

State of Vermont
Agency of Human Services

Global Commitment to Health
11-W-00194/1

Section 1115
Demonstration Year: 9
(10/1/2013 – 12/31/2014)

Quarterly Report for the Period
January 1, 2014 – March 31, 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 inter-departmental 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.

Monica Light, Financial Director within the AHS Central Office, has replaced Stephanie Beck as the AHS Director of Health Care Operations, Compliance and Improvement as of April 2014. The AHSCO Financial Director position is under recruitment.

One of the Terms and Conditions of the Global Commitment Waiver requires the State "to submit progress reports 60 days following the end of each quarter. ***This is the second quarterly report for waiver year 9, covering the period from January 1, 2014 through March 31, 2014.***

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 16-20th, 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.

II. Enrollment Information and Counts

Key updates from Q2 2014:

- Table 1 presents point-in-time enrollment information and counts for Demonstration Populations during the second quarter of Federal Fiscal Year (FFY) 2014.
- For additional information on substantial fluctuations observed in Demonstration Populations during this quarter, please see *Section VII Member Month Reporting*.

Table 1 presents point-in-time enrollment information and counts for Demonstration Populations for the Global Commitment to Health Waiver during the second 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 CHIP.

Table 1 is populated based on reports run the Monday after the last day of the quarter, in this case on April 7, 2014. Results yielding ≤5% fluctuation 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 the 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 second quarter (Q2) of FFY 2014, please see *Section VII Member Month Reporting*.

Table 1. Enrollment Information and Counts for Demonstration Populations*, Q2 FFY 2014

Demonstration Population	Current Enrollees Last Day of Qtr 3/31/2014	Previously Reported Enrollees Last Day of Qtr 12/31/2013	Variance 12/31/2013 to 3/31/2014
Demonstration Population 1:	263,544	145,498	81.13%
Demonstration Population 2:	138,633	130,263	6.43%
Demonstration Population 3:	40,892	28,998	41.02%
Demonstration Population 4:	N/A	N/A	N/A
Demonstration Population 5:	3,466	2,598	33.41%
Demonstration Population 6:	5,617	8,322	-32.50%
Demonstration Population 7:	6,143	105,494	-94.18%
Demonstration Population 8:	30,501	30,620	-0.39%
Demonstration Population 9:	7,776	7,783	-0.09%
Demonstration Population 10:	N/A	N/A	N/A
Demonstration Population 11:	25,264	41,962	-39.79%

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

III. Outreach Activities

i. Provider and Member Relations

Key updates from Q2 2014:

- Three member handbooks were translated into seven languages and published online.
- The Provider and Member Relations (PMR) Unit published three banners alerting providers of issues related to co-pays and the ICD-10 transition.*
- The Medicaid and Exchange Advisory Board (MEAB) held three meetings during this quarter.

The PMR Unit is responsible for member and provider communication and outreach, and maintains the GreenMountainCare.org member website and the DVHA.vermont.gov website. The PMR Unit ensures an adequate provider network for member medical and dental needs, enrolls providers, and manages the

Medicaid non-emergency medical transportation program.

During Q2 FFY 2014, three member handbooks were translated into seven languages that were recommended by the AHS Limited English Proficiency Committee. These member handbooks were published on the Green Mountain Care (GMC) website. A Frequently Asked Questions document with answers to recurring questions about transition from Catamount Health with Premium Assistance (CHAP) to Medicaid was added to the GMC website in March 2014.

The following banners were published this quarter:

- Co-pays: A banner alerting providers: 1) that they may not deny services or prescriptions to Medicaid beneficiaries due to a beneficiary's inability to pay, and 2) of state and federal policy that while members are required to make co-payments under Medicaid, if the member states he/she cannot make the payment, Medicaid providers may not deny services.
- ICD-10 transition: A banner providing assistance with the ICD-10 transition by directing providers to DVHA's ICD-10 website for information (<http://dvha.vermont.gov/for-providers>).*
- ICD-10 for dentists: A banner alerting dentists to implications of the ICD-10 transition (i.e., those ICD-10 changes apply to dental services).*

Also during this quarter, the MEAB held meetings were held on January 13, February 10 and March 10. Minutes from these meetings are available via: <http://gmcbboard.vermont.gov/meetings>.

**In April, the Protecting Access to Medicare Act of 2014 was signed into law (H.R. 4302). Included in this bill is legislation that delays the national implementation of the next-generation of the ICD-10 until October 1, 2015, at the earliest. This change means that the current ICD-9 CM diagnosis codes sets will not convert to ICD-10 CM/PCS in 2014. The DVHA plans to report on the impact of this federal legislation on its policies and programs in the Q3 FFY 2014 Global Commitment Report.*

IV. Policy and Operations Developments

i. DVHA Policy and Operations Activities

In the second quarter of FFY 2014, the DVHA completed its budget document for State Fiscal Year (SFY) 2015. The budget document was shared with the Vermont Legislature and is publicly available via: <http://dvha.vermont.gov/budget-legislative/dvha-sfy15-budget-document-v2.pdf>.

ii. Vermont Health Connect

Key updates from Q2 2014:

- By end of March, 87,974 individuals had applied for health insurance, and 48,320 individuals were enrolled in health insurance plans.
- During this quarter, the Vermont Health Connect (VHC) began successfully processing credit cards for premium payments and continued to make progress toward full change of circumstance functionality.

