with eligibility were by far the most common reason for a complaint about affordability, but the underlying reasons varied greatly

- *Coordination of benefits* for DVHA beneficiaries who had other insurance as primary. Usually these presented as the beneficiary being billed the co-insurance or copayment, and usually the primary insurer or the provider were at fault.
- *Lack of dental coverage*, or insufficient dental coverage.
- *Out of network problems*, or providers who would not accept Vermont Medicaid.
- *Cost-sharing* such as the inability to cover the cost of copayments, or problems with copayments.
- *Medicare cost-sharing*, often connected to spenddowns or the Medicare Savings Programs.

*Recommendations to DVHA:* Reduce churn and the transitions from program to program. Decrease premiums and cost-sharing. Increase dental coverage. Increase payment levels to providers, so more will be willing to become enrolled with Vermont Medicaid. Assign a designated eligibility worker to assist beneficiaries on the spenddown program.

**D. Desire for more information about DVHA programs remains high.**

The HCO continues to provide consumer education about DVHA programs to a high percentage of callers. It was the second most common issue overall. Interest in DVHA's programs is due to a number of factors: the cost of commercial plans, the high degree of complexity of the programs which results in questions about the rules and navigating the requirements for eligibility, confusing notices from DCF, and insufficient education provided by DCF workers or Member Services.

*Recommendation to DVHA:* Encourage DCF staff and Member Services to make sure their clients understand how the programs work, and provide additional training and staffing if necessary. Improve notices to make them readable and clear. Provide applicants and beneficiaries with written materials that explain the programs and checklists.

**E. Access to prescription drugs continues to be a problem for many.**

For the second consecutive quarter, calls about access to prescription medication increased. There was about a 12 % increase from last quarter in access to prescription medication calls, an increase from 82 to 94 calls. Access to prescription drugs was a major problem for all consumer groups throughout 2012 and continues to be one in 2013. The reasons for this problem vary.

**F. DVHA beneficiaries are increasingly having problems finding a primary care physician.**

Calls from DVHA beneficiaries who could not find a primary care physician more than doubled, jumping from 10 to 23. By comparison, only 1 individual on commercial insurance called with a PCP access issue, and only 3 uninsured individuals did so.

*Recommendation to DVHA:* Continue to work to increase the number of PCPs who are willing to accept Vermont Medicaid beneficiaries as new patients.

### **G. Dissatisfaction with providers continues to be a problem, especially among DVHA beneficiaries.**

This quarter 55 DVHA beneficiaries complained about their providers, compared to 47 last quarter, about a 15% increase. Overall, though, the number of these complaints from all callers dropped slightly from 97 to 89.

### **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:** 835 calls;
  - **DVHA beneficiaries:** 440 calls or **53%** of total calls;
  - **Commercial plan beneficiaries:** 133 calls or **16%**; and
  - **Uninsured Vermonters:** 84 calls or **10%**.

## **II. Green Mountain Care Board activities**

Pursuant to Act 48 of 2011 and Act 171 of 2012, the Green Mountain Care Board (GMCB) is required to consult with the HCO about various health care reform issues. HCO activities for the past quarter included:

- Attending ten GMCB meetings.
- Participating in two meetings of the Accountable Care Organization (ACO) Measures Work Group convened by the Board's Director of Payment Reform. This work group is one of three groups working to support the Board's initiative to establish population-based payment pilots with ACO's. The group will identify standardized measures that will be used for commercial plans and Medicaid to: evaluate the performance of Vermont's Accountable Care Organizations (ACOs), qualify and modify shared savings payments and guide improvements in health care delivery.
- Working with the GMCB and insurers on legislative revisions of the rate review process.
- Commenting on the GMCB's global budget in January. We emphasized the importance of including the costs of home and community based long term care services in the budget, placing increased focus on quality measures and not creating new incentives to limit medically necessary treatment

## **III. Rate review activities**

There were very few rate filings which were ready for review by the Green Mountain Care Board in this calendar quarter. The HCO filed appearances in five new rate cases, appeared at two contested hearings and filed two memoranda. At the end of March there were 22 rate filings pending at either the Department of Financial Regulation (DFR) initial review stage or the DFR recommendation stage of the review process. These include the BCBS and MVP filings for products to be offered on the Health Benefit Exchange, Vermont Health Connect.

