

State of Vermont
Agency of Human Services

Global Commitment to Health
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Section 1115
Demonstration Year: 9
(10/1/2013 – 9/30/2014)

Quarterly Report for the period
July 1, 2014 – September 30, 2014

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I. Background and Introduction

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

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).

The Global Commitment provides Vermont 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 interdepartmental collaboration and reinforces consistency across programs.

An extension effective January 1, 2011, was granted and included modifications based on the following amendments: 2006 - inclusion of Catamount Health to fill gaps in coverage for Vermonters by providing a health services delivery model for uninsured individuals; 2007 - a component of the Catamount program was added enabling the State to provide a premium subsidy to Vermonters who had been without health insurance coverage for a year or more, have income at or below 200 percent of the Federal Poverty Level (FPL), and who do not have access to cost effective employer-sponsored insurance, as determined by the State; 2009 - CMS processed an amendment allowing the State to extend coverage to Vermonters at or below 300 percent of the FPL; 2011 - inclusion of a palliative care program for children who are at or below 300 percent of the FPL, and have been diagnosed with life limiting illnesses that would preclude them from reaching adulthood. This program allows children to receive curative and palliative care services such as expressive therapy, care coordination, family training and respite for caregivers.

In 2012, CMS processed a cost-sharing amendment providing the authority for the State to eliminate the \$75 inpatient co-pay and to implement nominal co-pays for the Vermont Health Access Plan (VHAP).

In 2013, CMS approved Vermont's Waiver Renewal for the period from October 2, 2013-December 31, 2016. AHS and DVHA have been working closely with Vermont's Medicaid Fiscal Agent HP to support all ACA reporting requirements, including identification of those services reimbursed at a different Federal match rate and in support of the revised MEG bucketing effective with the latest STC package.

In 2013, CMS approved Vermont's correspondence, dated November 19, 2013, which requested authorization for expenditure authority for the period from January 1, 2014-April 30, 2014, to ensure temporary coverage for individuals previously eligible and enrolled as of December 31, 2013, in coverage through VHAP, Catamount Premium Assistance, and pharmacy assistance under Medicaid demonstration project authority.

One of the Terms and Conditions of the Global Commitment Waiver requires the State "to submit progress reports 60 days following the end of each quarter. ***This is the fourth quarterly report for waiver year 9, covering the period from July 1, 2014 through September 30, 2014.***

i. 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, 2013, 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,th 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, 2013, 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, 2013, 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, 2013, 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, 2013, 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.

The comment period concluded on March 23, 2013; the AHS compiled and considered the comments and questions received, made changes to the waiver renewal document as appropriate, generated responses to the comments/questions and made the document publicly available.

The AHS submitted its waiver renewal request to the HHS Secretary on April 23, 2013: the request packet included the transmittal letter, public notice, renewal request including budget neutrality documents, interim evaluation plan, and a summary of the Choices for Care Waiver. On May 17, 2013, AHS submitted an updated waiver renewal request with the evaluation plan.

AHS received CMS approval of its Waiver renewal request effective as of October 2, 2013. The approval allows Vermont to sustain and improve its ability to provide coverage, affordability, and access to health care by making changes that conform to the new coverage opportunities created under the Affordable Care Act, such as adoption of the new adult group in the Medicaid State Plan, and the authority to provide hospice care concurrently with curative therapy for adults.

CMS and AHS continue to collaborate on review of Vermont's requests related to use of modified adjusted gross income (MAGI) for MAGI exempt beneficiaries, and consolidation of the Choices for Care waiver and the Children's Health Insurance Program (CHIP) into the Global Commitment to Health Waiver.

AHS and CMS are in negotiations regarding Vermont's waiver consolidation request, to move the Choices for Care demonstration under the Global Commitment 1115 waiver, with a target effective date of January 1, 2015.

II. Enrollment Information and Counts

Key updates from Q4 2014:

- Increases greater than 5% seen in Demonstration Populations 2 and 5.

Table 1 presents point-in-time enrollment information and counts for Demonstration Populations for the Global Commitment to Health Waiver during the fourth quarter of FFY 2014. Due to the nature of the Medicaid program, beneficiaries may become retroactively eligible and may move between eligibility groups within a given quarter or after the end of a quarter. Additionally, since the Global Commitment to

Health Waiver involves most of the State’s Medicaid program, Medicaid eligibility and enrollment in Global Commitment are synonymous, with the exceptions of the Choices for Care Waiver and the Children’s Health Insurance Program (CHIP).

Table 1 is populated based on reports run the Monday after the last day of the quarter, in this case on October 6, 2014. Results yielding $\leq 5\%$ fluctuation from quarter to quarter are considered as illustrating normal deviations reflecting retroactive eligibility determinations and expected terminations. Results reflecting $> 5\%$ fluctuation between quarters are reviewed by staff from DVHA and AHS to provide further detail and explanation of the changes in enrollment. For explanation on substantial fluctuations observed in several Demonstration Populations during the fourth quarter (Q4) of FFY 2014, please see Section VII: Member Month Reporting.

Table 1. Enrollment Information and Counts for Demonstration Populations*, Q4 FFY 2014

Demonstration Population	Current Enrollees Last Day of Qtr 9/30/2014	Previously Reported Enrollees Last Day of Qtr 6/30/2014	Percent Variance 6/30/2014 to 9/30/2014	Variance by Enrollee Count 6/30/2014 to 9/30/2014
Demonstration Population 1:	96,272	95,001	1.34%	1,271
Demonstration Population 2:	54,779	51,961	5.42%	2,818
Demonstration Population 3:	11,289	11,718	-3.66%	(429)
Demonstration Population 4:	N/A	N/A	N/A	
Demonstration Population 5:	2,145	1,990	7.79%	155
Demonstration Population 6:	0	0	0	0
Demonstration Population 7:	0	1	-100.00%	(1)
Demonstration Population 8:	9,707	9,894	-1.89%	(187)
Demonstration Population 9:	2,453	2,496	-1.72%	(43)
Demonstration Population 10:	N/A	N/A	N/A	0
Demonstration Population 11:	0	0	0	0
	176,645	173,061	2.07%	

* Demonstration Population counts are person counts, not member months.

III. Outreach Activities

i. Member Relations

Key updates from Q4 2014:

- The Green Mountain Care Member Newsletter is planned for publication to communicate renewal information for health care programs.
- Non-Emergency Medical Transportation (NEMT) contracts are in place effective July 1, 2014, plus one additional contract effective October 1, 2014.
- The Medicaid and Exchange Advisory Board (MEAB) met three times this quarter.

The Provider and Member Relations (PMR) Unit is responsible for member relations, outreach and communication, including the GreenMountainCare.org member website. The PMR Unit ensures an adequate network of providers for covered services, enrolls and manages the provider network, and has responsibility for the Medicaid Non-Emergency Medical Transportation Program.

Publication of the Green Mountain Care Member Newsletter is on hold and planned for a soon-to-be-

determined date to communicate information regarding health care renewals for all members along with general health and preventative information.

Contracts with 7 brokers for the NEMT program services are effective July 1, 2014 for 1-year periods, with 2 possible 1-year extensions. One additional contract started October 1, 2014. This additional contract resulted from a Request for Proposals (RFP) issued in June, when an existing contractor requested their service territory be reduced.

A banner to providers will be published in October reminding them of access to care and waiting time standards.

The MEAB held meetings on July 14, August 11 and September 8. Agendas and minutes are publicly posted at <http://gmcboard.vermont.gov/meetings>.

IV. Operational/Policy Developments/Issues

i. Vermont Health Connect

Key updates from Q4 2014:

- As of September 25, 168,021 Vermonters were covered by Vermont Health Connect (VHC) plans.
- Due to issues with successfully transitioning Medicaid renewals from the State's legacy ACCESS system to the Marketplace, VHC has temporarily halted these renewals. Vermont has submitted a renewals and verification plan to CMS and is awaiting CMS response to its proposed plan.
- In August, the State announced its plan to transition to a new systems integrator (SI) vendor, Optum Insight. The State is currently negotiating a SI agreement with Optum to complete the work that was not delivered under the original contract.
- VHC is now finalizing its preparations for open enrollment 2015.

The first open enrollment period for Vermont Health Connect ended March 31, 2014. Vermonters who are eligible for Medicaid or Dr. Dynasaur and those who experience a qualifying event, such as having a baby, getting married or moving to the State, can still enroll outside of open enrollment. The State is now finalizing its preparations for 2015 open enrollment, which begins on November 15, 2014.

Following the close of 2014 open enrollment, Vermont's insurance marketplace was recognized for having the highest per capita enrollments. As of September 25, 168,021 Vermonters were covered by VHC plans. About 104,246 enrolled in the newly expanded Medicaid program that is now available to more low-income Vermonters than ever before; of those, about 33,500 of these individuals were automatically transitioned from the Catamount (CHAP) or VHAP programs to Medicaid by the State in January 2014.

Vermont Health Connect then focused on successfully transitioning the 80,000 Medicaid individuals who needed to transition from the State's legacy ACCESS eligibility system to the Marketplace upon renewal of their coverage. However, in June, it became clear to the State that fewer individuals than expected successfully transitioned from the ACCESS system to VHC at their annual renewal. The State received permission from CMS to reinstate coverage for approximately 14,000 Medicaid and Dr. Dynasaur recipients, as well as to temporarily halt legacy system renewals. Vermont has submitted a renewals and verification plan to CMS that proposes resuming the transition of this population in April 2015, pending implementation of automated renewals functionality in VHC. The State's renewal plan also proposes

postponing renewals for Vermonters enrolled into Medicaid during the last open enrollment period through VHC until after the 2015 open enrollment period. The State is awaiting CMS response to its proposed plan.

Maximus has been contracted to manage the VHC Customer Support Center (call center) and is operating at full capacity with 90 seats in Vermont and 25 seats in Chicago. The call center serves Vermonters enrolled in both public and private health insurance coverage, providing Level 1 call center support, which includes phone applications, payment, and basic coverage questions. Maximus is also the entry point for individuals requiring greater levels of assistance with case resolution. They transfer calls to the State's Health Access Eligibility Unit for resolution and log service requests, which are escalated to the appropriate resolver group.

Vermonters can and have been using the Vermont Health Connect system to determine their eligibility for public health plans and financial help to make coverage more affordable, compare health coverage options, select and enroll in coverage and pay for their health insurance premiums.

As previously reported, significant functionality is not available through VHC, including the small business marketplace, self-service renewals, and change of circumstance functionality. Optum provided the state with an IT assessment on August 29. The State is currently analyzing functional gaps and prioritizing the delivery of additional technological capabilities. Optum has been engaged in staff augmentation to support backlog processing since June, and it currently operates two call centers that assist the State with resolving the backlog of Change of Circumstance requests. All outgoing and incoming calls are related to the resolution of these cases. In November, their call centers will begin processing renewal requests for 2015 open enrollment.

After many months of working with the previous SI to advance deployment of needed functionality and improve performance and delivery, in August, the State announced its plan to transition this work to a new SI vendor, Optum Insight. The State is currently negotiating a SI agreement with Optum to complete the work that was not delivered under the original contract.

In addition, the State voluntarily closed the site to consumers in September to allow for system upgrades ahead of open enrollment. During this time, Vermonters can apply and pay for coverage via postal mail or over the phone. The State is on track to have the portal up and running again for consumers in time for open enrollment.

At the close of 2014 open enrollment, VHC concluded its ambitious outreach and education campaign for year one but continues to actively collaborate with key stakeholders, including insurance carriers, brokers, small business owners, and community partners. The Outreach and Education team is now focused on 2015 open enrollment. Vermont continues to deploy its comprehensive training plan and continues to work with agencies and departments to ensure that roles and responsibilities are clearly defined, business processes are fully mapped, and adequate resources are in place to support daily operations.

V. Expenditure Containment Initiatives

i. Vermont Chronic Care Initiative (VCCI)

Key updates from Q4 2014:

- The Enterprise Medicaid Management Information Systems (MMIS)/Care Management (CM) RFP resulted in receipt of seven proposals, which are currently under review.
- DVHA leadership met with its chronic care vendor, APS Healthcare, to discuss SFY 2015 priorities as part of their final contract year, including data transition requirements and a related draft transition plan to assure migration of historic data into the new Care Management system, post vendor selection.
- The VCCI met with an Accountable Care Organization (ACO) partner—One Care Vermont—on collaboration strategy to assure integration and referral requirements for high cost/risk members, without service redundancy.
- The VCCI took part in a statewide Care Management and Care Models workgroup, developing an Integrated Care Management Learning Collaborative in 3 communities statewide.
- The Pediatric Palliative Care Program (PPCP) and related staff have been relocated to the Vermont Department of Health (VDH) to better integrate with other pediatric initiatives. Staff remain under the DVHA budget with clinical and quality reporting to DVHA as the Managed Care Organization (MCO).

The goal of the VCCI is to improve health outcomes of Medicaid beneficiaries by addressing the increasing prevalence of chronic illness through various support and care management strategies. Specifically, the program is designed to identify and assist Medicaid members 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 and supporting improvement in medical and behavioral health, as well as socioeconomic issues that are often barriers to sustained health improvement. Medicaid members that are eligible for the VCCI account for the top 5% of service utilization, or are on a trajectory to become ‘super-utilizers’ of services. The VCCI’s strategy of embedding staff in high-volume hospitals and primary care sites continues to support population engagement at the point-of-need in areas of high service utilization. By targeting predicted high-cost members, resources can be allocated to areas representing the greatest opportunities for clinical improvement and cost savings.

The VCCI had expanded the embedded staffing model with licensed staff in high volume Medicaid primary care sites and hospitals that experience high rates of ambulatory care sensitive (ACS) Emergency Department (ED) visits and inpatient admissions/readmissions. Due to space constraints at some provider sites concurrent with VCCI staff attrition, the VCCI partner footprint was reduced in the previous quarter. However, with new staff hired, VCCI has revisited existing partner sites with part time co-location. During Q4 2014, the VCCI was embedded in 6 primary care practice sites and 2 hospitals, and it is assessing the capacity for expanding on-site staff in 2 additional hospitals.

The VCCI is also supplementing its embedded model with a nurse ‘liaison’ model, given space constraints at provider and hospital sites. The liaison staff will meet regularly with hospital case managers to support

the reduction of ED utilization and transitions from inpatient care. Liaisons will also meet with large Medicaid practices to support referrals and communication on high risk/high cost members. The goal is to have a VCCI hospital liaison in all hospital services areas (HSAs) by the end of the first quarter in FFY 2015. These efforts will facilitate communication and support mutual goals of the Medicaid VCCI and Medicaid ACO partners to achieve common goals.