Vermont Health Connect

The VHC, a state-based health insurance marketplace, launched on October 1, 2013. Between October 1, 2013 and March 31, 2014, nearly 88,000 individuals in Vermont applied for coverage through VHC. In November 2013, Vermont launched premium processing functionality for individuals and worked with the insurance carriers to effectuate coverage for January 1, 2014. This functionality was expanded to include credit card processing in March 2014. Delays in system functionality prompted Governor Shumlin to

issue an order allowing individuals to extend their 2013 insurance coverage for three months and for small businesses to directly enroll through insurance carriers. Many of these individuals in Vermont transitioned to VHC by March 31 and the State continues to work with these individuals to achieve coverage by April 1, 2014.

VHC's Customer Support Center went live on September 3, 2013 and is currently assisting Vermonters with eligibility questions and telephonic applications. VHC continues to implement an ambitious outreach and education campaign and to collaborate with key stakeholders, including insurance carriers, brokers, small business owners, and community partners. This outreach and education campaign ended on March 31, 2014 and will begin again in preparation for 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 operations. The VHC plans to expand its functionality to include enrollment for small businesses during the open enrollment period in 2015.

Marketplace Subsidy Program

In accordance with the STC 31b reporting requirements, the AHS and DVHA report on the state-funded marketplace subsidies program, which began on January 1, 2014, in *Attachment 2*. Beginning with this report for Q2 2014 (January 1, 2014 to March 31, 2014), the AHS and DVHA provides an update on the implementation and progress of the subsidies program, including data on: 1) the number of individuals served by the program, 2) the size of the subsidies, and 3) a comparison of projected costs with actual costs.

V. Expenditure Containment Initiatives

i. Vermont Chronic Care Initiative

Key updates from Q2 2014:

- The Vermont Chronic Care Initiative (VCCI) demonstrated financial savings (net ROI) in SFY 2013 of \$23.5 million over anticipated expenses; these savings are attributable to a reduction in ambulatory sensitive emergency department (ED) visits (-17%), inpatient (IP) admissions (-37%), and reduction in 30-day readmission rates (-34%).
- The VCCI is collaborating with a subgroup of the Vermont Health Care Innovation Project (VHCIP) Care Management and Care Models workgroup to develop a pilot Learning Collaborative focused on high-risk/high-cost populations in three hospital service areas in Vermont.
- The DVHA is actively pursuing an enterprise care management system; a request for proposal (RFP) was released in February 2014. Concurrently, the VCCI and DVHA will be pursuing a contract extension with the current vendor, APS Healthcare, pending the procurement and onboarding of a new vendor.
- During Q1 of FFY 2014, the VCCI average caseload was 603, with 751 unique members served during the first six months of the year.

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 who 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 has expanded its embedded staffing model with licensed staff in high volume Medicaid primary care sites and hospitals that experience high rates of ambulatory sensitive ED visits and inpatient admissions/readmissions for ambulatory care sensitive conditions. The VCCI has staff in 19 locations including nine AHS district offices, three hospitals and seven primary care provider locations. The embedded approach offers several advantages. 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 real-time, daily inpatient data from hospital inpatient and ED admissions through data exchanges from partner hospitals (via secure FTP site transfers). The VCCI aims to secure data from all 14 hospitals in Vermont. While some hospitals have not supported these strategies in the past, the advent of Medicaid Accountable Care Organizations (ACOs) may help facilitate new relationships based on common goals. 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 who may be delivering skilled nursing care post-discharge.

In Q2 of FFY 2014, the VCCI encountered some challenges in its embedding staffing model related to physical space constraints at partner sites, cultural acceptance of Medicaid staff within the office setting, and perceived ‘competition’ with the VCCI related to ACO goals and strategies. The VCCI is subsequently reevaluating its ‘embedded’ model and exploring the use of a ‘liaison’ role in the future.

The VCCI continues to experience challenges related to both timely recruitment and retention of skilled nurse care managers. Due to their Medicaid knowledge and experience, 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 on methods to incentivize nurses to work for DVHA.

The VCCI remains strategically aligned with another important Vermont health care reform effort in Vermont, known as the Blueprint for Health, which is further described in *Section V.ii*.

Pediatric Palliative Care Program

The Pediatric Palliative Care Program is a statewide program that maintains an active enrollment of approximately 35-40 children and families at any time, with some new children becoming eligible while others may leave the program due to stability, relocation or death. The VCCI is in the early phases of quality monitoring, which includes an assessment of skill and confidence among practitioners providing services and audits of home health agencies that have provided services for a 12 months. In Q2 of FFY 2014, consumer satisfaction surveys were developed and initiated, and will continue to be disseminated concurrent with the six-month reassessment for eligibility process. Early data suggest that consumers are satisfied with the care and service supports they receive as part of the program, and that nurses desire additional training. The next training session for nurses is planned for September 2014.

Pregnancy Care Connection

The VCCI launched a pilot program for the High Risk Pregnancy Case Management program on October 1, 2013 in two counties in Vermont; on January 1, 2014 a third county was included in the program. This new service, recently renamed the *Pregnancy Care Connection*, is a partnership between the DVHA and VDH and focuses on direct case management as well as the system of care for at-risk/vulnerable pregnant women and their unborn child(ren). The program also must align with the Affordable Care Act (ACA) Health Homes Initiative to support individuals with substance abuse disorders and align with the VDH programs and services available for maternal and child health.