In December 2012, the HCO spoke to a number of actuaries about the possibility of doing independent analysis of some of the Vermont rate filings to determine whether such independent reviews would add new and helpful information to the rate review process. We ultimately contracted with Allan I. Schwartz of AIS Risk Consultants in Freehold, New Jersey to review the filing in GMCB 2-13-rr, the Blue Cross and Blue Shield of Vermont First Quarter through Third Quarter 2013 Non-Group Rate Filing. This filing proposed increasing rates by an average of 11.4% over 2012 rates for policy holders renewing in the first quarter of 2013, 19.6% for those renewing in the second quarter and 19.5% for those renewing in the third quarter. The Commissioner of DFR recommended modifying the rate increases by eliminating a proposed 2% contribution to surplus, resulting in quarterly rates of 9.4%, 17.6%, and 17.5%. Mr. Schwartz testified by phone at the hearing on the filing on March 20, 2013. The Board disapproved the requested rate increases, based largely on Mr. Schwartz's testimony.

HCO staff attended ten meetings of the Green Mountain Care Board this quarter. At the February 21, 2013, meeting we recommended that the State develop materials explaining the timing of the rate review process for plans offered through Vermont Health Connect. The Board's Stakeholder Engagement Coordinator subsequently worked with DFR and DVHA to develop a time line explaining milestones for both the qualified health plan approval process and the means for consumers to review and enroll in plans. This timeline was published in March.

The HCO commented on draft changes to the Board's rate review regulations, Rule 2.000, in February. After receiving comments, the Board decided not to change the rule at this time and to wait until the legislature decides whether or not to change the current two-step rate review process. Such legislation is currently pending.

HCO staff participated in several training and educational activities related to rate reviews this quarter. Staff attended a DFR presentation on new federal rating requirements and rate submission requests in January. In February, we participated in two phone calls with staff working on rate review issues in other states and in national back up centers. We also participated in a webinar training about Vermont Health Connect in February.

The HCO added additional staff to work on rate reviews this quarter. Kaili Kuiper began working as a full-time staff attorney with the HCO on February 4, 2013. She spends about 50% of her time on rate review activities, including doing research in preparation for the rate review filings for the Qualified Health plans to be offered through Vermont Health Connect. She co-counseled cases with staff attorney Lila Richardson in the recent BCVT 1Q-3Q13 non-group rate filing and the TVHP 1Q-2Q13 small group rate filing. In addition, the HCO selected a law school intern to assist on rate review cases, including the filings for the Exchange. She will begin in May.

#### **IV. Hotline call volume by type of insurance:**

The HCO received 835 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 **53%** (440 calls), compared to 44% (373) 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 **30%** (249), compared to 28% (233) last quarter;
  - **9% of all callers** (73) had **Medicare only**;
  - **19%** (156) 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%** (4) had a **Medicare Supplemental** plan;
  - **<1%** (6) had a **Medicare Advantage (Medicare Part C)** plan; 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%** (133), compared to 16% (150) last quarter; and
- **Uninsured** callers made up **10%** (84) of the calls, compared to 11% (94) last quarter.
- In the remainder of calls the insurance status was either unknown or not relevant.

## V. Disposition of closed cases

### All Calls

We closed 813 cases this quarter, compared to 872 last quarter.

- 37% (304 cases) were resolved by brief analysis and advice;
- 23% (191) were resolved by brief analysis and referral;
- 16% (132) of the cases were complex interventions, which involves complex analysis, usually direct intervention, and more than two hours of an advocate's time;
- 15% (122) were resolved by direct intervention, including calling an insurance company, calling providers, writing letters, gathering supporting medical documentation, etc.;
- 3% (23) of the cases were resolved in the initial call.
- In the remaining cases, clients withdrew, resolved the issue on their own, or had some other outcome
- Appeals: 43 cases involved help with appeals.

### DVHA Beneficiary Calls

We closed 418 DVHA cases this quarter, compared to 391 last quarter.