The VCCI believes that the embedded approach offers several advantages, and it hopes that the liaison role may garner similar benefits. First, it fosters strong provider relationships and direct referral for high-risk populations. Second, it encourages ‘real time’ case findings at the point-of-service within primary care physician (PCP) and hospital sites to assist in reducing hospital readmission rates in high-risk populations. The VCCI has access to hospital data on inpatient and ED admissions through data sharing from partner hospitals (via secure FTP site transfers). While the VCCI currently receives electronic data from 5 partner hospitals, the goal is to have electronic census data from all hospitals in FFY 2015. While some hospitals have not supported these strategies in the past, the advent of Medicaid ACOs may help facilitate new relationships based on common goals and financial incentives. Third, the embedded staffing model provides an opportunity for enhanced coordination and care transitions with hospital partners and primary care sites, as well as with home health agencies that may be delivering skilled nursing care post-discharge. This enhanced service coordination is a goal of the Vermont Health Care Innovation Project (VHCIP) care management and care models (CMCM) workgroup, which is currently working on learning collaboratives in 3 locations—Rutland, Burlington and St. Johnsbury.

The VCCI continues to experience challenges related to both timely recruitment and retention of skilled nurse care managers. Due to their Medicaid knowledge and case management experience, VCCI nurse care managers have been frequently hired by partners of the VCCI, and at a higher pay scale than provided by the State. The VCCI is continuing to work with senior DVHA leadership, and an AHS leadership team is currently assessing a market factor adjustment for nursing positions to support both recruitment and retention.

The VCCI remains strategically aligned with the Blueprint for Health, which is further described in *Section V.ii*.

Pediatric Palliative Care Program

The Pediatric Palliative Care Program (PPCP) is a statewide program funded by DVHA, however, based on needs of partners in VDH and a potentially better fit of this service to be colocated with other programs servicing special needs children, the program and staff have been transitioned to VDH effective September 2014. VDH will provide DVHA with clinical and operational measures on program performance and clinical quality on a periodic basis to ensure that the program is operating according to the terms outlined in the 2013 Global Commitment to Health Waiver. The intergovernmental agreement (IGA) with VDH will be expanded to ensure that these measures are attained.

High Risk Pregnancy Care Management (Pregnancy Care Connection)

The VCCI launched its initial pilot program for the High Risk Pregnancy (HRP) Case Management service in October 2013 but lost both staff in Q3 as per earlier reports. While strides were made, the clinical team recommended that 2 registered nurses (RNs) were not indicated as a centralized resource, and a better model to support clinical and quality goals could be achieved via one HRP expert functioning as a liaison with other state and community partners and as an expert consultant to the VCCI field staff receiving high risk pregnancy referrals. Subsequently, one high risk pregnancy position has been converted into a field based nurse case manager, and recruitment for the centrally located high risk pregnancy expert is currently underway. Data supports the opportunity to positively impact pregnancy

outcomes for high risk women, particularly those with mental health and substance use/abuse diagnoses.

APS Contract

Since 2007, DVHA has contracted with APS Healthcare for assistance in providing disease management assessment and intervention services to Vermont Medicaid beneficiaries with chronic health conditions. APS Healthcare provides several services to support the VCCI, including supplemental professional staffing and data analytics. APS Healthcare delivers enhanced information technology and sophisticated decision-support tools to assist case management staff in doing outreach to the most costly and complex beneficiaries. Additionally, APS Healthcare provides supplemental population-based reports on gaps in care to PCP's, which support ACO providers and case managers working with patients who are considered high utilizers and/or at risk to become so.

In 2011, the VCCI implemented a combination of individual- and population-based strategies for disease management, with a primary focus on the top 5% of beneficiaries accounting for the highest service utilization. That same year, DVHA's contract with APS Healthcare was 100% risk-based with a guaranteed 2:1 return on investment (ROI). In SFY 2012, the VCCI delivered a net \$11.5 million ROI, which included both the APS and DVHA staff efforts. In SFY 2013, the VCCI significantly exceeded its 2012 results, with a \$23.5 million net savings over anticipated expense for this population. Consistent with these results, the VCCI demonstrated a 17% reduction in ACS ED usage, a 37 % reduction in ACS hospitalizations, and a 34% reduction in 30-day readmission rates among the top 5% of members. SFY 2013 was the first year that it was feasible to conduct a comparative analysis on the top 5% of members. Results for SFY 2014—the last year of a fully risk based contract with APS—are pending the 6 month claim run out.

To assure continuity of the VCCI business operations during the MMIS/CM procurement process, the DVHA has extended its contract with APS Healthcare through June 30, 2015. This will allow for a thoughtful procurement, contracting and onboarding process. APS has not submitted a bid in response to the MMIS/CM RFP so a vendor transition is assured. Challenges related to the final contract year with APS are anticipated and have already included the resignations of the APS clinical manager, the clinical liaison positions, and RN staff. DVHA is in discussions with APS regarding the filling of key leadership positions and negotiation of appropriate staffing levels as the contract comes to a close.

There were no Provider Health Registries (PHRs) developed/released this quarter, however DVHA and APS met to outline priorities for the remaining contract year. As a result, APS completed an analysis of recurring gaps in care (by condition) in an effort to define the value and changes resulting from education of providers and members on treatment gaps. Further analysis and a recommended intervention strategy are pending from APS.

Activities supported by APS in Q4 include:

- Submission of a draft 'data transition' plan to support data migration to the new CM vendor and prevent interruption of VCCI services to Medicaid members.
- A flu vaccination mailing/campaign has been prepared for high risk pediatric and adult eligible members, with a target release date of early October.
- Average VCCI caseload (DVHA/APS): 475; unique members: 1275
- Buprenorphine clinical guideline monitoring report developed for DVHA's quarterly review and intervention with the medication-assisted treatment (MAT) provider network, and based on select indicators including concurrent prescribing of opioids, lack of urine drug testing, etc.
- APS report on persistent care gaps post PHR dissemination for select conditions including

depression, asthma, congestive heart failure, and diabetes. Analysis and follow-up recommendations/strategic approach to address the findings are pending.

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

Key updates from Q4 2014:

- The Hub program has well established statewide operations and continues to see caseload growth; serving 2,506 Vermonters as of September 16, 2014.
- In addition to providing methadone MAT, as they have traditionally done, Hubs now provide buprenorphine MAT to complex patients; and approximately one third of the patients being prescribed buprenorphine.
- Curriculum development for a new series of learning collaboratives was completed, and topics will include management of chronic pain, use of buprenorphine during pregnancy, and treatment for anxiety disorders. Recruitment of practice teams to participate in the collaboratives is going well.

The Blueprint for Health (Blueprint) is Vermont's State-led initiative charged with guiding a process that results in sustainable health care delivery reform. The Blueprint uses multi-insurer payment reforms to improve infrastructure and care provided by PCPs. It includes advanced primary care practices recognized as patient-centered medical homes, multi-disciplinary core Community Health Teams (CHTs), and specialized care coordinators. The Blueprint supports the State's National Committee for Quality Assurance (NCQA) certification and performance-based payments. In 2013, the Blueprint continued to grow and strengthen the underlying model in all geographic regions, or Health Service Areas, in the state. The Blueprint for Health 2013 Annual Report to the Vermont Legislature was published online in January, 2014 and is available via:

<http://hcr.vermont.gov/sites/hcr/files/pdfs/VTBlueprintforHealthAnnualReport2013.pdf>.

As part of the Blueprint, the Hub and Spoke Initiative creates a framework for integrating treatment services for opioid addiction. This Initiative represents AHS and DVHA's efforts to collaborate with community providers to create a coordinated, systemic response to the complex issues of opioid addictions in Vermont. The Hub and Spoke Initiative is focused on beneficiaries receiving Medication-Assisted Treatment (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. The two primary medications used to treat opioid dependence are methadone and buprenorphine. Buprenorphine is typically prescribed by specially licensed physicians in a medical office setting, and methadone is provided only in specialty opioid treatment programs. Both of these treatment regimens are associated with substantial service fragmentation as providers are not well integrated into the larger health care and mental health care systems.

To address this service fragmentation and better serve a patient population with high overall health care costs, Vermont has developed State Plan Amendments (SPAs) in partnership with CMS to provide Health Home services to the MAT population under section 2703 of the ACA. The SPAs supported geographically staggered MAT Health Home implementation throughout Vermont. 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.

As part of the Initiative, five regional Hubs were established, which build upon the existing methadone opioid treatment programs, and provide buprenorphine treatment to a subset of clinically complex patients

(Table 2). These Hubs serve as the regional consultants and subject matter experts on opioid dependence and treatment. Hubs are replacing episodic care based exclusively on addiction illness with comprehensive health care and continuity of services. Three Hubs were implemented under the first Health Home SPA, effective on July 1, 2013. Two additional regional Hubs were implemented through the second SPA beginning in January 1, 2014.

In addition to Hubs, Spoke staff is embedded directly in the prescribing practices to allow more direct access for patients to mental health and addiction services, promote continuity of care, and support the provision of multidisciplinary team care. Spoke staff provide service free of cost to patients receiving MAT. Spokes include a physician prescribing buprenorphine in office-based opioid treatment 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. Registered nurses and licensed addictions/mental health clinicians, who are part of the Blueprint CHTs, also provide support to the Spoke providers and their patients receiving MAT.

For updates from Q4 of FFY 2014, please see the above “key updates.” Blueprint practice facilitators continue to work extensively with Hub and Spoke providers on common measurement, practice-level quality improvement, and implementation of evidence-based care. In addition, the practice facilitators are working with the Hub programs on preparing to meet the NCQA Patient-Centered Specialty Practice standards. This will further align these specialty addictions programs with the patient-centered medical home primary care providers.

Spoke staffing is scaled at 1 registered nurse and 1 licensed clinician for every 100 patients receiving MAT. The following tables present the caseloads of regional Hubs and Spoke staffing as of September, 2014.

Table 2. Hub Caseload: September 16, 2014

Region (Counties in Vermont)	Start Date (Month/Year)	Total Number of Clients (Buprenorphine and Methadone)	Number of Clients Receiving Buprenorphine	Number of Clients Receiving Methadone
Chittenden, Franklin, Grand Isle & Addison	1/2013	899	290	609
Washington, Lamoille, Orange	7/2013	267	117	150
Windsor, Windham	7/2013	548	140	408
Rutland, Bennington	11/2013	360	140	219
Essex, Orleans, Caledonia	1/2014	432	141	219
Total		2506	802	1704

Table 3. Spoke Staffing: September 2014

Region	Providers Serving 10 or more Medicaid Beneficiaries	Staff FTE Funding	Staff FTE Hired	Medicaid Beneficiaries
Bennington	6	3.5	3.5	173
St. Albans	6	5.5	3.8	262
Rutland	5	5.0	3.1	253
Chittenden	14	8.0	7.70	357
Brattleboro	7	4.5	5.4	230
Springfield	1	1.0	1.0	41
Windsor	2	2.0	1.75	82
Randolph	4	2.5	1.8	110
Barre	7	4.5	4.5	212
Lamoille	4	2.5	1.5	135
Newport & St Johnsbury	5	2.0	2.0	100
Addison	1	.5	.90	17
Total	62	42	36.95	2,014

iii. Behavioral Health

Key updates from Q4 2014:

- A new Autism Specialist was hired to manage applied behavioral analysis (ABA) services.
- Staff throughout AHS were trained in McKesson InterQual behavioral health care criteria.
- Hosted an informational webinar for providers on the McKesson InterQual Criteria.

The DVHA mental health and substance abuse team offers a comprehensive approach for behavioral health care coordination. The mental health team is responsible for concurrent review and authorization of inpatient psychiatric and detox services for Medicaid primary beneficiaries. The team works closely with discharge planners at the inpatient facilities to ensure timely and appropriate discharge plans. The substance abuse team authorizes payment for opioid treatment medications and coordinates its MAT efforts with the Hub and Spoke Initiative, the VCCI and the Pharmacy Unit to provide beneficiary oversight and outreach. The substance abuse team also manages the Team Care Program (lock-in) for Medicaid beneficiaries.

During Q4 2014, DVHA hired an Autism Specialist who will be a member of the behavioral health team. This position was created in response to the additional funding appropriated by the State Legislature for the provision of services for children diagnosed with autism spectrum disorders. The Autism Specialist will develop a system for managing and authorizing payment of these services.

During this quarter, DVHA hosted a 2-day training on the McKesson InterQual behavioral health care criteria tool for internal DVHA staff as well as VDH, the Department of Mental Health (DMH) and the Department for Children and Families (DCF). DVHA also hosted an informational webinar on the tool for

providers.

The substance abuse team met extensively with Goold Health Systems, DVHA's newly selected Prescription Benefits Management (PBM) vendor and discussed the team's current role as prior authorization reviewers. A work plan was developed in order to assist in the process of transitioning those duties to Goold.

iv. Pharmacy and 340B Drug Discount Program

Key updates from Q4 2014:

- Vermont has realized \$83,491.00 net cost savings this quarter and year-to-date net cost savings of \$ 411,612.00 through Medicaid participation of a relatively small number of eligible covered entities.
- Brattleboro Memorial Hospital began participating in the 340B program this quarter and is also taking part in the 340B Medicaid initiative.

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

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 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).

Vermont has made substantial progress in expanding 340B availability since 2005. This expansion was aided by federal approval of the statewide 340B network infrastructure, which is operated by five federally qualified health centers (FQHCs) in Vermont. In 2010, DVHA aggressively pursued enrollment of 340B covered entities made newly eligible by the ACA and as a result of the Challenges for Change legislation passed in Vermont. As of October 2011, all but two Vermont hospitals and some of their owned practices were 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 include Medicaid in their 340B programs. In 2012, the DVHA received federal approval for a Medicaid pricing 340B

methodology. To encourage participation in the Vermont Medicaid 340B program, providers receive an incentive payment (described below). The methodology for the 340B incentive payment is the lesser of 10% of the total Medicaid savings or \$3 per claim for non-compound drugs and \$30 per claim for compound drugs. 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. DVHA continues to encourage Medicaid enrollment with the goal of enrolling all eligible and HRSA-enrolled covered entities in Vermont.

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

- Vermont Department of Health, for the AIDS Medication Assistance Program, Sexually-Transmitted Disease Drugs Programs, and Tuberculosis Program; all of these programs are specifically allowed under federal law.
- **Planned Parenthood of Northern New England's Vermont clinics**
- **Vermont's FQHCs**, operating 41 health center sites statewide
- **Brattleboro Memorial Hospital**
- **Central Vermont Medical Center**
- Copley Hospital
- **Fletcher Allen Health Care and its outpatient pharmacies**
- Gifford Hospital
- Grace Cottage Hospital
- **Indian Stream Health Center (New Hampshire)**
- North Country Hospital
- Northeastern Vermont Regional Hospital
- *Notch Pharmacy (new as of FFY Q3)*
- Porter Hospital
- Rutland Regional Medical Center
- **Springfield Hospital**

340B Reimbursement and Calculation of Incentive Payment

DVHA identified the following goals in establishing its proposed 340B reimbursement methodology:

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

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. 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 established a flat rate payment at the low end of this range (\$15.00) and presents the opportunity, subject to demonstrated Medicaid program savings, for entities to share in Medicaid 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 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. Using the Global Commitment authority, the 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 rates of 340B covered entity-employed prescribers and Medicaid beneficiary participation in the program.