The Pregnancy Care Connection is not receiving the robust referrals the VCCI and DVHA anticipated, with only 25 referrals since inception in 2013. Of these referrals, only 14 were eligible and eight are being actively managed. Challenges related to referrals include population identification and clinical monitoring of results that relate to the nature of bundled service billed post-partum, as well as challenges in associating the infant with the mother post-delivery. To address these challenges, the VCCI is seeking data for early identification using early pregnancy markers, such as administrative HEDIS measures, pharmacy reports on pregnant women receiving Medication Assisted Therapy (MAT) or Makena, lab and ultrasound data that suggest pregnancy, and Medicaid categorical eligibility codes related to pregnancy. The VCCI team also hosted a meeting in March 2014 with other AHS partners to facilitate referrals, design systems to identify early pregnancy, and coordinate a system for ‘triage’ of potentially high risk pregnancy cases. Additionally, the VCCI is securing information on the FTP site from participating hospitals to determine if there are early indications for pregnancy and/or pregnancy risk factors for which staff can offer support.

APS Contract

Since 2007, the DVHA has contracted with APS Healthcare for assistance in providing disease management assessment and intervention services to Vermont Medicaid beneficiaries with chronic health conditions. In SFY 2012, the contract migrated to a focus on the top 5% Medicaid utilizers. APS Healthcare provides several services to support the DVHA/VCCI, including supplemental professional staffing and data analytics. APS Healthcare delivers enhanced information technology and sophisticated decision-support tools to assist case management staff outreach to the most costly and complex beneficiaries, based on risk factors. Additionally, APS Healthcare provides supplemental reports on population-based gaps in care to the DVHA field-based staff, which support ACO providers working with patients who are considered high utilizers.

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 highest service utilization. That same year the DVHA’s contract with APS Healthcare was 100% risk-based with a guaranteed 2:1 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 savings over anticipated expense for this population. Consistent with these results, the VCCI demonstrated a 17% reduction in ambulatory care sensitive (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.

Currently, a RFP process is underway as the DVHA anticipates procurement of an enterprise-level care management system. To assure continuity of the VCCI business operations, the DVHA is in the process of extending its contract with APS Healthcare through June 30, 2015 (with an early cancellation option). This will allow for a thoughtful procurement, contracting and onboarding process, without interruption of the VCCI services, should APS not be the selected vendor.

Hub and Spoke Initiative: Integrated Treatment for Opioid Dependence

Key updates from Q2 2014:

- The second State Plan Amendment (SPA) for Hub and Spoke Health Home was submitted to CMS in March 2014. Hub and Spoke Health Homes are now implemented statewide.
- In addition to providing methadone MAT, as they have traditionally done, Hubs now provide buprenorphine MAT to complex patients. These patients represent approximately 27% of the total caseload of Hubs.
- Spoke staffing is scaled at 1 registered nurse and 1 licensed clinician for every 100 patients receiving MAT.
- To date, over three-fourths (83%) of the 40 new Spoke staff are hired for statewide implementation of the program. These Spoke staff work with 57 buprenorphine providers serving 1,888 Medicaid beneficiaries receiving MAT.
- Practice facilitators are working extensively with Hub and Spoke providers on common measurement, practice-level quality improvement, and implementation of

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 a multi-insurer payment reforms to improve infrastructure and care provided by PCPs. It includes advanced primary care practices that are recognized as patient-centered medical homes, multi-disciplinary core CHTs, and specialized care coordinators. The Blueprint supports the State's National Committee for Quality Assurance 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 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 is developing SPAs to provide Health Home services to the MAT population under section 2703 of the ACA. The SPAs support 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 this Initiative, DVHA established five regional Hubs, 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 will be implemented through the second SPA beginning in January 1, 2014.

In addition to Hubs, Spoke staff are 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 an 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 Q2 of FFY 2014, please see the above “key updates.” During this quarter, Hub and Spoke Health Homes were implemented statewide and over three-fourths of the Spoke staff for the statewide program are now hired, allowing for expanded service offerings of MAT. The following tables present the caseloads of regional Hubs and Spoke staffing, as of March 2014.

Table 2. Hub Caseload

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	7/2013	745	230	515
Washington, Lamoille, Orange	7/2013	162	49	113
Windsor, Windham	7/2013	505	106	399
Rutland, Bennington	1/2014	154	61	93
Essex, Orleans, Caledonia	1/2014	346	79	267
Total		1912	525	1387

Manage Substance Abuse Services

Key updates from Q2 2014:

- During this quarter, the DVHA reviewed codes and is in the process of determining an appropriate code for services provided under the Capitated Program for the Treatment of Opiate Dependency (CPTOD).
- Updates to the buprenorphine program payment summary are presented in Table 5.

In 2012, the DVHA established a Substance Abuse Unit to consolidate its substance abuse services into a single, unified structure and point of contact for prescribers, pharmacists, and beneficiaries. This Unit provides seamless and integrated care to beneficiaries receiving MAT and/or those participating in the Team Care program or who have a Pharmacy Home. The Substance Abuse Unit coordinates with Hub and Spoke Initiative, the VCCI and the DVHA Pharmacy Unit to provide beneficiary oversight and outreach. All beneficiaries receiving MAT services with buprenorphine have a pharmacy home that dispenses all their prescriptions. In addition to overseeing these programs, the Substance Abuse Unit coordinates and facilitates prescriber reconsideration requests and appeals when prior authorizations for controlled substances are denied.