- 36% (152 cases) were resolved by brief analysis and advice;
- 25% (103) were resolved by brief analysis and referral;
- 16% (66) were considered complex intervention, which involves complex analysis, usually direct intervention, and more than two hours of an advocate's time;

- 17% (71) were resolved by direct intervention on the caller's behalf, including advocacy with DVHA and providers, writing letters, and gathering medical information;
- 2% of calls (10) from DVHA beneficiaries were resolved in the initial call.
- In the remaining cases, clients withdrew, resolved the issue on their own, or had some other outcome.
- Appeals: 31 cases involved help with appeals, of which 2 were internal appeals and 29 were Fair Hearings.

## VI. Case outcomes

### All Calls

The HCO helped 42 people get insurance and prevented 23 insurance terminations or reductions. We obtained coverage for services for 15 people. We got 26 claims paid, written off or reimbursed. We assisted 2 people complete applications for DVHA programs and estimated program eligibility for 17 more. We provided billing assistance to 19 individuals. We obtained patient assistance for 2 people. We provided 466 individuals with advice and education. We obtained other access or eligibility outcomes for 42 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 \$31,541.60.**

### DVHA Beneficiary Calls

The HCO prevented 22 terminations or reductions in coverage for DVHA beneficiaries, and got 6 more people onto different DVHA programs. We estimated the eligibility for other programs for 4 DVHA beneficiaries. We got 14 claims paid, written off or reimbursed. We got other billing assistance for 10 people, and hospital patient assistance for 1 individual. We obtained coverage for services for 12 individuals. We provided 236 DVHA beneficiaries with advice or education, and obtained other access or eligibility outcomes for 27 more people.

Here are some examples of the kinds of work we did this quarter:

- Facilitated prescription coverage: Ms. A was pregnant and very ill. She suffered from severe morning sickness and as a result was losing weight. Her provider had written a prescription for this, but when she went to pick it up, the pharmacist told her it was not covered. Because Ms. A could not afford the full cost of the drug and was so sick, she left the pharmacy and went to the emergency room for care. She subsequently contacted the HCO. The HCO advocate worked with the provider, the pharmacy, and DVHA to get the proper prior authorization for the medication so she could afford it.
- Educated consumers about insurance: Ms. B was overwhelmed with medical bills and insurance paperwork. Pregnant and unsure about what her insurance covered and how she could pay for pre-natal care, she contacted the HCO. The HCO advocate reviewed Ms. B's insurance plan with her, explained her coverage and helped her understand the costs that were her responsibility.
- Saved consumers money: The C family was denied premium assistance for Catamount or CHAP. Because they knew they really needed insurance, the family paid the full

premium price for three months, which was a serious financial hardship for them. After they called the HCO because they could no longer afford the full cost of their Catamount plan, the HCO advocate determined that they actually were eligible for CHAP. The family was reimbursed more than \$2,500.

- Prevented terminations of coverage: Mr. D called because he received a notice that his VHAP was terminating due to increased income. The HCO advocate checked his eligibility and determined that although he was no longer eligible for VHAP, he was eligible for CHAP. The advocate worked with DCF to make sure that Mr. D transitioned to CHAP and did not suffer a gap in coverage.

## VII. 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 233 cases had Eligibility as the primary issue, there were actually a total of 430 calls in which we spent a significant amount of time assisting consumers regarding access to health insurance. See the breakdowns of the issue numbers in the individual data reports for a more detailed look at how many callers had questions about issues other than the primary reason for their call.

The information in this section is for All Calls and includes calls in which the issue listed was the caller's primary issue. See the DVHA data report for a similar breakdown for the DVHA beneficiaries who called us.

- **27.43%** (229) of our total calls were regarding **Access to Care**;
- **15.21%** (127) were regarding **Billing/Coverage**;
- **.36%** (3) were questions regarding **Buying Insurance**;
- **7.78%** (64) were **Consumer Education**;
- **27.90%** (233) were regarding **Eligibility** for state programs, Medicare and Catamount Health plans; and
- **21.44%** (179) were categorized as **Other**, which includes Medicare Part D, communication problems with providers or plans, access to medical records, changing providers or plans, enrollment problems, confidentiality issues, and complaints about insurance premium rates.