For the reporting period, Vermont has realized \$83,491.00 net cost savings for FFY Q4 and year-to-date net cost savings of \$411,612.00 through Medicaid participation of a relatively small number of eligible covered entities.

v. **Mental Health System of Care**

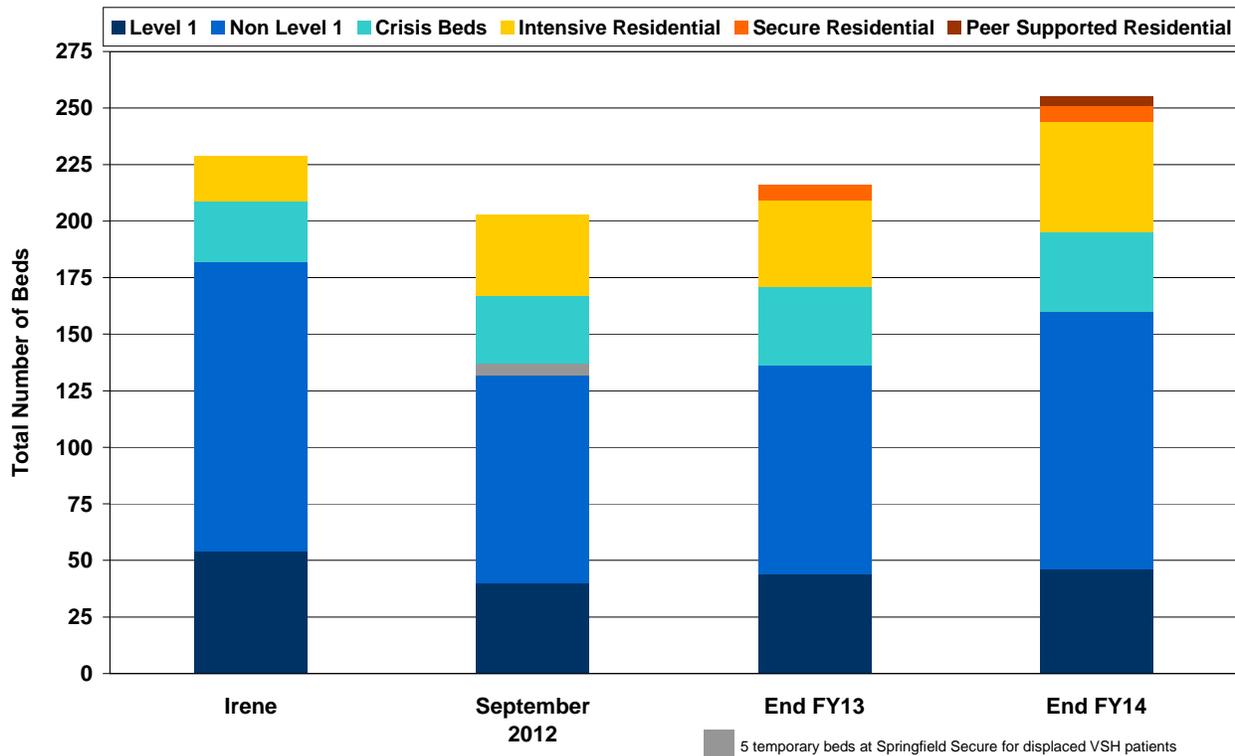
State Hospital Inpatient Replacement Planning

On July 2nd, 2014, the Green Mountain Psychiatric Care Hospital in Morrisville closed and the Vermont Psychiatric Care Hospital in Berlin opened with 7 of the 8 patients from the Morrisville site. (One patient was discharged from Morrisville.) At the end of this quarter VPCH was operating with 21 beds and is on track to be fully open with 25 beds by late fall.

During this period, fourteen Level I beds at the Brattleboro Retreat and 7 Level I beds at Rutland Regional Medical Center have been operational, and once the new hospital becomes fully operational with 25 beds, DMH expects to see changes, especially in the area of emergency room waiting times. With the full completion of Vermont's Level I beds soon approaching, DMH has outlined an assessment of where we are at and what we foresee next. This assessment, entitled "Beyond Level I", addresses: NON-LEVEL 1 HOSPITAL BEDS; SECURE RESIDENTIAL; INTENSIVE RESIDENTIAL RECOVERY FACILITIES; CRISIS BEDS; SOTERIA HOUSE; SUPPORTED INDEPENDENT LIVING AND OTHER MENTAL HEALTH SUPPORT SERVICES; OUTPATIENT SERVICES; CARE MANAGEMENT SYSTEM; TRANSPORT; and PEER SERVICES. In each of the above areas, waits, gains and challenges are addressed. DMH's multi-year efforts to develop a new system of care with a broad range of community partners culminated with the opening of VPCH. The system has much work ahead, but a great deal has been accomplished through the creation and building of this new configuration of programs and services.

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 of Mental Health (DMH) Act 79 report and follows below.

Vermont Department of Mental Health Psychiatric Beds in System of Care



While DMH did not fully meet this target, one of the last two residential programs, MapleWood Recovery Residence, opened during this period. This four-bed intensive residential program will provide long-term transitional housing and active treatment for adults experiencing persistent mental illness. The program is the latest intensive residential program in Vermont’s mental health system of care. It is owned by the Vermont Southern Alliance for Community Care, a joint venture of Rutland Mental Health Services and Health Care and Rehabilitation Services of Springfield. Located in a new building at 195 Stratton Road in Rutland City, residents are empowered to manage the symptoms of their illness and to become productive members of society. The services at MapleWood integrate one-on-one therapy, group therapy, and support from various community-based programs including visits from therapy dogs, and activities at the Godnick Senior Center in Rutland. Friends and family often join residents for meals, and community meetings are held regularly to get ideas from residents. Staff also provides peer support services and promotes involvement in community based peer support groups. MapleWood offers a level of care for which there is a pressing need in the Rutland area. Closure of the former Vermont State Hospital in Waterbury in 2011 exacerbated a statewide shortage of options for transitional living in a recovery-oriented environment. Act 79 of 2012 addressed the needs of the mental health system in a comprehensive way, authorizing a continuum of services and levels of care designed to meet the needs of Vermonters in appropriate settings to advance recovery. The new Rutland program serves individuals who historically have required extended lengths of stay in inpatient psychiatric settings, and those who have had their stays in these settings extended due to a lack of appropriate community resources. The focus at MapleWood is on persons who are experiencing impairments in functioning primarily as a result of a mental health condition, including those with co-occurring substance use disorders, and others who are not ready for independent living. A resident’s length of stay is expected to range from three to eighteen months, during which time they work on increasing independent living skills. MapleWood offers four single-occupancy bedrooms, and residents share a living area, dining area and kitchen. Group activities such as bowling, crafting and exercise

encourage residents to develop new interests and hobbies, and build socialization skills. Seeking employment is encouraged. One has become active in the Special Olympics.

Soteria-Vermont will be the last of the last of the facilities conceptualized in Act 79 to open. The building is currently being renovated to accommodate a five-bed residence located in Burlington's Old North End. Soteria will offer a supportive environment for individuals going through an early experience of psychosis, will practice a cautious and limited use of psychoactive medications, and will provide a safe, flexible, empowering, home-like environment. Soteria Vermont development is coming down the home stretch in terms of meeting its obligations for policies and procedures, accessible design, staffing, licensing, and a Certificate of Occupancy from the City of Burlington. Job postings will begin shortly. Over the next few months, Soteria will purchase furniture and household goods, office equipment and a house vehicle. An Open House is planned prior to opening early next year. Many in the mental health community had a chance to hear more details from the project managers who offered a workshop at September's DMH conference in Killington. The Green Mountain Care Board issued Soteria Vermont a Certificate of Need, requiring CON Implementation Reports every six months. Soteria's first report was approved and posted on the DMH website.

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 monitored by a web-based electronic bed board of inpatient and crisis bed census information that is available to service providers, components of the care management system have been operational with availability of staff and administrators weekdays and 24/7 on weekends throughout this period. 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. State Fiscal Year 14 funding supported 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 was submitted to the Vermont Legislature on January 15, 2014. The report provides an overview of the significant program development areas and preliminary data collection and outcomes findings and can be found at:
<http://mentalhealth.vermont.gov/sites/dmh/files/report/legislative/2014%20AFinal%202014%20Legislative%20Report%20-%20Act%2079.pdf>

Integrated Family Services (IFS) Initiative

The AHS continues to act on opportunities to improve quality and access to care, within existing budgets, using managed care flexibilities and payment reforms available under 42 CFR 438 and the 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 administered across the IGA partners so work continues to enhance integration. 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 AHS 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 and flexible choices for self-managed services. Each of these is described in brief below. This integration is an ongoing process that is evolving into a very positive direction for children and families.

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

The initial IFS pilot, in Addison County has finished the second full state fiscal year and we have started the second pilot region in Franklin/Grand Isle counties on April 1, 2014. The initial pilot included consolidation of over 30 state and federal funding streams into one unified whole through one master grant agreement; the second pilot also includes consolidation of several state and federal funding streams. The state has created an annual aggregate spending cap for two providers in Addison and one in Franklin/Grand Isle (this provider houses the Designated Agency and Parent Child Center). This has created a seamless system of care to ensure no duplication of services for children (prenatal to 22) and families. For Addison, the aggregate annual budget for this pilot is approximately \$4M with \$3M being Global Commitment covered services, and in Franklin/Grand Isle the Global Commitment covered services are near \$5.4M. 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.
- Initial numbers indicate an ability to serve more children and families with the same amount of resources.

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 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.

The interest in moving statewide continues and more providers, including Federally Qualified Health Centers (FQHCs) are expressing interest in being a part of IFS. Additionally IFS continues to work on statewide healthcare reform and aligning approaches to achieve an integrated behavioral health and physical health system.

VI. Financial/Budget Neutrality Development/Issues

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

Based on the availability of State Matching funds, AHS had to make the June 1, 2014 capitation fund payment in two installments. The first installment occurred on the regularly scheduled date; the second installment occurred during this past quarter on July 25, 2014 when additional State Matching funds became available.

CMS partners traveled to Vermont for a site-visit on September 16th, 2014. During this site visit, Vermont AHS Financial staff brought to CMS’ attention the discrepancies between APDs and MBES. In some cases, APD allotment amounts were not matching MBES, and in other cases the allotments were missing in MBES. This resulted in AHS reporting expenses under inaccurate APDs in MBES for the QE0614 CMS-64 filing. On October 2nd, 2014, CMS updated most of the APD allotments in MBES. This allowed AHS to correct prior quarters’ APD expense reporting with the CMS-64 QE0914 filing.

In May 2014, there was a SPA that was approved allowing Vermont to administer CHIP as part of the Medicaid state plan effective January 1, 2014. With the exception of CHIP Admin and Outreach expenses which are still reported on the CMS-21, AHS transferred CHIP expenses to the CMS-64.21U(P) for the current and prior quarters.

AHS entered into a one year contract extension with its actuarial consultant, Milliman, effective April 1, 2014, for FFY15 PMPM rate development, and worked on the rate development process throughout QE0914. AHS has received a draft copy of the report; we are very close to accepting a final draft.

AHS has worked with DVHA and CMS throughout QE0914 to ensure all the new reporting requirements per the October 2, 2013 STCs are met. The State's eligibility system has faced some difficulty with accurate beneficiary coding post-ACA implementation; AHS and DVHA are currently working through issues with the Eligibility Services unit to ensure enrollees are properly bucketed in the proper MEGs. We are working to institute a permanent automated solution.

VII. Member Month Reporting

Key updates from Q4 2014:

- In Q4 FFY 2014, there were several fluctuations in enrollment, which led to an overall increase in enrollment of 2.07%.
- Increased enrollment was seen in Demonstration Populations 2 and 5. The largest increase in enrollment count was in Demonstration Population 2, which accounted for 2,818 enrollees (or a variance of 5.42%). Demonstration Population 5 also saw an increase of 155 enrollees (or a variance of 7.79%).

Demonstration Populations are not synonymous with Medicaid Eligibility Group (MEG) reporting in Table 5. The numbers presented in the following table may represent duplicated population counts. For example, an individual in Demonstration Population 4, which is home and community-based services, and Demonstration Population 10 may in fact be in MEG 1 or 2.

This report is run the first Monday following the close of the month for all persons eligible as of the 15th day of the preceding month. Data reported in Table 4 are not used in Budget Neutrality Calculations or Capitation Payments, as information will change at the end of the quarter. The information in this table cannot be summed across quarters. All payments are adjusted at the end of the year to reconcile expected population movement between eligibility groups.

Table 4. Number of Recipients, by Month for FFY 2014

Demonstration Population	Q1 FFY 2014			Q2 FFY 2014			Q3 FFY 2014			Q4 FFY 2014		
	Oct. 2013	Nov. 2013	Dec. 2013	Jan. 2014	Feb. 2014	March 2014	April 2014	May 2014	June 2014	July 2014	Aug. 2014	Sept. 2014
Demonstration Population 1	48,576	48,616	48,833	86,074	87,603	89,867	95,507	92,966	89,852	94,779	95,436	95,490
Demonstration Population 2	43,603	43,729	43,767	45,826	46,190	46,617	48,661	47,914	46,613	53,001	53,984	54,255
Demonstration Population 3	9,817	9,831	9,853	13,485	13,627	13,780	12,280	11,466	10,506	11,682	11,169	11,187
Demonstration Population 4	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Demonstration Population 5	861	873	873	1,103	1,155	1,208	1,639	1,716	1,694	2,017	2,074	2,080
Demonstration Population 6	2,903	2,748	2,709	2,175	1,857	1,585	0	0	0	0	0	0
Demonstration Population 7	34,992	35,065	35,882	2,379	2,021	1,743	11	1	0	2	2	0
Demonstration Population 8	10,149	10,143	10,120	10,168	10,203	10,130	9,963	10,027	9,986	9,832	9,797	9,752
Demonstration Population 9	2,573	2,576	2,583	2,607	2,588	2,581	2,546	2,557	2,510	2,471	2,470	2,466
Demonstration Population 10	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Demonstration Population 11	13,778	14,182	13,923	9,759	8,327	7,178	6	0	0	0	0	0
	167,252	167,763	168,543	173,576	173,571	174,689	170,613	166,647	161,161	173,784	174,932	175,230

Table 5. Enrollment Information and Counts for Demonstration Populations*, Q4 FFY 2014

Demonstration Population	Current Enrollees Last Day of Qtr 9/30/2014	Previously Reported Enrollees Last Day of Qtr 6/30/2014	Percent Variance 6/30/2014 to 9/30/2014	Variance by Enrollee Count 6/30/2014 to 9/30/2014
Demonstration Population 1:	96,272	95,001	1.34%	1,271
Demonstration Population 2:	54,779	51,961	5.42%	2,818
Demonstration Population 3:	11,289	11,718	-3.66%	(429)
Demonstration Population 4:	N/A	N/A	N/A	
Demonstration Population 5:	2,145	1,990	7.79%	155
Demonstration Population 6:	0	0	0	0
Demonstration Population 7:	0	1	-100.00%	(1)
Demonstration Population 8:	9,707	9,894	-1.89%	(187)
Demonstration Population 9:	2,453	2,496	-1.72%	(43)
Demonstration Population 10:	N/A	N/A	N/A	0
Demonstration Population 11:	0	0	0	0
	176,645	173,061	2.07%	

* Demonstration Population counts are person counts, not member months.