Team Care Program

Federal Medicaid Law (42 CFR 431.54(e)) guides Vermont’s policies around locking in members who over-utilize Medicaid services and it states “If a Medicaid agency finds that a recipient has utilized Medicaid services at a frequency or amount that is not medically necessary, as determined in accordance with utilization guidelines established by the State, the agency may restrict the recipient for a reasonable period of time to obtain Medicaid services from designated providers only.”

In many circumstances beneficiaries who exceed certain thresholds for opiates and other controlled substances or who utilize multiple prescribers and pharmacies to obtain controlled substance prescriptions are identified by the Team Care program. The Team Care program personnel (through a collaborative process) will often designate one prescribing physician and one pharmacy (known as a “pharmacy home”) to improve coordination of care and decrease over-utilization and misuse of services by participants.

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

Buprenorphine Program

The DVHA, in collaboration with the VDH’s Alcohol and Drug Abuse Programs, maintains a CPTOD. The CPTOD provides an enhanced remuneration for physicians in a step-wise manner depending on the number of beneficiaries treated by a physician enrolled in the program. The Capitated Payment Methodology is depicted in the following table (Table 3).

Table 3. Capitated Program for Treatment of Opiate Dependency

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

The total payment for the Buprenorphine Program in the first quarter of 2014 (October 2013- December 2013) was \$29,729.72 (Table 4). The payment in January 2014 was \$10,988.52.

Table 4. Buprenorphine Program Payment Summary FFY 2014

FIRST QUARTER, FFY 2014	
October 2013	\$12,041.22
November 2013	\$17,688.50
December 2013	\$19,508.14
1st Quarter Total	\$49,237.86
SECOND QUARTER	
January 2014	\$10,988.52
February 2014	(No data at this time)
March 2014	(No data at this time)
2nd Quarter Total, to date	\$10,988.52
Grand Total	\$60,226.38

*340B Drug Discount Program***Key updates from Q2 2014:**

- As part of the 340B program, Vermont realized \$110,829.82 for Q1 2014 net cost savings through Medicaid participation of a relatively small number of eligible covered entities.

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 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.

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

Covered entities 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, the 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.

The 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 eligible 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. The 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
- **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
- Porter Hospital
- Rutland Regional Medical Center
- **Springfield Hospital**

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

Safeguards for Overprescribing

While the DVHA is confident that prescribers, covered entities, and pharmacies will continue to operate in an ethical and medically-appropriate fashion, the DVHA has many controls and processes in place to monitor and prevent overprescribing. These controls include monitoring features of our Program Integrity Unit (PIU) and the Drug Utilization Review (DUR) program, both of which that are vetted through the State's Drug Utilization Review Board (DURB).

The goal of the DVHA's DUR programs is to promote appropriate prescribing and use of medications. We identify prescribing, dispensing, and consumption patterns which are clinically and therapeutically

inappropriate and do not meet the established clinical practice guidelines. A variety of interventions are then employed to correct these situations. Drug Utilization Review programs take a multilevel approach to identifying, filtering, and communicating important information pertaining to the prescribing and/or consumption of medications. It is an approach that analyzes patterns of utilization at a patient-specific level, as well as the unique prescribing habits and the pharmaceutical care provided by the physician. The criteria, research and compilation of data, and recommended actions are reviewed and approved by consensus of the DURB.

In addition, the DVHA's PIU performs data-mining activities, which identify potential overpayments and problem claims in all spending categories, including pharmacy claims. For example, one algorithm looked at possible pharmacy errors in the billing of drugs dispensed in a kit. A common error occurs when the pharmacist enters a drug quantity (units billed to Medicaid) as the number of items in the kit instead of a quantity of "one" kit, resulting in overpayments to the pharmacy. Recently, the PIU recouped \$12,442.38 from two pharmacies after requesting copies of prescription orders for claims that were suspected of incorrect quantity billing.

The Drug Utilization Review and PIU programs continue to develop and run data-mining queries to detect improper prescribing, dispensing, and reimbursement. Findings are discussed, as deemed necessary and appropriate, with various other departments in the DVHA and agencies including, but not limited to the Pharmacy Unit, Clinical Utilization Review Board (CURB), DURB, and the Clinical Unit. If potential fraud is detected, the PIU may refer cases to the Attorney General's Medicaid Fraud and Residential Abuse Unit (MFRAU), the Vermont Medical Practice Board, and/or the Secretary of State's Office of Professional Regulations (OPR). Any Program Integrity investigation may also run parallel or in conjunction with any other investigation initiated by MFRAU, Vermont Medical Practice Board and/or OPR. Standard Program Integrity guidelines and protocols are utilized to ensure appropriate steps are taken.

340B Reimbursement and Calculation of Incentive Payment

Determination of Dispensing Fee and Savings Sharing Amounts

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

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

Vermont researched available resources regarding pharmacy dispensing costs, which included consultation with local pharmacists. Vermont determined that a reasonable estimate of pharmacy dispensing costs falls in the range of \$12.00 to \$15.00 per prescription. The DVHA also determined that pharmacies' additional costs associated with 340B program management would equal \$3.00 per prescription. Therefore, Vermont determined that a reasonable 340B dispensing fee would range from \$15.00 to \$18.00 per prescription. Vermont's proposed reimbursement methodology 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 340B covered entity-employed prescriber and Medicaid beneficiary participation in the program.

For the reporting period, Vermont has realized \$110,829.82 for Q1 2014 net cost savings through Medicaid participation of a relatively small number of eligible covered entities.