### A. Access to Care (27.43% of all calls)

We received 229 calls from individuals for whom the primary issue was difficulty getting specific health care, a very slight increase from last quarter's 224 calls. The top Access to Care issues, out of over 35 codes were, in descending order:

- 40 calls were for problems obtaining Prescription Drugs, not including Medicare Part D, compared to 45 last quarter;
- 21 Transportation to medical appointments, compared to 19;
- 19 Dental, Dentists, Dentures or Orthodontic care, compared to 22;
- 18 Primary Care Doctor, compared to 7;
- 14 Durable Medical Equipment (DME), Supplies and Wheelchairs, compared to 13;
- 14 Affordability of health care, compared to 11;
- 10 Mental Health (not including Substance Abuse), compared to 17; and

- 10 Specialty Care, compared to 22.

#### **B. Billing/Coverage (15.21%)**

We received 127 calls related to primary issues with billing, compared to 115 last quarter. The top billing related issues were:

- 21 Hospital billing, compared to 21 last quarter;
- 17 Claim denials by insurers, compared to 13;
- 15 Copayments, compared to 3;
- 11 Provider problems, compared to 11;
- 7 Premiums, compared to 7; and
- 6 Part D plans, compared to 4.

#### **C. Consumer Education (7.66%)**

We received 64 calls in which consumer education was the primary issue, compared to 90 last quarter. The top consumer education issues were:

- 24 Information about applying for DVHA programs, compared to 38 last quarter;
- 9 Medicare, compared to 15;
- 8 General questions about insurance, compared to 13; and
- 5 Fair hearings, compared to 2; and
- 4 Catamount, compared to 13.

#### **D. Eligibility (27.90%)**

We received 233 calls from individuals for whom eligibility for state programs was the primary issue, as compared to 216 last quarter. The top issues in this category were:

- 46 VHAP, compared to 44 last quarter;
- 37 Medicaid, compared to 42;
- 31 Catamount and Premium Assistance, compared to 34;
- 27 DCF Mistake compared to 6;
- 18 Medicaid Spend Down, compared to 18;
- 14 Long Term Care Medicaid, compared to 11;
- 12 Buy In Programs, compared to 16.

#### **E. Other (21.44%)**

We received 179 calls in this category for which the primary issue was categorized as Other, compared to 185 last quarter. The top issues in this category were:

- 28 Communication/Complaints with providers, compared to 36 last quarter;
- 13 Access to Medical Records, compared to 6;
- 11 Provider Error/Medical Malpractice, compared to 9;
- 7 DVHA ID card problems, compared to 2;
- 6 Communication problems with plan, compared to 3;
- 6 Communication Problems with DCF, compared to 10;

- 5 Information about the HCO, compared to 6;
- 5 Choosing/Changing Providers, compared to 4; and
- 5 Personal injury, compared to 3.

**VIII. Table of All Calls by Month and Year**

<b>All Cases</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>	<b>2013</b>
<b>January</b>	241	252	178	313	280	309	240	218	329	282	289
<b>February</b>	187	188	160	209	172	232	255	228	246	233	283
<b>March</b>	177	257	188	192	219	229	256	250	281	262	263
<b>April</b>	161	203	173	192	190	235	213	222	249	252	
<b>May</b>	234	210	200	235	195	207	213	205	253	242	
<b>June</b>	252	176	191	236	254	245	276	250	286	223	
<b>July</b>	221	208	190	183	211	205	225	271	239	255	
<b>August</b>	189	236	214	216	250	152	173	234	276	263	
<b>September</b>	222	191	172	181	167	147	218	310	323	251	
<b>October</b>	241	172	191	225	229	237	216	300	254	341	
<b>November</b>	227	146	168	216	195	192	170	300	251	274	
<b>December</b>	226	170	175	185	198	214	161	289	222	227	
<b>Total</b>	2578	2409	2200	2583	2560	2604	2616	3077	3209	3105	835

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	Lamoille 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