Demonstration Population 7 saw a coverage drop of -100.00%; however, the percent is deceptive because the beneficiary count dropped from 1 to 0. With coverage under VHAP ending on April 1, 2014, these reductions in enrollment were expected by DVHA.

Increased enrollment over 5% was seen for Demonstration Populations 2 and 5. The largest percent increase in enrollment was in Demonstration Population 5, with an increase of 7.79% (or 155 beneficiaries). This increase is largely due to the change in the MEG rate group from 'optional' to 'underinsured,' which went into effect on January 1, 2014. The largest recipient variance was in Demonstration Population 2 with an increase of 2,818 recipients since the third quarter of FFY 2014.

In Q4 of FFY 2014, the overall fluctuations led to an increase in enrollment of 5.12% since Q3 FFY 2014. The totals for each quarter of FFY 2014 are reflected in Table 4.

VIII. 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 reports provided to DVHA (see Attachment 3). Member Services works to resolve the issues raised by beneficiaries, and their data helps DVHA look for any significant trends. The reports are seen by several management staff at DVHA and staff ask for additional information on complaints that may appear to need follow-up to ensure that the issue is addressed.

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

there are trends that may benefit from a performance improvement project.

The third mechanism to track consumer issues is the Office of Health Care Ombudsman (HCO) report which is a comprehensive report of all contacts with beneficiaries (see Attachment 5). These include inquiries, requests for information, and requests for assistance. The HCO's role is to assist individuals to navigate health care insurance systems, and help to resolve eligibility and coverage problems.

IX. Quality Improvement

Key updates from Q4 2014:

- The reconfigured (Managed Care Entity) MCE Quality Committee, including IGA Partner representatives, met on September 15, 2014.
- The Follow-Up After Hospitalization for Mental Illness Performance Improvement Project's interim study indicator tracking started in July 2014, with reports due to the designated hospitals in October 2014.
- Results Based Accountability Scorecard software became available to DVHA during Q4 2014, which will allow for the development of a performance dashboard. DVHA Quality Improvement staff will attend software training in Q1 2015.
- The interventions for the Initiation and Engagement of Alcohol and Other Drug Dependence Treatment Performance Improvement Project were implemented July 1. They will run through June 30, 2015.

The DVHA Quality Improvement (QI) and Clinical Integrity Unit monitors, evaluates and improves the quality of care to Vermont Medicaid beneficiaries by improving internal processes, identifying performance improvement projects and performing utilization management. Efforts are aligned across the Agency of Human Services and community providers. The Unit is responsible for instilling the principles of quality throughout DVHA; helping everyone in the organization to achieve excellence. The Unit's goal is to develop a culture of continuous quality improvement throughout DVHA.

Quality Committee Updates

DVHA's Medical Director and QI Administrator successfully collaborated with its IGA Partners' Commissioners to solidify their Departments' representation on the Quality Committee, which has been appropriately re-named as the MCE Quality Committee. An important activity of this committee is to re-establish performance measures that each Department will routinely report on for the Medicaid population(s) they serve.

The Quality Committee tasked a joint AHS-DVHA workgroup with an in-depth analysis of the current *Global Commitment for Health* investment expenditures earlier this year. The review is expected to determine whether the investment expenditures are realizing optimal outcomes, as well as identify whether existing investments could become programmatic or administrative claims instead. This workgroup continued to make progress towards those goals during Q4 2014 by determining our analysis criteria and starting to interview appropriate subject matter experts.

Formal (Validated) Performance Improvement Project

DVHA continues to lead an AHS-wide Performance Improvement Project (PIP) on Follow-up After Hospitalization (FUH) for Mental Illness, the study indicator for which is the Healthcare Effectiveness Data

and Information Set (HEDIS) measure of the same name (FUH HEDIS). During Q4, members of the FUH PIP implementation team rolled out the first study intervention. The intervention includes educating local designated hospitals (the hospitals in Vermont with inpatient psychiatric floors and who accept involuntary admissions) on Medicaid's discharge planning and discharge policies and procedures. The intervention included face-to-face meeting time between the hospital staff and PIP team members. Updated materials and follow-up appointment scheduling reports that the MCE is able to track for each designated hospital were reviewed. Moving forward, the FUH implementation team will provide this appointment scheduling data to the designated hospitals on a quarterly basis and will meet with them in person to share learning and best practices bi-annually.

Consumer Assessment of Healthcare Providers and Systems Survey

DVHA continued to coordinate the Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys during Q4. DVHA's contracted vendor, WBA Research, distributed and collated both the Adult and Children's Medicaid CAHPS 5.0H surveys during Q3 2014. They also provided DVHA an analysis of results for both surveys during Q4 2014. Those results will be shared with DVHA leadership and the MCE Quality Committee in order to identify possible areas for improvement.

AHS Performance Accountability Committee

DVHA's Quality Unit Director and QI Administrator continued to represent Vermont Medicaid's *Global Commitment for Health* activities at the monthly AHS-lead Performance Accountability Committee (PAC) meetings.

Adult Quality Measures Grant

In Q4 FFY 2014, DVHA staff finished up the seven hour series of trainings provided by the Lewin Group on how to complete PIPs using CMS protocols. Topics included developing PIP interventions, reporting PIP results, and evaluating PIPs. The Lewin Group also provided training on "Using Data to Drive Change" to members of the Managed Care Medical Committee.

DVHA staff continued to develop the internal capacity to complete hybrid HEDIS chart reviews. Building on the training received in Q3, the chart review committee drafted a Chart Review Operating Principle and the internal process for the spring 2015 hybrid chart review. DVHA is currently in the process of renewing the contract with Verisk, the vendor that produced the 2014 HEDIS measures. Once there is a signed contract, DVHA will move forward with obtaining training in the use of their online web portal for medical record abstractions.

The Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET) PIP implemented two interventions during this quarter:

Initiation Intervention:

On July 1, 2014, DVHA sent 153 PCPs information on alcohol treatment referral best practices and an expanded list of substance abuse clinicians with the goal of improving the initiation rate of new episodes of alcohol abuse or dependence diagnosed by a PCP for Medicaid beneficiaries ages 18 and older, living in Addison, Bennington and Rutland Counties.

Engagement Intervention:

By July 1, 2014, DVHA had provided substance abuse clinicians enrolled in the project with training on alcohol treatment best practices and on July 1, 2014, DVHA implemented a pay-for-performance model of reimbursement for clinicians enrolled in the project with the goal of improving the engagement rate of new episodes of alcohol abuse or dependence diagnosed by a PCP for Medicaid beneficiaries ages 18+, living in Addison, Bennington, and Rutland Counties.

CHIPRA Grant

The DVHA's Quality Unit continued to staff the CHIPRA grant (Child Health Improvement Program Reauthorization Act). Following two full-day meetings held in the second quarter, the CHIPRA Care Coordination Collaborative moved into its next phase with monthly phone calls attended by the ten practices that make up the collaborative. This collaborative aims to share techniques and experience gained within the member practices under the guidance of a local pediatrician who is a national leader and expert on this subject. It is contracting with another national expert (out-of-state) to provide consultation and to speak at one of the three statewide learning sessions.

The practices agreed to ask parents to fill out an advance version of a soon-to-be released questionnaire reflecting on parent/family experiences with care coordination and care conferences. These questionnaires will be evaluated by the Vermont Child Health Improvement Program evaluator and should offer data on the results of CHIPRA implementation. In contrast to the number of newly NCQA-scored practices, the questionnaire will assist in assessing whether parents and families perceive their care as being improved.

The DVHA QI Administrator, in concert with other team members from Vermont and Maine, also began the task of setting the agenda and preparing for the last meeting of the CHIPRA Executive Committee in New Hampshire in November. Preliminary discussions centered on the sustainability of the grant.

AHS Monitoring Activity

- *AHS Performance Accountability Committee*

During this quarter, the AHS Performance Accountability Committee (PAC) spent time reviewing its performance. According to the committee charter, the group is required to conduct such a review annually. Activities included a comparison of the PAC outputs with the requirements of the charter as well as identifying any improvements to the Committee Charter deemed necessary or desirable by the PAC. Feedback included the concern that the current structure and/or format of the group does not allow adequate time for each of the departments participating in the meeting to address their specific needs. During the next quarter, the group will continue to take feedback – and modify its structure/format to meet the needs of all participants.

- *Quality Strategy*

The AHS Quality Improvement Manager continued to work with the members of the AHS Performance Accountability Committee (PAC) to update the current GC Quality Strategy. Rather than seeking public comment – and finalizing an updated version – it was decided to modify the existing document to accommodate the quality assessment and improvement activities associated with the Choices for Care 1115 Waiver. This waiver is expected to be consolidated with the GC Waiver in January, 2015. An updated version of the strategy will still need to be reviewed by the AHS Integrated Operations and Planning Team (IOPT) and AHS Executive Committee, and made

available for public comment. After incorporating public comments, the final document will be forwarded to CMS for review/approval. In addition to including the aforementioned elements, the updated version of the strategy will follow the formatting requirements as set forth in Section 508 of the Rehabilitation Act (29 U.S.C. §794d). Going forward, the AHS Performance Accountability Committee will be responsible for conducting periodic reviews of the quality strategy to evaluate its effectiveness.

- *External Quality Review Organization (EQRO)*

During this quarter the three required External Quality Review activities took place (i.e., validation of performance improvement project, validation of performance measures, and review of compliance with standards). For this year's 2013–2014 performance improvement project validation, DVHA submitted a new PIP topic: *Follow-up After Hospitalization for Mental Illness*. The study topic selected by DVHA addressed CMS' requirements related to quality outcomes—specifically, the quality, timeliness, and accessibility of care and services. In its PIP evaluation and validation, the EQRO used the Centers for Medicare & Medicaid Services (CMS) publication, *Validating Performance Improvement Projects: A Protocol for Use in Conducting Medicaid External Quality Review Activities*, final protocol, Version 1.0, May 1, 2002 (CMS PIP Protocol). The PIP validation evaluated the technical methods of the PIP (i.e., the study design and implementation/evaluation). The PIP received an overall *Met* validation status when originally submitted. DVHA elected not to resubmit the PIP for a second validation because the original submission had 100 percent of evaluation elements receive a *Met* score. The EQRO conducted the validation of performance measures activities as outlined in the Centers for Medicare & Medicaid Services (CMS) publication, *EQR Protocol 2: Validation of Performance Measures Reported by the MCO: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 1, 2012. The EQRO conducted the review via the following off site activities: *Information Systems Capabilities Assessment Tool (ISCAT) and supporting documents, source code (programming language) for performance measures, and SFY 2012–2013 Validation of Performance Measures report*. On-site activities included the following: evaluation of system compliance, overview of data integration and control procedures, and opening/closing conferences. The EQRO determined that all performance measures were fully compliant with the specified standards and AHS should accept the measures as reliable and valid. Finally, the EQRO reviewed DVHA's ability to comply with the Centers for Medicare & Medicaid Services (CMS) Structure & Operations Standards (42 CFR 438 §214-230) as well as state-specific requirements contained in the AHS/DVHA intergovernmental agreement (IGA). The EQRO performed an office-based desk review of DVHA's documents as well as an on-site review that included reviewing additional documents and conducting interviews with key DVHA staff members. Of the 93 applicable requirements, DVHA obtained a score of *Met* for 79 of the requirements and a score of *Partially Met* for 14 elements. As a result, DVHA obtained a total percentage of compliance score of 92 percent across the applicable elements.

X. Compliance

Key updates from Q4 2014:

- Several improvements were made to the departmental IGAs to clarify reporting requirements.
- DVHA is working with AHS to develop a new AHS to DVHA IGA in anticipation of major changes to our GC and LTC waivers.
- DVHA received a draft report of our EQRO Audit Findings and is developing a corrective action plan in response. The draft report showed improvements over the previous audit and has excellent suggestions for improvements.

The Managed Care Compliance program is responsible for ensuring that managed care operations are in compliance with all governing policies, regulations, agreements and statutes. This is accomplished through audits and corrective actions coordinated by the Managed Care Compliance Committee. This work is coordinated across AHS through IGAs with the departments involved in managed care programs.

DVHA's IGAs with our partner departments have been updated to make reporting requirements more clear. Specifically, we improved our language around how services delegated by departments should be monitored and reported. These drafts are currently being reviewed by the individual departments. Once implemented, we will have more consistent reports and will be better able to monitor and improve the performance of our managed care system.

DVHA is seeking approval from CMS to merge our Global Commitment and Long Term Care 1115 waivers into a single comprehensive waiver. Once approved, several important structural changes will need to occur in order for us to integrate the management of these services. Staff from DVHA, DAIL and AHS have been working to review the current IGA between AHS and DVHA to create a new draft that would combine the services of the Global Commitment and Long Term Care waivers. This process has been an excellent opportunity for us to analyze these two programs to identify administrative efficiencies and opportunities for better collaboration.

DVHA completed an annual EQRO audit in June, and received a positive draft report from the auditors. The report identified several areas where improvements can be made to Medicaid's Grievance and Appeals system, as well as improvements in communication to members and providers about certain key topics. Overall, the draft report gave DVHA a score of 92% (up from 90% the last time this set of standards was audited). DVHA expects the final report shortly and has a draft corrective action plan ready.

XI. Demonstration Evaluation

During this quarter, the AHS Institutional Review Board (IRB) final approval was granted for Research Triangle Institute's (RTI) external SIM evaluation plan. Also during this quarter, the AHS QIM participated in the IMPAQ evaluation kick-off meeting. Unlike the aforementioned RTI evaluation – this work focuses on the review of state specific activities. The agenda consisted of the following items: evaluation framework, evaluation design, intervention inventory and timeline, and performance measure set. The AHS QIM will continue to work with members of Vermont's System Innovation Model (SIM) grant to develop its internal evaluation plan. Finally, the AHS QIM continued to review evaluation documents associated with Long Term Care (LTC) program – specifically those linked to Vermont's current Choices for Care waiver. As the state plans to consolidate their existing Medicaid 1115 waivers –

more attention needs to be given to how this change might impact the current Global Commitment evaluation plan. The AHS QIM will continue to work with staff at the Pacific Health Policy Group (PHPG) to follow these developments and modify the plan as needed.