Utilization Management

Utilization Management is a systematic evaluation of the necessity, appropriateness, and efficiency of managed care model services. These activities are designed to influence providers’ resource utilization and clinical practice decisions in a manner consistent with established criteria or guidelines to maximize appropriate care and minimize or eliminate inappropriate care. The DVHA has in place mechanisms to detect both under/over-utilization of services and to assess the quality and appropriateness of care furnished to enrollees with special health care needs.

Clinical Utilization Review Board

Key updates from Q2 2014:

- In Q2 FFY 2014, the CURB held two meetings. The Board discussed proposed initiatives, the TIA Treatment Protocol and Outcomes and the Partial Hospitalization Program (an outcome-based payment model). The CURB also introduced a new topic, the concept of providing psychiatric resources in the primary care setting.

The Clinical Utilization Review Board (CURB) was established by Act 146 Sec. C34, 33 V.S.A. Chapter 19, Subchapter 6 during the 2010 legislative session. The DVHA was tasked to create the CURB to examine existing medical services, emerging technologies, and relevant evidence-based clinical practice guidelines and make recommendations to the DVHA regarding coverage, unit limitations, place of service, and appropriate medical necessity of services in the State’s Medicaid programs.

The CURB is comprised of 10 members with diverse medical experience, appointed by the Governor upon recommendation of the DVHA Commissioner. The CURB solicits additional input as needed from individuals with expertise in areas of relevance to the CURB’s deliberations. The Medical Director of the DVHA serves as the State’s liaison to CURB.

Additional information on these guiding principles and upcoming clinical projects considered by the CURB members are available in the CURB’s 2013 annual report submitted to the Vermont Legislature in January 2014, and available via: <http://www.leg.state.vt.us/reports/2014ExternalReports/295874.pdf>.

In Q2 FFY 2014, the CURB held two meetings. Information on the CURB meetings, including agendas and minutes, is available via: <http://dvha.vermont.gov/advisory-boards>.

Drug Utilization Review Board

Key updates from Q2 2014:

- In Q2 FFY 2014, the DURB held two meetings. The Board heard drug reviews and updates on FDA safety alerts (risks associated with testosterone products and acetaminophen prescription combination products), and unanimously approved a recommendation for adoption of criteria related to new cholesterol treatment guidelines.

The DURB was authorized by Congress under Section 4401, 1927(g) of the Omnibus Reconciliation Act of 1990. This act mandated that the AHS develop a drug use review program for covered outpatient drugs, effective January 1, 1993. The Act required the establishment of a DURB to:

- 1) Review and approve drug use criteria and standards for both retrospective and prospective drug use reviews,
- 2) Apply these criteria and standards in the application of DURB activities,
- 3) Review and report the results of DUR programs, and
- 4) Recommend and evaluate educational intervention programs.

Additionally, per State statute that the DVHA Commissioner establishes pharmacy best practices and cost control program, the DURB was designated as the entity to provide clinical guidance on the development of a Preferred Drug List for Medicaid beneficiaries. The DURB typically includes 10-12 members, who are appointed to two-year terms. At least one-third, but not more than half, of the Board's members are licensed and actively practicing physicians, and at least one-third of its members are licensed and actively practicing pharmacists. Other interested and qualified people also may be appointed to DURB. Board members are recommended by the DVHA Commissioner and approved by the Governor.

Meetings of the DURB occur monthly or bimonthly depending upon the numbers of drugs and issues to be reviewed. In Q2 FFY 2014, the DURB held two meetings. Information on the DURB and its activities in 2014 is available via: <http://dvha.vermont.gov/advisory-boards>.

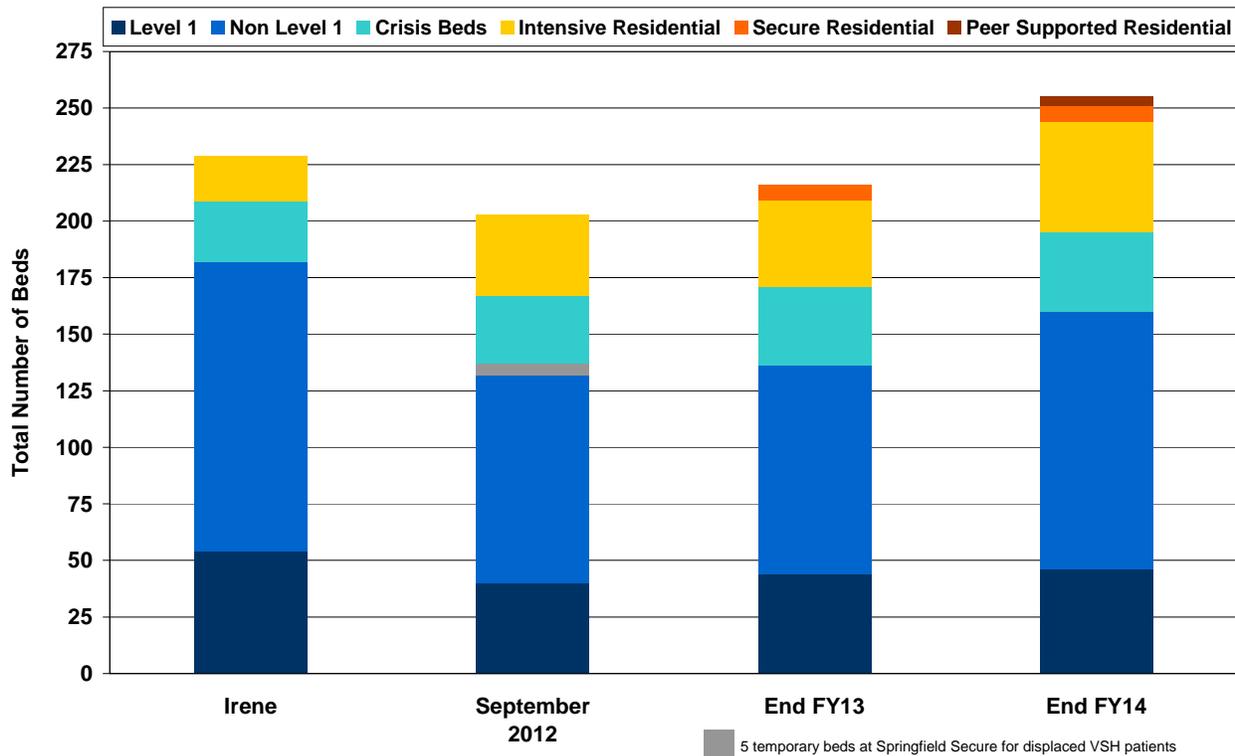
VI. **Mental Health System of Care**

State Hospital Inpatient Replacement Planning

As referenced in earlier reports, an additional 28 psychiatric inpatient beds to serve Level I patients, individuals who would otherwise have been treated at the former state-run psychiatric hospital, were authorized via legislation while a new 25 bed hospital is under construction. Level I beds at the Green Mountain Psychiatric Care Center (GMPCC), Brattleboro Retreat, and Rutland Regional Medical Center have been operational throughout this period. Construction of the new 25 bed hospital (Vermont Psychiatric Care Hospital- VPCH) remains on target for opening in early summer, 2014.

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



During this period, GMPCC received a Notice of Decision on March 20, 2014 that the temporary eight bed state-run hospital in Morrisville has been accepted as an approved CMS provider. This milestone allows a State of Vermont psychiatric hospital to be a participating CMS provider, thereby eligible for federal funding, for the first time since 2003. This CMS notification decision carries an effective date of March 7, 2014 for the small hospital. The certification follows two on site surveys, one in December 2013 assessing standards applied to all hospitals, and one in February of this year that assessed standards for psychiatric hospitals. GMPCC was accredited by the Joint Commission in August 2013. Joint Commission accreditation and CMS certification are two nationally recognized standards showing excellence in hospital care. GMPCC has achieved these organizational accomplishments in strong partnership with Copley Hospital and Lamoille County Community Mental Health Services during its fourteen months of operation. GMPCC will transition to its new location in Berlin as the Vermont Psychiatric Care Hospital when construction is completed later this year.

The intensive residential recovery program *Second Spring – Westford* was fully operational during this period. This program was planned and developed as part of the Act 79 implementation and will provide greater access to this level of care in northwestern Vermont while also sharing resources with Second Spring Williamstown in Orange County. The 8-bed residence will be utilized primarily as a step-down program for individuals leaving one of Vermont’s Level I inpatient hospital units.

Development of two additional residential programs continue to move forward. Pathways Vermont filed their Certificate of Need application on October 23rd to develop Soteria Vermont at a residential property in Burlington’s Old North End, and the application is under review by the Green Mountain Care Board, which has regulatory authority for the CON process. Pathways Vermont seeks to develop a 5-bed therapeutic care residence for persons experiencing an initial episode of psychosis. Soteria is a program component of the continuum of care modal for delivery of mental health services outlined in Act 79 of

2012. The new framework includes alternative treatment options for individuals seeking to avoid or reduce reliance on medications. The legislation states that the Soteria “residence shall be peer supported and noncoercive, and treatment shall be focused on a nontraditional, interpersonal, and psychosocial approach, with minimal use of psychotropic medications to facilitate recovery in individuals seeking an alternative to traditional hospitalization.” Pathways Vermont chose the Chittenden County location due to its many younger people, a target population of the project. Read application here:

http://gmcboard.vermont.gov/sites/gmcboard/files/Soteria_Application_2013_10_23.Pdf.

Pdf.

Rutland Mental Health Services continues to work toward the completion of a 4-bed intensive residential recovery program in Rutland with room for expanding the building to eight beds without changing the building footprint.

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. Fiscal Year 14 funding supports the implementation of service expansion in several support and services areas that will offer a stronger continuum of care for the public mental health system. Each new initiative carries reporting requirements to inform the Department of Mental Health (DMH) regarding overall contribution to the system of care and impacts to persons served. A full report of Act 79 funded initiatives and early outcomes 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 with caseload and shared savings incentives 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 almost 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 pilot includes two levels of incentives for: 1) caseload, and 2) decreasing utilization and expenditures in intensive more restrictive settings.

This shift continues to be addressed both programmatically and financially. There is a review of the method used to establish the PMPM to see if there is a more effective method. There are currently three other regions interested in undertaking this model.

The AHS applied for a CMMI grant to bring resources to IFS to more fully develop the funding and service delivery model but have yet to hear of a decision. 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.

VII. Financial/Budget Neutrality Development/Issues

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

AHS has worked with CMS since QE1212 toward continued resolution of issues pertaining to approval of the FFY11, FFY12 and FFY13 IGAs and selected PMPM rates. Vermont would bear a significant retroactive and ongoing financial risk in the event the selected PMPM rates in the IGAs and actuarial certifications for FFY11, FFY12 and FFY13 are not approved as submitted. Resolution of the remaining issues as expediently as possible remains a top priority for the State. It is Vermont’s understanding that these issues are resolved with waiver renewal and updated STC language, and AHS awaits confirmation from CMS to this effect. AHS will deliver the FFY14 IGA and rate package upon resolution of the outstanding issues.