XII. 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 2014.

XIII. Enclosures/Attachments

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

Attachment 1: Budget Neutrality Workbook

Attachment 2: Enrollment and Expenditures Report

Attachment 3: Complaints Received by Health Access Member Services

Attachment 4: Medicaid Managed Care Entity Grievance and Appeal Reports

Attachment 5: Office of the Health Care Advocate Report

Attachment 6: State Fiscal Year 2014 Managed Care Entity Investments

XIV. State Contact(s)

Fiscal:	Jim Giffin, CFO VT Agency of Human Services 208 Hurricane Lane Williston, VT 05495	802-871-3005 (P) 802-871-3001 (F) jim.giffin@state.vt.us
Policy/Program:	Monica Light, Director AHS Health Care Operations, Compliance, and Improvement VT Agency of Human Services 208 Hurricane Lane Williston, VT 05495	802-871-3254 (P) 802-871-3001 (F) monica.light@state.vt.us

Managed Care Entity: Mark Larson, Commissioner
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Date Submitted to CMS: November 25, 2014

ATTACHMENTS

Global Commitment Expenditure Tracking

QE	Quarterly Expenditures	PQA: WY1	PQA: WY2	PQA: WY3	PQA: WY4	PQA: WY5	PQA: WY6	PQA: WY7	PQA: WY8	PQA: WY9a	PQA: WY9b	PQA: WY10	PQA: WY11	Net Program PQA	Net Program Expenditures as reported on 64	Excess New Adult Expenditures as reported on 64 per STC 55e	non-MCO Admin Expenses	Total columns J:K for Budget Neutrality calculation - Includes New Adult	Cumulative Waiver Cap - Excluding New Adult per 10/2/13 STCs	Variance to Cap under/(over)	
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		\$ 5,939,459	\$ 1,018,930,298	\$ 4,700,022,174	\$ 255,911,342	
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	\$ 369,688,737	
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							\$ 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	\$ 1,134,526,550		\$ 5,751,066	\$ 1,140,277,616	\$ 7,113,290,903	\$ 477,488,286	
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	\$ 336,946,361	\$ -	\$ -	\$ -	\$ -	\$ 29,814,314	\$ (125,679)							\$ 29,688,635	\$ 366,634,996						
0913	\$ 286,067,548	\$ -	\$ -	\$ -	\$ -	\$ 2,162,772	\$ 288,230,320							\$ 2,162,772	\$ 288,230,320						
WY8 SUM	\$ 1,191,700,038	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 33,842,100	\$ 2,037,093						\$ 35,879,193	\$ 1,199,887,555		\$ 6,260,794	\$ 1,206,148,349	\$ 8,450,684,486	\$ 608,733,520	
Cumulative																					
1213	\$ 319,939,651	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 3,652,767							\$ 3,652,767	\$ 323,592,418						
WY9a SUM	\$ 319,939,651	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 3,652,767						\$ 3,652,767	\$ 319,921,780		\$ 1,214,631	\$ 321,136,411	\$ 8,955,886,798	\$ 792,799,422	
Cumulative																					
0314	\$ 288,542,475	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 2,159,834							\$ 2,159,834	\$ 290,702,309						
0614	\$ 288,845,927	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 288,845,927						\$ -	\$ 288,845,927						
0914	\$ 242,449,803	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 337,823	\$ (17,871)	\$ 1,743,008					\$ 2,062,960	\$ 244,512,763						
1214	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -					\$ -	\$ -						
WY9b SUM	\$ 819,838,205	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 2,497,657	\$ (17,871)	\$ 1,743,008			\$ 4,222,794	\$ 821,581,213		\$ 3,618,254	\$ 825,199,467	\$ 10,290,338,883	\$ 1,302,052,040	
Cumulative																					
0315	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -					\$ -	\$ -						
0615	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -					\$ -	\$ -						
0915	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -					\$ -	\$ -						
1215	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -					\$ -	\$ -						
WY10 SUM	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -		\$ -	\$ -	\$ 8,988,286,843	\$ 11,706,456,093	\$ 2,718,169,250
Cumulative																					
0316	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -					\$ -	\$ -						
0616	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -					\$ -	\$ -						
0916	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -					\$ -	\$ -						
1216	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -					\$ -	\$ -						
WY11 SUM	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -		\$ -	\$ -	\$ 8,988,286,843	\$ 13,209,265,211	\$ 4,220,978,368
Cumulative																					
	\$ 8,738,957,871	\$ 10,166,327	\$ (16,042,281)	\$ 79,876,130	\$ 41,153,315	\$ 19,453,990	\$ 4,878,725	\$ 48,036,100	\$ 8,187,517	\$ (17,871)	\$ 1,743,008	\$ -	\$ -	\$ -	\$ 8,936,392,831	\$ -	\$ 51,894,012	\$ -	\$ -	\$ -	

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)

New Adult - Adults who are at or below 138% of the FPL

Exchange Vermont Premium Assistance - Individuals enrolled in qualified health plans (QHP) with incomes at or below 300% FPL

Exchange Vermont Cost Sharing - Individuals enrolled in qualified health plans (QHP) with incomes at or below 300% FPL

Underinsured Child – Beneficiaries age 18 or under with household income 237-312% FPL with other insurance

CHIP – Beneficiaries under 18 with household income 237-312% FPL with no other insurance

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

Choices for Care - Vermont's Long Term Care Medicaid Program; for Vermonters in nursing homes, home-based settings, and/or enhanced residential care (ERC)



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The Department of Vermont Health Access
Caseload and Expenditure Report ~ All AHS Medicaid Spend
All AHS YTD '15
 Thursday, November 13, 2014

	SFY '15 Appropriated			SFY '15 Actuals thru Sept. 30, 2014			% of Approp. Spent to Date
	Caseload	Expenses	PMPM	Caseload	Expenses	PMPM	
ABD Adult	15,004	\$ 197,166,749	\$ 1,095.09	15,438	\$ 42,875,803	\$ 925.78	21.75%
ABD Dual	17,558	\$ 204,585,893	\$ 970.98	17,455	\$ 39,403,073	\$ 752.48	19.26%
General Adult	11,679	\$ 87,415,381	\$ 623.72	15,817	\$ 23,072,901	\$ 486.24	26.39%
New Adult	35,059	\$ 200,940,297	\$ 477.62	48,653	\$ 55,574,036	\$ 380.75	27.66%
Sunsetted Program*					\$ 577,405		
Exchange Premium Assistance #	42,785	\$ 13,831,832	\$ 26.94	17,260	\$ 1,779,926	\$ 34.38	12.87%
Exchange Cost Sharing #	15,849	\$ 3,117,367	\$ 16.39	5,204	\$ 265,076	\$ 16.98	8.50%
ABD Child	3,714	\$ 88,536,493	\$ 1,986.31	3,903	\$ 19,098,503	\$ 1,631.10	21.57%
General Child	55,846	\$ 238,543,353	\$ 355.96	58,722	\$ 56,552,841	\$ 321.02	23.71%
Underinsured Child	775	\$ 2,094,117	\$ 225.31	2,074	\$ 1,371,141	\$ 220.41	65.48%
SCHIP	4,329	\$ 10,846,411	\$ 208.79	3,051	\$ 2,420,380	\$ 264.44	22.32%
Pharmacy Only	12,489	\$ 6,166,252	\$ 41.14	12,260	\$ 928,784	\$ 25.25	15.06%
Choices for Care	3,875	\$ 204,357,566	\$ 4,394.63	4,063	\$ 52,688,785	\$ 4,322.65	25.78%
Total Medicaid	218,964	\$ 1,257,601,710	\$ 478.62	203,899	\$ 296,608,653	\$ 484.90	23.59%

* - Sunsetted Programs defined as VHAP, VHAP ESI, Catamount and ESIA Medicaid Eligible Groups

Exchange Premium Assistance and Cost Sharing PMPMs were budgeted based on member count. Actual PMPM is based on subscriber count, which may include more than one member per plan



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The Department of Vermont Health Access
Caseload and Expenditure Report ~ DVHA Only Medicaid Spend
DVHA YTD '15

Thursday, November 13, 2014

	SFY '15 Appropriated			SFY '15 Actuals thru Sept. 30, 2014			% of Approp. Spent to Date
	Caseload	Expenses	PMPM	Caseload	Expenses	PMPM	
ABD Adult	15,004	\$ 116,363,012	\$ 646.30	15,438	\$ 26,930,366	\$ 581.49	23.14%
ABD Dual	17,558	\$ 51,697,940	\$ 245.36	17,455	\$ 11,693,630	\$ 223.31	22.62%
General Adult	11,679	\$ 78,610,062	\$ 560.89	15,817	\$ 21,018,970	\$ 442.95	26.74%
New Adult	35,059	\$ 185,490,566	\$ 440.90	48,653	\$ 51,886,561	\$ 355.49	27.97%
Sunsetted Programs*					\$ 571,607		
Exchange Premium Assistance #	42,785	\$ 13,831,832	\$ 26.94	17,260	\$ 1,779,926	\$ 34.38	12.87%
Exchange Cost Sharing #	15,849	\$ 3,117,367	\$ 16.39	5,204	\$ 265,076	\$ 16.98	8.50%
ABD Child	3,714	\$ 33,638,400	\$ 754.67	3,903	\$ 7,725,409	\$ 659.78	22.97%
General Child	55,846	\$ 132,635,027	\$ 197.92	58,722	\$ 32,886,677	\$ 186.68	24.79%
Underinsured Child	775	\$ 637,389	\$ 68.58	2,074	\$ 959,043	\$ 154.16	150.46%
SCHIP	4,329	\$ 8,093,421	\$ 155.80	3,051	\$ 1,981,686	\$ 216.51	24.49%
Pharmacy Only	12,489	\$ 6,166,252	\$ 41.14	12,260	\$ 928,784	\$ 25.25	15.06%
Choices for Care	3,875	\$ 204,357,566	\$ 4,394.63	4,063	\$ 52,688,785	\$ 4,322.65	25.78%
Total Medicaid	218,964	\$ 834,638,834	\$ 317.65	203,899	\$ 211,316,519	\$ 345.46	25.32%

* - Sunsetted Programs defined as VHAP, VHAP ESI, Catamount and ESIA Medicaid Eligible Groups

Exchange Premium Assistance and Cost Sharing PMPMs were budgeted based on member count. Actual PMPM is based on subscriber count, which may include more than one member per plan

**Questions, Complaints and Concerns Received by Health Access Member Services
June 30, 2014 – September 27, 2014**

June 30 – July 5

- There are no topics to report for this week.

July 7 – July 12

- New UID card requests: CSR's ordered cards per Taking Changes guide.
- PCP Enrollment and Information Updates: CSR's updated account as needed.
- Covered service inquiries: CSR's either referred to KB or to the Primary Care Physician.
- Letters regarding premium issues: CSR's referred to the KB article that was published during the week.

July 14 – July 19

- PCP Enrollment and Information Updates: CSR's updated account as needed.
- Covered service inquiries: CSR's either referred to KB or to the Primary Care Physician.
- Persistent RxClaim system discrepancies for clients starting Medicare on 8/1/2014, but OVHAD segment showing up early and client is unable to pick up prescriptions: CSR's escalated to supervisor to supervisor for resolution.

July 21 – July 26

- Review notices: CSR's advised to caller to complete review application.
- Closure letters for VPharm (non-payment): CSR's advised if payment was received or provided payment mailing information.
- Persistent RxClaim system discrepancies for clients starting Medicare on 8/1/2014, but OVHAD segment showing up early and client is unable to pick up prescriptions: CSR's escalated to superviso for resolution.

July 28 – August 2

- PC Plus Enrollment: CSR's assisted callers with enrolling in their PCP of choice.



August 4 – August 9

- Dr. Dynasaur refunds: CSR's referred to the GMC Premium Ultimate and advised the caller accordingly.
- Reinstatements: CSR's referred to the KB and escalated as necessary.

August 11 – August 16

- Active OVHAD claims in RxClaims billing system prior to Medicare becoming active causing inability to pick up prescriptions: CSR's created a SR and supervisors forwarded it to Catamaran.
- Infants reported through ESD not screened for benefits as Health Care is not selected within the new member panel when created: CSR's sent CATN's and escalated the call the HAEU if an access to care issue.

August 18 – August 23

- Active OVHAD claims in RxClaims billing system prior to Medicare becoming active causing inability to pick up prescriptions: CSR's created a SR and supervisors forwarded it to Catamaran.
- UID Card reorders: CSR's requested a new card.
- VPharm closing for non-payment: CSR's reviewed account activity and advised that payments are due by the first business day of the following month and whether a new application was needed.
- PC Plus Enrollment: CSR's assisted callers with enrolling in their PCP of choice.
- Covered service inquiries for Medicaid and Dr. Dynasaur: CSR's address the caller's question, or referred to a provider if needed.

August 25 – August 30

- Active OVHAD claims in RxClaims billing system prior to Medicare becoming active
- causing inability to pick up prescriptions: CSR's created a SR and supervisors
- forwarded it to Catamaran.
- PC Plus Enrollment: CSR's assisted callers with enrolling in their PCP of choice.
- Change of income: CSR's updated information in JINC panel in ACCESS and sent a
- CATN.

September 1 – September 6

- Active OVHAD claims in RxClaims billing system prior to Medicare becoming active causing inability to pick up prescriptions: CSR's created a SR and supervisors forwarded it to Catamaran.
- PC Plus Enrollment: CSR's assisted callers with enrolling in their PCP of choice.
- New UID card requests: CSR's ordered cards per Taking Changes guide.

- Review mail arrival: CSR's advised that reviews have been extended and to watch the mail.
- People checking on GMC reviews: CSR's explained that reviews have been extended and advised to watch the mail.

September 8 – September 13

- Active OVHAD claims in RxClaims billing system prior to Medicare becoming active causing inability to pick up prescriptions: CSR's created a SR and supervisors forwarded it to Catamaran.
- PC Plus Enrollment: CSR's assisted callers with enrolling in their PCP of choice.
- People checking on GMC reviews: CSR's explained that reviews have been extended and advised to watch the mail.
- Premium refunds issued when clients paid for both VHC and GMC: CSR's notified client why they were receiving a refund.

September 15 – September 20

- Active OVHAD claims in RxClaims billing system prior to Medicare becoming active causing inability to pick up prescriptions: CSR's created a SR and supervisors forwarded it to Catamaran.
- Pharmacies rejecting prescriptions due to TPL flag in their billing system: CSR's checked system to ensure we did not have TPL on file, closed it out if there was one, and provided a phone number to ensure the policy is closed from the reject error.

September 22 – September 27

- Active OVHAD claims in RxClaims billing system prior to Medicare becoming active causing inability to pick up prescriptions: CSR's created a SR and supervisors forwarded it to Catamaran to correct dates.



**Grievance and Appeal Quarterly Report
Medicaid MCE All Departments Combined Data
July 1, 2014 – September 30, 2014**

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 (DAAIL), 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 DAAIL. Each entity should have at least one assigned grievance and appeal coordinator who enters data into the MCE database. This report is based on data compiled on October 3, 2014, from the centralized database for grievances and appeals that were filed from July 1, 2014 through September 30, 2014.

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 12 grievances filed with the MCE; with four of them being addressed during the quarter. Grievances must be addressed within 90 days of filing, so having pending cases at the end of the quarter is to be expected. Acknowledgement letters of the receipt of a grievance must be sent within five days; the average was two days. Of the grievances filed, 75% were filed by beneficiaries, 17% were filed by a representative of the beneficiary, and 8% by another source. Of the 12 grievances filed, DMH had 84%, DVHA had 8%, and VDH had 8%.

There were no Grievance Reviews filed this quarter.

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

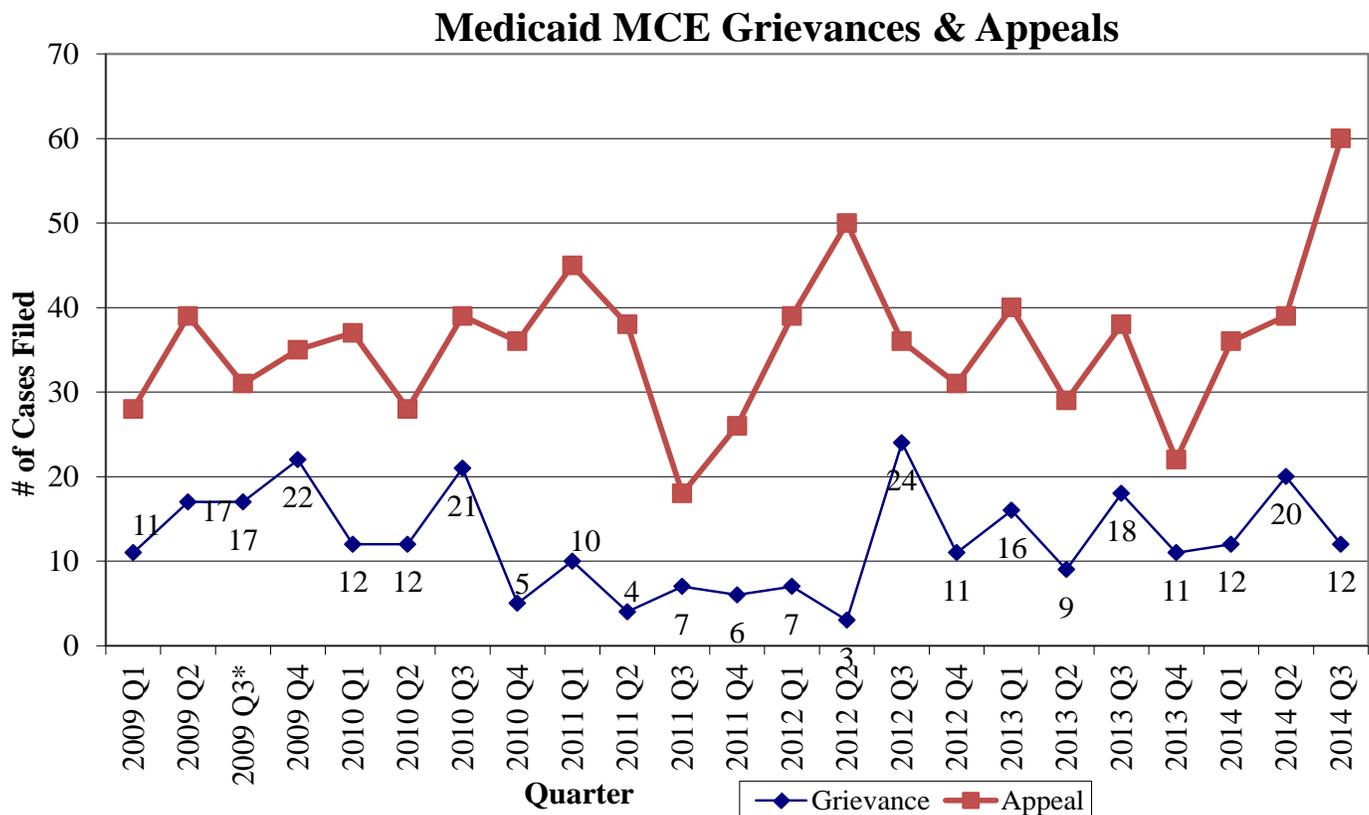
1. denial or limitation of authorization of a requested covered service or eligibility for service, including the type, scope or level of service;
2. reduction, suspension or termination of a previously authorized covered service or a service plan;
3. denial, in whole or in part, of payment for a covered 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 60 appeals filed with the MCE; 22 requested an expedited decision, with all 22 of them meeting the criteria. Of these 60 appeals, 50 were resolved (83% of filed appeals), 9 were still pending (15%), and 1 was withdrawn (2%). In twenty three cases (46% of those resolved), the original decision was upheld by the person hearing the appeal, in twenty five cases (50%) the original decision was reversed, and in 2 cases the decision was modified (4%).

Of the 50 appeals that were resolved this quarter, 100% were resolved within the statutory time frame of 45 days; 64% were resolved within 30 days. The average number of days it took to resolve these cases was 23 days. Acknowledgement letters of the receipt of an appeal must be sent within five days; the average was three days, with one of them being late.

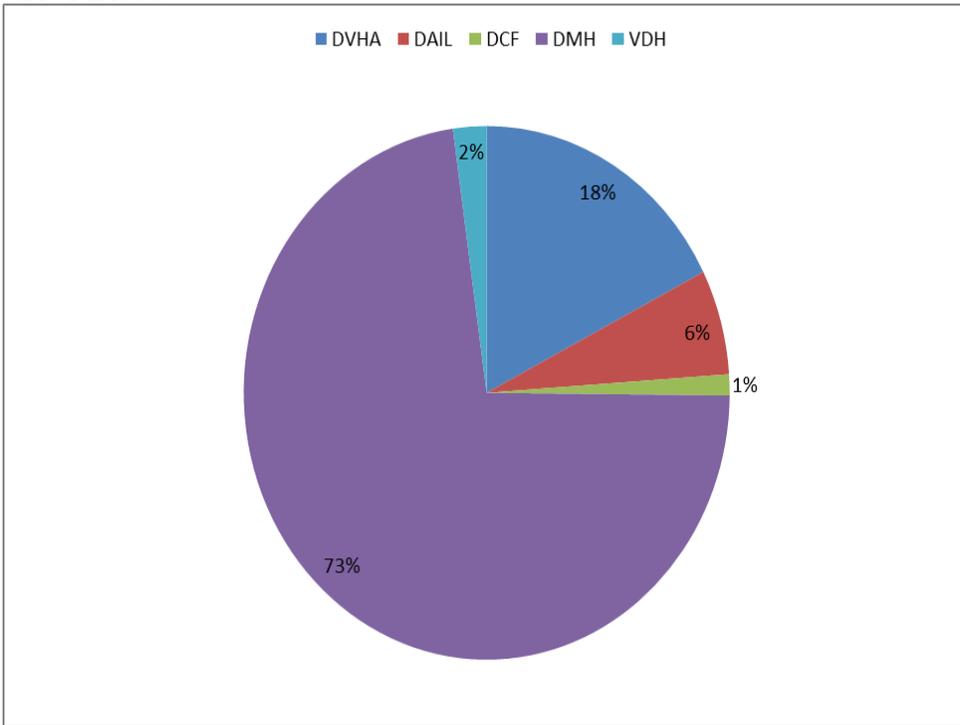
Of the 60 appeals filed, 33 were filed by beneficiaries (55%), 22 were filed by a representative of the beneficiary (37%), and 5 (8%) were filed by the provider. Of the 60 appeals filed, DVHA had 85%, DAIL had 12%, and DMH had 3%.

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 seven fair hearing filed this quarter.

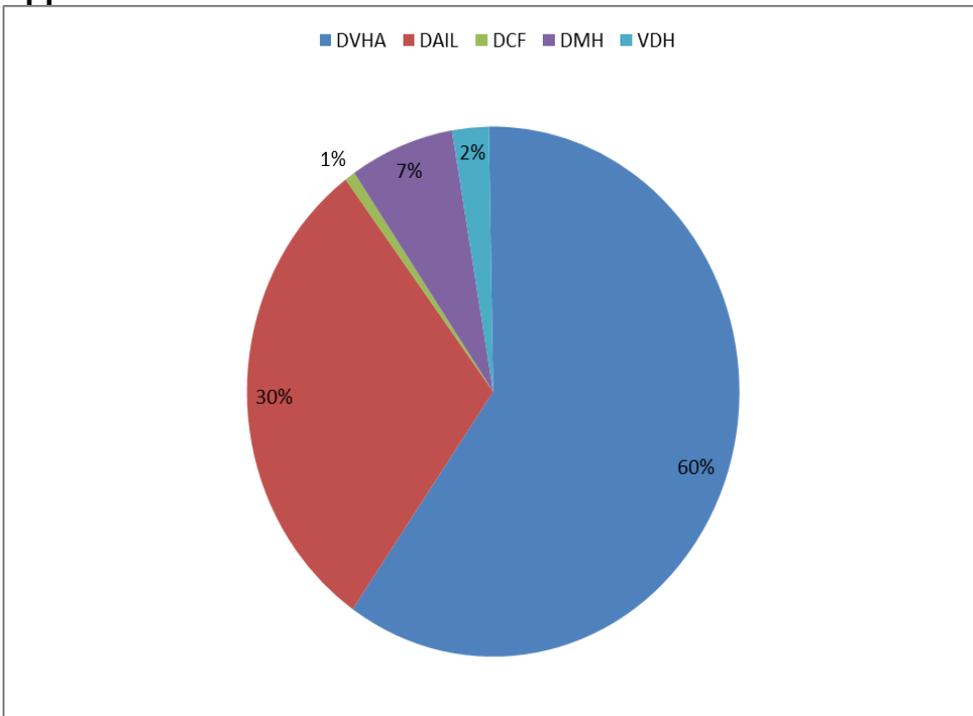


MCE Grievance & Appeals by Department From January 1, 2009 through September 30, 2014

Grievances



Appeals



VERMONT LEGAL AID, INC.

OFFICE OF THE HEALTH CARE ADVOCATE

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BURLINGTON, VERMONT 05402
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BURLINGTON
RUTLAND
ST. JOHNSBURY

OFFICES:

MONTPELIER
SPRINGFIELD

QUARTERLY REPORT

July 1, 2014 – September 30, 2014

to the

Agency of Administration

submitted by

Trinka Kerr, Chief Health Care Advocate

October 17, 2014

I. Introduction

The Office of the Health Care Advocate (HCA) provides consumer assistance to individual Vermonters on questions and problems related to health insurance and health care. The HCA also engages in consumer protection activities on behalf of the public before the Green Mountain Care Board, other state agencies and the state legislature.

The following information is contained in this quarterly report:

- This narrative which includes sections on **Individual Consumer Assistance**, **Consumer Protection Activities** and **Outreach and Education**
- Six data reports
 - **All calls/all coverages:** 1,096 calls
 - **DVHA beneficiaries:** 403 calls or **37%** of total calls
 - **Commercial plan beneficiaries:** 265 calls or **24%**
 - **Uninsured Vermonters:** 152 calls or **14%**
 - **Vermont Health Connect:** 441 calls or **40%** (this data report draws from the All Calls data set above)
 - **Reportable Activities (Summary & Detail):** 134 activities, 54 documents

II. Individual Consumer Assistance

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

The HCA received 1,096 calls this quarter. We divided these calls into five issue categories. The figures below are based on the All Calls data. The percentage and number of calls in each issue category based on the caller's primary issue were as follows:

- **21.53%** (236) of our total calls were regarding **Access to Care**;
- **15.05%** (165) were regarding **Billing/Coverage**;
- **1.64%** (18) were questions regarding **Buying Insurance**;
- **10.49%** (115) primarily involved **Consumer Education**;
- **28.19%** (309) were regarding **Eligibility** for VHC programs and Medicare; and
- **23.08%** (253) were categorized as **Other**, which includes Medicare Part D, communication problems with providers or plans, access to medical records, changing providers or plans, confidentiality issues, and complaints about insurance premium rates, as well as other issues.

We have a customized case management system. This system 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. For example, although 309 cases had Eligibility for state health care programs as the primary issue, there were actually a total of 1,039 calls in which we spent a significant amount of time assisting consumers regarding eligibility for health insurance. In each section of this narrative we indicate whether we are referring to data based on just primary issues, or primary and secondary issues combined. One call can involve multiple secondary issues. [See the breakouts of the issue numbers in the individual data reports for a more detailed look at how many callers had questions about issues in addition to the primary reason for their call.]

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

See our recommendations to the state at the end of this section, beginning on page 10.

A. The HCA's call volume continued to set record high levels primarily due to problems with Vermont Health Connect.

The HCA's call volume was 46% higher than in the same quarter last year, although calls increased only 7% from last quarter. The state launched its health benefit exchange, Vermont Health Connect (VHC), on October 1, 2013, as required by the federal Affordable Care Act (ACA). The rollout was rocky, and VHC continues to be plagued by operational problems. As a result, our call volume has hit record levels month after month since December 2013.

We received 1,096 calls this quarter, compared to 1,022 last quarter. This compares to 751 calls in the third quarter of calendar year 2013. Thus, our SFY 2015 Q 1 call volume was 46% higher than SFY 2014 Q 1. Because about 40% of our calls this quarter were related to VHC, it

seems safe to assume that this big increase was mainly attributable to problems with the exchange. The number of calls involving VHC increased just slightly from last quarter, from 418 to 441, a 5% increase. However, this was below the 541 VHC calls in the first quarter of 2014.

In each month this quarter we saw a record number of calls for that particular month. July's call volume was 381, compared to 271 last year; August's was 342 compared to 224; and September's was 374 compared to 256.

B. Problems with Vermont Health Connect premium processing more than doubled, and surpassed the number of cases involving Change of Circumstance issues.

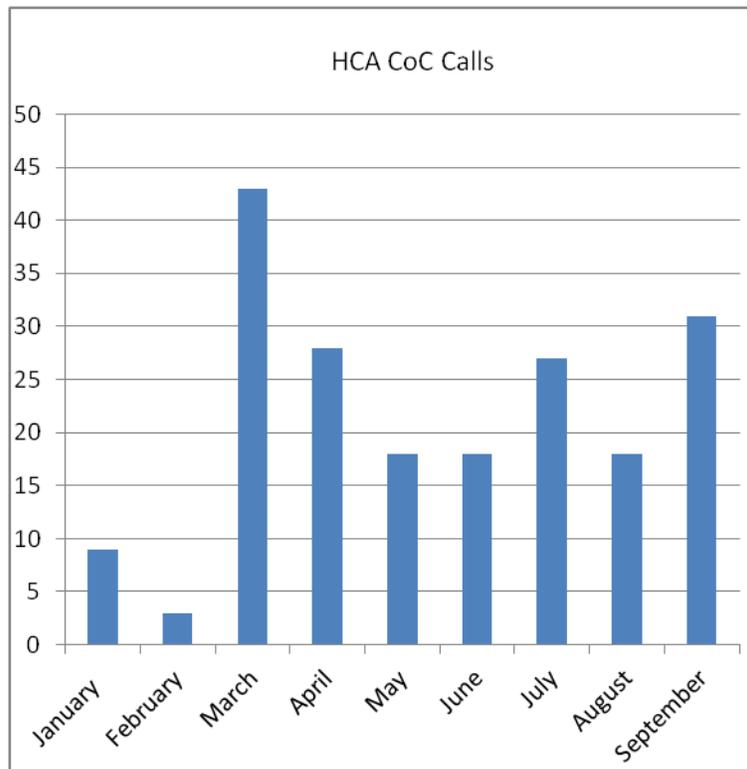
Many consumers who purchased Qualified Health Plans from VHC are having problems getting the coverage they bought. The problems include non-receipt of invoices, multiple invoices in one month, delays in processing, and sometimes longer delays in actually getting correct coverage. Some people reported that they had made payments for months which did not seem to be recorded anywhere. Frequently these problems resulted in individuals going without coverage for months. In many cases they were deferring or going without care or medications because their insurance had not been activated. Thus, it is small consolation for people to get retroactive coverage when things are finally fixed if they went without care while waiting for their coverage to be active. Not to mention that many do not want to pay for coverage retroactively that they were unable to access.