The FMAP SPA, to allow Vermont to draw in its expansion state FFP at 2.2% and New Adult enhancement, was not approved until May 14, 2014; accordingly, this caused a cash flow issue and AHS did not draw in these funds during QE0314. AHS will do a retroactive draw during QE0614 to receive the enhancement funds under the now approved SPA.

AHS entered into a one year contract extension with its actuarial consultant, Milliman, effective April 1, 2014, for FFY15 PMPM rate development, and has begun work on the rate development process.

AHS has worked with DVHA and CMS throughout QE0314 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 expect to have an interim solution by the end of QE0614. We are working on a permanent automated solution.

VIII. Member Month Reporting

Key updates from Q2 2014:

- In Q2 FFY 2014, there were several fluctuations in enrollment, which lead to an overall increase in enrollment of 4.05%.
- Substantial decreases in enrollment were seen in Demonstration Populations 6, 7 and 11 due to coverage under VHAP and Vermont’s Employer-Sponsored Insurance Premium Assistance Program (ESIA and Catamount-ESIA) ending on April 1, 2014.
- Increased enrollment was seen in Demonstration Populations 1, 2, 3, and 5. The largest increase in enrollment (81.13%) was in Demonstration Population 1, mostly due to the reclassifying of several aid category codes that target the ABD population.

Demonstration Populations are not synonymous with Medicaid Eligibility Group (MEG) reporting in the Table 6. The numbers presented in the following table may represent duplicated population counts. For example, an individual in the 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 month for all persons eligible as of the 15th day of the preceding month. Data reported in the Table 5 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 the quarters. All payments are adjusted at the end of the year to reconcile expected population movement between eligibility groups.

Table 5. Demonstration Populations, by Quarter for FFY 2014

Demonstration Population	Total for Quarter Ending 2nd Qtr FFY '14	Total for Quarter Ending 1st Qtr FFY '14	Total for Quarter Ending 4th Qtr FFY '13	Total for Quarter Ending 3rd Qtr FFY '13
Demonstration Population 1:	263,544	145,498	145,446	145,178
Demonstration Population 2:	138,633	130,263	131,481	132,125
Demonstration Population 3:	40,892	28,998	29,618	29,439
Demonstration Population 4:	N/A	N/A	N/A	N/A
Demonstration Population 5:	3,466	2,598	2,657	2,748
Demonstration Population 6:	5,617	8,322	8,826	9,790
Demonstration	6,143	105,494	107,354	109,242

Population 7:				
Demonstration Population 8:	30,501	30,620	30,505	30,450
Demonstration Population 9:	7,776	7,783	7,794	7,833
Demonstration Population 10:	N/A	N/A	N/A	N/A
Demonstration Population 11:	25,264	41,962	40,093	36,909

In Q2 of FFY 2014, there were several enrollment fluctuations. These fluctuations lead to an overall change in enrollment of +4.05%. A month-by-month table of the Demonstration Populations whose enrollment numbers have a $\pm 5\%$ change is below.

Table 6. Number of Recipients, by Month for FFY 2014, Q1 and Q2

	FFY 2014 Q1			FFY 2014 Q2		
	October 31, 2013	November 30, 2013	December 31, 2013	January 31, 2014	February 28, 2014	March 31, 2014
Demonstration Population 1	48,576	48,616	48,833	86,074	87,603	89,867
Demonstration Population 2	43,603	43,729	43,767	45,826	46,190	46,617
Demonstration Population 3	9,817	9,831	9,853	13,485	13,627	13,780
Demonstration Population 5	861	873	873	1,103	1,155	1,208
Demonstration Population 6	2,903	2,748	2,709	2,175	1,857	1,585
Demonstration Population 7	34,992	35,065	35,882	2,379	2,021	1,743
Demonstration Population 11	13,778	14,182	13,923	9,759	8,327	7,178

Substantial decreases in enrollment were seen in several populations due to changes in coverage as programs closed. There was a decrease of 32.50% for enrollment in Demonstration Population 6 and a decrease of 94.18% for enrollment in Demonstration Population 7. With coverage under VHAP ending on April 1, 2014 these reductions in enrollment were expected by the DVHA. There was a decrease in enrollment of 39.79% for Demonstration Population 11. This decrease also was anticipated, as coverage under Vermont's Employer-Sponsored Insurance Premium Assistance Program (ESIA and Catamount-ESIA) ended on April 1, 2014. These decreases in enrollment due to program closures and coverage changes also will be reflected in the Q3 FFY 2014 report.

Increased enrollment was seen for Demonstration Populations 1, 2, 3, and 5. The largest rise in enrollment was in Demonstration Population 1, with an increase of 81.13% (or 118,046 beneficiaries) since the first quarter of FFY 2014. Most of this increase is due to the reclassifying of several aid category codes that target the ABD population that occurred on January 1, 2014. This reclassification accounted for 110,997 of the 118,046 beneficiaries. The change in Demonstration Population 2 (+6.43%) is less than found in other populations, and is mostly attributed to the reassignment of eligibility aid categories until all enrollees are transitioned to their new aid categories later in 2014. An increase in enrollment of 33.41% was observed in Demonstration Population 5; 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.