This quarter we received 117 calls involving premium processing, compared to 54 last quarter when primary and secondary issues are counted, an increase of more than 100%. In 58 of these cases a payment issue was identified as the primary problem, compared to just 17 cases last quarter.

Payment problems substantially outnumbered Change of Circumstance (CoC) problems this quarter. There were 117 payment cases and 76 CoC cases. Fifteen of our premium processing cases also involved access to care issues.

C. Complaints related to Vermont Health Connect's lack of Change of Circumstance functionality continued to increase.

At the beginning of the summer the State hired Optum to assist with the CoC backlog. They have reportedly made significant inroads into resolving those cases. However, this work is not yet showing up in the HCA's statistics. Calls to the HCA related to CoC problems have not decreased: they increased 19%, from 64 to 76.



Twelve of our CoC cases involved access to care issues. These cases are often complex and time-consuming for the HCA, difficult for the State to resolve, and extremely distressing for the consumers.

D. Vermont Health Connect began sending out Notices of Decision which did not cause the feared level of confusion.

NODs about eligibility status finally went out to the thousands of people who applied through VHC starting last October. Despite our concern that this would generate a large number of calls to both the call center and our office, that did not happen. We only received 33 calls related to problems with notices, down from 36 last quarter.

E. Access to care complaints caused by the cost of health care have significantly decreased since last year.

We only received 57 calls related to access to care problems caused by the lack of affordability of health care. Last year for this quarter we received 137 affordability calls, so that is a 58% decrease. We received 102 calls in the first quarter of calendar year 2014 and 65 last quarter, so these types of calls have steadily decreased since January. This may signify that more people have insurance and are thus finding care to be more affordable.

F. Medicaid eligibility calls dropped 16%.

Both MAGI Medicaid and MABD Medicaid calls decreased this quarter, as the State reinstated individuals who had been terminated for failure to re-enroll through VHC. Medicaid renewals have been pushed out into 2015. Last quarter we received 213 calls related to Medicaid eligibility, and this quarter we received 179.

G. Complaints about the Economic Services Division have decreased substantially over the last three quarters.

Calls about problems with ESD fell from 138 in the first quarter of this calendar year, to 67 last quarter, to 32 this quarter. This is a significant improvement!

H. Three new areas of concern are appearing: Advanced Premium Tax Credits, Special Enrollment Periods and grace periods.

APTCs

The number of calls related to premium tax credits increased from 55 to 73. We expect to get increasingly more calls about the calculation of PTC and its implications for the upcoming tax season. We have had significant difficulty getting clarification of how exactly VHC and Siebel (the VHC computer system) are calculating PTC, especially in complex tax households.

SEPs

Special Enrollment Periods are available to individuals who experience specific qualifying life events like divorce, marriage, loss of coverage through employment, etc. We received 45 calls about SEPs this quarter, compared to 21 last quarter. It is inevitable the SEPs would be more of an issue outside the Open Enrollment Periods.

Grace periods

Many people appear to be confused about Vermont's premium payment grace periods. Individuals without APTC get a one month grace period to catch up on their premiums if they fall behind; individuals with APTC get three months. We received 31 calls this quarter about terminations connected to grace period problems. Some of these problems are related to the timing of payments. Payments must be mailed by the end of the month, but dunning notices go out immediately at the beginning of the next month. This was a new code so we do not have earlier figures.

I. The top issues generating calls

This section includes both primary and secondary issues.

All Calls (1,096, compared to 1,022 last quarter)

1. VHC complaints 198 (compared to 190 last quarter)

2. Information about VHC 185 (138)
3. Complaints about providers 146 (132)
4. Information about DVHA programs 138 (116)
5. VHC website/technology problem 127 (109)
6. Premium Billing 121 (70) [107 of these were VHC-related]
7. VHC Invoice Problem 117 (54)
8. Access to Prescription Drugs 101 (116)
9. MAGI Medicaid eligibility 92 (102)
10. Medicaid (non-MAGI) eligibility 87 (110)
11. Change of Circumstance 76 (63)
12. Premium Tax Credit eligibility 73 (53)
13. Buying QHPs through VHC 67 (54)
14. Medicare consumer education 67 (45)
15. Affordability access problem 57 (60)

Vermont Health Connect Calls (441, compared to 418 last quarter)

1. VHC complaints 197 (190 last quarter)
2. Information about VHC 181 (138)
3. VHC website/technology problem 127 (109)
4. VHC Invoice problem 117 (54)
5. Premium billing problem 107 (55)
6. MAGI Medicaid eligibility 82 (97)
7. Change of Circumstance 76 (62)
8. Information about applying for DVHA programs 71 (55)
9. Premium Tax Credit eligibility 71 (53)
10. Buying QHPs through VHC 67 (54)

DVHA Beneficiary Calls (403, compared to 414 last quarter)

1. Complaints about Providers 84 (67 last quarter)
2. Information about DVHA programs 56 (59)
3. Access to Prescription Drugs 41 (63)
4. Medicaid Billing 37 (36)
5. Medicaid (non-MAGI) eligibility 34 (54)
6. VHC complaints 28 (41)
7. MAGI Medicaid eligibility 25 (42)
8. Medicare consumer education 24 (8)
9. Choosing/changing providers 23 (13)
10. Out of state billing 20 (13)
11. Transportation 20 (12)

Commercial Plan Beneficiary Calls (265, compared to 208 last quarter)

1. Information about VHC 99 (56 last quarter)
2. VHC complaints 92 (80 last quarter)
3. Premium billing 80 (37)
4. VHC invoice problem 69 (32)

5. VHC website/technology problem 57 (30)
6. Change of Circumstance 44 (25)
7. Premium Tax Credit eligibility 40 (16)
8. Buying QHPs through VHC 38 (19)
9. MAGI Medicaid 29 (17)
10. Access to Prescription Drugs 22 (22)

J. Hotline call volume by type of insurance:

The HCA received 1,096 total calls this quarter. Callers had the following insurance status:

- **DVHA program beneficiaries** (Medicaid, VPharm, or both Medicaid and Medicare aka “dual eligibles”) insured **37%** (403 calls), compared to 40% (414) last quarter;
- **Medicare¹ beneficiaries** (Medicare only, Medicare Advantage Plans, 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 **19%** (209), compared to 21% (210) last quarter;
- **Commercial plan beneficiaries** (employer sponsored insurance, small group plans, or individual plans) insured **24%** (265), compared to 20% (208) last quarter; and
- **Uninsured** callers made up **14%** (152) of the calls, compared to 13% (137) last quarter.
- In the remainder of calls the insurance status was either unknown or not relevant.

K. Dispositions of closed cases

All Calls

We closed 1,086 cases this quarter, compared to 1,021 last quarter.

- 28% (307 cases) were resolved by brief analysis and advice;
- 26% (287) were resolved by brief analysis and referral;
- 22% (236) of the cases were complex interventions involving complex analysis, usually direct intervention, and more than two hours of an advocate’s time;
- 17% (186) were resolved by direct intervention, including calling an insurance company, calling providers, writing letters, gathering supporting medical documentation, etc.;
- <1% (3) 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: 28 cases involved help with appeals: 3 commercial plan appeals, 19 Fair Hearings, 4 DVHA internal MCO appeals and 2 Medicare appeals. Most of our cases involving VHC and DVHA are resolved without using the formal appeals process.

¹ Since Medicare beneficiaries can also have commercial or DVHA coverage, these Medicare numbers overlap with those figures.

DVHA Beneficiary Calls

We closed 407 DVHA cases this quarter, compared to 401 last quarter.

- 29% (120 cases) were resolved by brief analysis and advice;
- 30% (124) were resolved by brief analysis and referral;
- 17% (69) were considered complex intervention, which involves complex analysis, usually direct intervention, and more than two hours of an advocate's time;
- 20% (80) were resolved by direct intervention on the caller's behalf, including advocacy with DVHA and providers, writing letters, and gathering medical information;
- Just 1 DVHA beneficiary call was resolved in the initial call.
- In the remaining cases, clients withdrew, resolved the issue on their own, or had some other outcome.
- Appeals: 23 cases involved appeals: 19 Fair Hearings and 4 internal MCO appeals.

Commercial Plan Beneficiary Calls

We closed 253 cases involving individuals on commercial plans, compared to 222 last quarter.

- 29% (73 cases) were resolved by brief analysis and advice;
- 18% (45) were resolved by brief analysis and referral;
- 31% (78) were considered complex intervention, which involves complex analysis, usually direct intervention, and more than two hours of an advocate's time (this measure increased by 20% over last quarter);
- 22% (55) were resolved by direct intervention on the caller's behalf, including advocacy with the carrier and providers, writing letters, and gathering medical information;
- No calls from commercial plan 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: 3 cases involved appeals.

L. Case outcomes

All Calls

The HCA helped 141 people get enrolled in insurance plans and prevented 9 insurance terminations or reductions. We obtained coverage for services for 43 people. We got 28 claims paid, written off or reimbursed. We helped 8 people complete applications and estimated VHC insurance program eligibility for 22 more. We provided other billing assistance to 41 individuals. We obtained hospital patient assistance for 8 people. We provided 555 individuals with advice and education. We obtained other access or eligibility outcomes for 61 more people, many of whom we expected to 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 after our assessment and advice, or do not have their issue resolved as expected.

In total, this quarter the **HCA saved individual consumers \$49,138.66** in cases opened this quarter. The amount of individual savings so far in calendar year 2014 was **\$269,103.21**.

M. Case examples

Here are a few examples of the problems we helped Vermonters resolve this quarter:

1. Wrong start date delayed coverage and held up proof of insurance for college student.
Mr. A called the HCA because he had signed up for a Qualified Health Plan (QHP) for his family through VHC and paid the premiums for two months, but the coverage was not active. He worked with a navigator and called VHC, but could not resolve the problem. His son was starting college in just a few weeks, and the college required proof of his insurance before the start of the school year. If Mr. A could not get the proof quickly, he would need to pay \$3,000 for the college's insurance so his son could start classes. When the HCA advocate contacted VHC, she learned that VHC had the wrong start date for Mr. A's QHP. The family had signed up for a July 1 start date, but VHC set it to begin September 1. The advocate worked with VHC to fix the start date and get the premiums applied to the correct months. She also got a letter from VHC to show the college that Mr. A's son had insurance. The family's coverage was activated and the son's college accepted VHC's letter, so he could begin school without paying the additional \$3,000.
2. Refugee forced onto QHP rather than Medicaid in error.
When Ms. B received a bill from a provider, she was puzzled. She thought that she had Medicaid, so she did not know why she was getting a bill. She called VHC and found out that her Medicaid coverage had been closed. She was also advised by VHC that she was ineligible for Medicaid and would need to purchase a QHP. So, Ms. B signed up for a QHP and paid the first premium, but then realized she could not afford the monthly premiums. She called the HCA to find out if she really was ineligible for Medicaid. The HCA advocate identified that VHC had made a mistake when it terminated her Medicaid. Ms. B came to the U.S. as a refugee and subsequently got a "green card." Usually an immigrant with a green card has to wait five years for Medicaid eligibility. However, there are exceptions to this rule, and the advocate pointed out to VHC that Ms. B fell into one of the exceptions. Because Ms. B had come to the country as a refugee, she was not subject to the five-year bar and was eligible for Medicaid as long as she was also income eligible. VHC put Ms. B back onto Medicaid and refunded the premiums she had paid.
3. Cancer patient unable to afford QHP copayments.
Ms. C called the HCA because she had been diagnosed with cervical cancer and was having trouble continuing treatment due to the high levels of cost-sharing in her QHP. Her plan required copayments every time she saw her providers. Her HCA advocate

figured out that Ms. C was eligible for a special type of Medicaid coverage specifically for individuals with breast or cervical cancer which does not require copayments. This Medicaid coverage, however, could not be activated until Ms. C's QHP was closed. The advocate contacted VHC and worked to get Ms. C's QHP closed quickly, and her Medicaid application rushed. The advocate helped ensure that there was a seamless transition onto Medicaid without any gap in coverage. Ms. C is now on Medicaid and able to continue her cancer treatment.

N. Table of all calls by month and year

All Cases (2004-2014)											
	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
January	252	178	313	280	309	240	218	329	282	289	428
February	188	160	209	172	232	255	228	246	233	283	304
March	257	188	192	219	229	256	250	281	262	263	451
April	203	173	192	190	235	213	222	249	252	253	354
May	210	200	235	195	207	213	205	253	242	228	324
June	176	191	236	254	245	276	250	286	223	240	344
July	208	190	183	211	205	225	271	239	255	271	381
August	236	214	216	250	152	173	234	276	263	224	342
September	191	172	181	167	147	218	310	323	251	256	374
October	172	191	225	229	237	216	300	254	341	327	
November	146	168	216	195	192	170	300	251	274	283	
December	170	175	185	198	214	161	289	222	227	340	
Total	2409	2200	2583	2560	2604	2616	3077	3209	3105	3257	3302

O. Recommendations

1. *The VHC invoice and payment system still needs improvement.*

We continue to hear from consumers who have had significant problems with the premium payment system. Some people are getting multiple invoices, are making payments for months without receiving coverage in a timely manner, have made payments that are not applied to their accounts, and have complex problems that are not resolved quickly. It might make more sense to have consumers pay the carriers directly, rather than send their payments to VHC. There are too many steps in the payment process which result in opportunities at each step for something to go wrong, and make resolving problems time-consuming.

2. *The backlog of Change of Circumstance cases must be eliminated before open enrollment begins on November 15th.*

As mentioned above, we are not yet seeing a reduction in CoC calls. VHC needs to double down on its efforts to get these cases resolved before renewals begin, or there will be a whole new set of problems for consumers.

3. *VHC staff and consumer education needs to be increased so that tax issues related to premium tax credits and exemptions from the Individual Shared Responsibility Payment can be more easily addressed.*

We are getting more and more concerned about the number and degree of potential problems that Vermonters may have with the IRS as a result of the ACA requirements. The Maximus call center, Optum and the Health Access Eligibility Unit (HAEU) staff all need to be thoroughly trained on premium tax credits and exemptions from the Individual Shared Responsibility Payment. They also need training on how to explain possible IRS-related consequences and options to consumers. A greater outreach and education effort is needed to inform consumers about what the amount of APTC received in 2014 will mean when they file their tax returns.

III. Consumer protection activities

A. Rate review work

Insurance carriers filed seven new rate cases with the Green Mountain Care Board (GMCB) in this quarter. The HCA filed Notices of Appearance in all of these new filings. We also filed memoranda in four of the rate cases filed during the prior quarter, and participated in the two contested hearings which were held this quarter.

Exchange Filings

The most significant rate review cases were the two filings for Vermont Health Connect filed by Blue Cross Blue Shield of Vermont (BCBSVT) and MVP in June, 2014. The HCA worked with its independent actuary to review these filings and prepare for the contested hearings held in August. The GMCB issued its decisions on September 2, 2014. The Board received 275 comments from the public about these proposed increases.

BCBSVT covers about 58,000 lives through its VHC plans. The company asked for an average **9.8%** rate increase for 2015. In the BCBSVT filing, both the HCA and the Board's actuaries argued that the rate should be lowered by 2% because the federal government had announced that it intends to provide a greater subsidy to insurers under its transitional reinsurance program. This program pays for part of the costs for members who have very large health care claims. The Board decided in favor of this reduction. The Board further reduced the rate based on a second recommendation made by both its actuary and the HCA's actuary. This change in the rate requires BCBSVT to use different factors developed by the federal government to make sure that members' health status is not used in setting premiums. Finally, the Board made a

small adjustment to the amount used to calculate the federal insurance fee BCBSVT must pay. The Board's decision in the BCBSVT filing reduced the average increase for the VHC plans by 2.2%, resulting in an overall rate increase of **7.7%**.

MVP's VHC plans cover about 4,800 lives. It asked for an average rate increase of **15.3%** for 2015. In this case the HCA argued the Board should require adjustments in four parts of the filing which would together lower the rate increase by 5.1%: administrative trends, pharmacy trends, family size estimates, age estimates, and MVP's "manual rate" calculation. In addition, the HCA asked the Board to lower MVP's proposed 1.5% contribution to surplus. In its decision, the Board ordered MVP to make changes to pharmacy trend, family size estimates, and age estimates, lowering the rate increase by 4%. The Board also lowered MVP's contribution to surplus by 0.5%. The decision reduced the average rate increase to **10.9%** for MVP's 2015 VHC plans.

A summer intern from the George Washington University Law School, Xavier Hardy, worked with HCA staff on policy issues before the Green Mountain Care Board during this quarter, including helping to review and analyze the VHC rate filings.

Policy Paper on the Rate Review Process

The HCA developed a policy paper on the health insurance rate review process in Vermont. The paper was posted to the HCA's website in July:

[Health Insurance Rate Review: A Critical Part of Health Care Reform in Vermont.](#)ⁱ

Other Rate Review Activities

The HCA contributed to two Families USA blogs on rate review during the quarter. Families USA is a national health care consumer advocacy organization.

B. Hospital Budget Review

In this quarter the Green Mountain Care Board reviewed the Fiscal Year 2015 budgets for Vermont's 14 hospitals. The HCA participated in the hospital budget review process, including:

- Reviewing each hospital's budget submission
- Meeting with the GMCB Director of Health System Finances
- Submitting suggested questions to the GMCB
- Attending all 13 hospital budget hearings
- Submitting written comments following the hospital budget hearings
- Submitting written comments following the hospital budget decisions

C. Certificates of Need

We continue to monitor new and pending Certificate of Need (CON) letters of intent, requests for jurisdictional determination, and applications. Additionally, this quarter we:

- Filed 2 Notices of Intervention as an Interested Party (GMCB-015-13con Copley Hospital Construction of New Surgical Suite and GMCB-013-14con Green Mountain at Fox Run Eating Disorder Treatment Program)
- Filed 2 sets of suggested questions to the applicant (GMCB-015-13con Copley Hospital Construction of New Surgical Suite and GMCB-015-14con Fletcher Allen Health Care Property Acquisition)
- Attended a site visit at the proposed South Burlington site for GMCB-015-14con Fletcher Allen Health Care Property Acquisition
- Attended a presentation at Fletcher Allen Health Care regarding the hospital's master facility plan, including the property acquisition proposed in GMCB-015-14con

D. Other Green Mountain Care Board activities

Pursuant to Act 48 of 2011 and Act 171 of 2012, the GMCB is required to consult with the HCA about various health care reform issues. The HCA is directed in Act 79 of 2013 to "suggest policies, procedures, or rules to the GMCB in order to protect patients' and consumers' interests." This quarter we:

- Attended 10 public meetings of the GMCB
- Attended 3 public meetings of the GMCB Data Governance Council
- Submitted 2 sets of comments to the GMCB on proposed changes to the standards for Vermont's Commercial Accountable Care Organization Shared Savings Programs
- Met 5 times with GMCB staff including the Executive Director, General Counsel, Health Policy Director, Deputy Director of Policy & Evaluation, and Health Care Project Director

E. Vermont Health Care Innovation Project

We continue to participate in the State's Vermont Health Care Innovation Project (VHCIP) aka the SIM grant. This quarter we:

- Participated in 3 meetings as a member of the VHCIP Steering Committee
- Participated, along with representatives from other projects of Vermont Legal Aid, as "active members" in six of the seven VHCIP work groups, including the Payment Models Work Group, the Quality and Performance Measures Work Group, the Population Health Work Group, The Care Models and Care Management Work Group, The Disability

and Long Term Services and Supports Work Group, and the Health Information Exchange/Health Information Technology Work Group. This quarter HCA staff attended 14 VHCIP work group meetings.

- Attended 4 meetings of the VHCIP Core Team
- Submitted comments to the Quality and Performance Measures Work Group, the Steering Committee, and the Core Team regarding measure sets for the second performance year of Vermont's Accountable Care Organization (ACO) Medicaid and Commercial Shared Savings Programs

F. Other Activities

Plain Language Materials

The HCA continues to advocate for the use of plain language in materials intended for health care consumers. This quarter we conducted research on health literacy issues and continued to encourage state agencies to use plain language in their health care communications. For example, we met with Green Mountain Care Board staff about improving the readability of the GMCB's consumer materials. We suggested that the GMCB implement a plain language policy for its communications with consumers and provided GMCB staff with a memo that included a proposal for the content and implementation of such a policy. We also worked with DVHA to improve the readability of its instructions for acquiring durable medical equipment through Medicaid.

Policy Paper on Cost Sharing

The HCA's 2014 summer intern developed a white paper examining research about the effects of cost sharing on patients' utilization of the health care system. It was posted to the website in September: [The Limits of Cost Sharing](#).ⁱⁱ

Other Boards, Task Forces, and Work Groups

The HCA participated in:

- 3 Medicaid and Exchange Advisory Board (MEAB) meetings
- 1 Governor's Consumer Advisory Council meeting
- 1 MEAB Improving Access Work Group meeting (a subgroup of the MEAB which works on improving access to Medicaid services, which the Chief Health Care Advocate Chairs)
- 2 MEAB VHC Individuals and Families Work Group meetings
- 3 VHC Consumer Experience Work Group meetings
- 4 VHC Customer Support meetings with Maximus, VHC, DVHA and HAEU
- 1 Act 75 Unified Pain Management Advisory Council meeting

Legislative Activities

- Testified before legislative committees 4 times
- Attended 5 additional legislative hearings on health care

Administrative Advocacy

- Commented on VHC notices 7 times
- Commented on VHC regulations once
- Participated in 2 informal meetings about VHC regulations
- Submitted complaints or suggestions about VHC operations multiple times

Collaboration with other organizations

The HCA worked with the following organizations this quarter:

- American Civil Liberties Union (ACLU)
- City of Burlington
- Families USA
- Howard Center
- Vermont Campaign for Health Care Security
- Vermont Family Network
- Vermont Public Interest Research Group (VPIRG)
- Voices for Vermont's Children

Trainings

- Consumers Union webinar, 'Protecting Consumers from Surprise Out-of-Network Bills' (July 2)
- Consumers Union national advocates call on rate review issues (July 22)
- Vermont Information Technology Leaders, Inc. (VITL) Health IT Summit (September 8 and 9)
- Families USA advocates call discussing SIM programs, other health reform (August 28)
- Federal Office of the National Coordinator for Health IT Annual Consumer Health IT Summit on Patient Engagement (September 19)
- First day of a 2-day Community Rounds program at Fletcher Allen Health Care (September 30)

IV. Outreach and education

A. Website

Vermont Law Help is a statewide website maintained by Vermont Legal Aid and Law Line of Vermont. The site includes a substantial Health section (www.vtlawhelp.org/health) with more than 150 pages of consumer-focused information maintained by the HCA. Since the launch of Vermont Health Connect, we have worked diligently to keep the site updated in order to provide the latest and most accurate information to Vermont consumers.

The dramatic increases in pageviews that we experienced over the past two years have leveled off and in some cases decreased, and there are significant differences in the type of information that visitors to our site are looking for. Analysis of these changes suggests two main drivers:

1. The 2013 statistics for this quarter reflected the results of months of steady improvements to the old site, as well as those of the newly launched website. Beginning this quarter, the 2014 and 2013 statistics no longer compare considerably different websites.
2. Nearly a year after the launch of Vermont Health Connect, fewer visitors are searching for information about applying for insurance and finding health care services. This is likely due to more Vermonters having insurance through Medicaid expansion and VHC plans. However, the HCA's high call volume and lower volume of web traffic suggest that Vermonters who are having problems want a live person to assist them, rather than looking for information online and trying to resolve issues on their own. Interestingly, the number of visitors looking for information about public participation in rate reviews and other aspects of health care reform and those seeking out more complex policy information has increased.

The total number of visits to health-related pages decreased by 18% (from 1,870 in 2013 to 1,530 in 2014), while other important measures showed significant increases:

- After slight decreases over the past couple of quarters, the average time spent on a page **increased by 88.41%** (2:27 vs. 1:18). As stated above and shown in more detail below, this appears to be because more visitors are accessing pages with higher level information.
- The bounce rate decreased by 29.78% (from 73.02% to 51.28%) A decrease in the bounce rate is a positive reflection of more user engagement with the site.

More Vermonters Are Seeking Information about Health Care Policy and How to Participate in Health Care Reform

Almost 600 out of 1,530 total visitors to the Health section of Vermont Law Help visited the Health main page. This page provides visitors with information about how the HCA can help Vermonters as well as how to contact us by phone or through an online intake form that can be submitted at Vermonters' convenience, 24/7.

The majority of the other visitors visited pages with information about these topics:

- Public participation in health care reform (195)
- Health care policy, white papers, presentations, reports (144)
- Health care forms (122)
- Other health care reform, Vermont Health Connect (115)

178 (27%) out of the 653 PDFs that were downloaded from the entire Vermont Law Help website were related to health care. Of those, seven of the top 10 were policy papers, comments or other high-level presentations from the HCA:

- Health Insurance Rate Review - A Critical Part of Health Care Reform in Vermont (29)
- Protected Health Information - What Vermonters Should Know (17)
- Advance Directive (short form) (13)
- Low Income Taxpayers and the Affordable Care Act for Non-tax Lawyers (13)
- May 2013 Health Fair Flyer (13)
- Advance Directive (long form) (11)
- Accountable Care Organizations - What is the Evidence? (10)
- HCA Comments to GMCB on Hospital Budget Review (10)
- US Health Reform for H-2A workers in VT (10)
- The Limits of Cost Sharing (9)

B. Education

During this quarter, the HCA provided direct education to at least 88 people in seven organizations. In most cases, members of the audience included people who are in a position to refer Vermonters who need assistance with health care/insurance issues to the HCA, increasing the potential impact of the presentations. The presentations included:

- People with Aids Coalition Retreat (July 11)
Presentation attended by four people; advice/referral to two additional people; outreach to others attending retreat. Answered questions about Vermont Health Connect issues and 2015 open enrollment. Provided brochures for retreat attendees.
- Medicaid & Exchange Advisory Board (MEAB) (July 14)
Attended by about 25 stakeholders representing consumers, businesses and health care providers. Presented how the public can participate in the rate review process.
- Association of Africans Living in Vermont (AALV), Vermont Refugee Resettlement Project (VRRP) (September 10)
Attended by 10 AALV/VRRP staff members. Discussed what the HCA does; gained information about AALV/VRRP clients' health care issues. Provided HCA brochures.
- Champlain Valley Office of Economic Opportunity (CVOEO) (September 15)
Attended by eight navigators/employees at CVOEO. Covered what the HCA is/how we can help; answered questions. Provided HCA brochures.
- Vermont Tax Professionals Association (September 16)
Attended by 33 tax professionals. Topic: The Affordable Care Act: 2014 Tax Returns and Beyond. Discussed Premium Tax Credit allocation regulations, ACA penalty assessment and collection issues, excess Premium Tax Credit assessment and collection issues, and potential filing season pitfalls.

- Committee on Temporary Shelter (COTS) (September 25)
Attended by seven COTS case management team members. Covered what the HCA is and how we can help. Distributed 25 brochures and two flyers.
- Ottaqueechee Health Foundation (September 30)
Spoke with the executive director of the foundation, which provides grants to organizations to promote and support programs that identify and help meet health care needs of Vermonters within a certain geographic region, about the types of cases that the organization can and should refer to the HCA for assistance. Provided 25 brochures for the staff to provide to their clients who need our services

Due to demand for information on the topic, the HCA PowerPoint presentation - *U.S. Health Reform: Information for H-2A Guestworkers in Vermont* - which was originally presented in a prior quarter, was provided to at least 80 people. The recipients included navigators, low income taxpayer clinics, and Vermont Tax Preparers Association listserv.

ⁱ See "Health Insurance Rate Review: A Critical Part of Health Care Reform in Vermont" http://www.vtlawhelp.org/sites/default/files/Health%20Insurance%20Rate%20Review%20%20A%20Critical%20Part%20of%20Health%20Care%20Reform%20in%20Vermont_0.pdf

ⁱⁱ See "The Limits of Cost Sharing" <http://www.vtlawhelp.org/sites/default/files/The%20Limits%20of%20Cost%20Sharing.pdf>

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.

SFY14 Final MCO Investments

8/27/14

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
2	VDH	WIC Coverage
4	VDH	Vermont Blueprint for Health
4	VDH	Area Health Education Centers (AHEC)
4	VDH	Community Clinics
4	VDH	FOHC Lookalike
4	VDH	Patient Safety - Adverse Events
4	VDH	Coalition of Health Activity Movement Prevention Program (CHAMPSS)
2	VDH	Substance Abuse Treatment
4	VDH	Recovery Centers
2	VDH	Immunization
4	VDH	Poison Control
4	VDH	Challenges for Change: VDH
3	VDH	Fluoride Treatment
4	VDH	CHIP Vaccines
4	VDH	Healthy Homes and Lead Poisoning Prevention Program
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
2	DMH	Seriously Functionally Impaired: DMH
2	DMH	Acute Psychiatric Inpatient Services
2	DMH	Institution for Mental Disease Services: DMH
4	DVHA	Vermont Information Technology Leaders/HIT/HIE/HCR
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	DVHA	Institution for Mental Disease Services: DVHA
2	DVHA	Family Supports
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	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
3	DCF	Building Bright Futures
2	DCF	Children's Integrated Services Early Intervention
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)
4	DDAIL	HomeSharing
4	DDAIL	Self-Neglect Initiative
2	DDAIL	Seriously Functionally Impaired: DAIL
2	DOC	Intensive Substance Abuse Program (ISAP)
2	DOC	Intensive Sexual Abuse Program
2	DOC	Intensive Domestic Violence Program
2	DOC	Community Rehabilitative Care
2	DOC	Return House
2	DOC	Northern Lights
4	DOC	Challenges for Change: DOC
4	DOC	Northeast Kingdom Community Action
2	DOC	Pathways to Housing