IX. 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.

X. Quality Assurance/Monitoring Activity

Key updates from Q2 2014:

- Documents used to guide the 2013-2014 External Quality Review activities are developed
- Key concepts associated with review tools are examined
- Conversations take place to ensure that key concepts match expectations
- Dates for review activities are finalized
- There are six Process Improvement Projects underway at the DVHA. The projects focus on performance evaluations, purchasing, PCP assignment, dental authorizations, and position classification.
- In January 2014, interventions for the Breast Cancer Screening Performance Improvement Project (PIP) were implemented.
- Utilizing resources from the Adult Quality Measures (AMQ) Grant, the DVHA contracted with the Lewin Group to provide several trainings to staff. The trainings focus on analyzing performance measures and implementing PIPs following the CMS protocols. The first training of the series was held in March 2014.
- The Managed Care & Compliance Director began preparations for the June 2014 External Quality Review Organization (EQRO) audit.
- The Managed Care & Compliance Unit is finalizing a new Inter-Governmental Agreement (IGA) template and expects to implement use of this template by the Q3 FFY 2014.

Due to the complexity of the External Quality Review Organization (EQRO) to develop documents for each of the required annual external quality review activities. In addition to developing letters, tools, and reference documents – timelines are developed for each activity. All timelines included the following elements: start date, completion date, task, and responsible party. Key tasks of the Performance Improvement Validation timeline include the following: feedback/comments on PIP documents, review/revise PIP validation tool, provide feedback on draft report, and review final report. The MCE is scheduled to receive the review documents during the next quarter. Key tasks of the Performance Measure Validation timeline included the following: identify measures for validation, review and provide feedback on documentation request letter and attachments, develop schedule of on-site visit, review and provide feedback on draft performance measure validation report. The MCE is scheduled to receive the review documents during the next quarter. Key tasks of the Compliance Review timeline included the following: finalize the scope of the review, review supporting documents and data collection tool, plan on-site visit, and review draft report. The MCE is scheduled to

receive the compliance review documents during the next quarter. Finally, key tasks of the Annual Technical Report timeline included the following: draft report outline and discuss overall expectations, provide feedback/comments on draft tool, and provide edits/comments to draft report. The report is scheduled to be completed during the first quarter of next year.

i. DVHA Quality Improvement

The DVHA Quality Committee (DQC) is responsible for: 1) developing the Quality Management Plan and the annual Quality Action Plan, 2) developing quality improvement initiatives and activities based on clinical standards and results/trends from current QAPI activities, and 3) guiding the implementation of planned activities and encouraging staff to become more integrated into the QAPI process. The DQC's focus on performance improvement, through data analysis, AMQ grant trainings, formal PIPs or internal AIM projects, is the bedrock for a culture of continuous quality improvement at the DVHA. The Committee continues to develop the DQC membership and knowledge base, identify quality metrics and analyze performance measures. The DQC is a cross-divisional committee chaired by the DVHA Medical Director and a Quality Improvement Manager. This Committee meets monthly to review critical indicators including, but not limited to, adverse outcomes, patient utilization, and other clinical areas that indicate over- or under- utilization of services, as well as all data elements required by CMS.

During the Q2 FFY 2014, the DQC discussed grievance and appeal (G&A) data and trends, resulting in the formation of a G&A sub-committee. This G&A sub-committee is working to streamline the G&A tracking systems for easier and more regular analysis and trend reporting. The DQC also reviewed the Initial Core Sets of Health Care Quality Measures for Medicaid-Eligible Adults and Children in order to build a general understanding of these measure sets and where they cross-over with other measure sets (e.g. HEDIS, health home, ACO measure sets). The DVHA's AMQ Grant Manager reported to the DQC on the quality improvement projects that fall within that grant, including Breast Cancer Screening and Initiation and Engagement of Alcohol Treatment. Finally, the DQC discussed the *Follow-up After Hospitalization for Mental Illness (FUH)* PIP. In 2014, the FUH PIP implementation team began work on the first year study design. A sub-committee formed for this PIP has made significant progress towards a data management plan.

Additional ongoing activities during 2014 include Process Improvement Projects, staff training sessions, distributions of surveys, and updates to the Quality Management plan provided to the DVHA's IGA partners. Currently, six Process Improvement Projects are being conducted by the DVHA. The projects focus on performance evaluations, purchasing, PCP assignment, dental authorizations and position classification. In March 2014, staff at the DVHA participated in the first of a series of trainings, led by the Lewin Group, focused on analyzing performance measures and implementing PIPs following the CMS protocols. Also in March, the MCE's Adult and Children's CAHPS 5.0H surveys were distributed. The DVHA is contracted with an NCQA-certified vendor, WBA Research, to distribute and collate both the surveys. All preparatory materials were created and coordinated by the DVHA Quality Improvement Administrator and a partner at WBA Research. Finally, the DVHA continued work on updating the Quality Management Plan and provided technical assistance to the DVHA's IGA partners. By the end of Q2 FFY 2014, two of the four IGA partners had completed their plans; the other two IGA partners are in the final stages of completing their plans. The DVHA continues to work closely with their IGA partners to identify performance improvement activities and to measure performance and outcomes.

- ii.* With the delivery of the final EQRO Annual Technical Report, the AHS Performance Accountability Committee (PAC) has begun to re-evaluate the strategy using its findings. In

addition, the group has reviewed the CMS Quality Strategy resource documents. Using these documents as a guide, a tool was developed to collect feedback from each of the committee members. Specifically, the tool asked for feedback in the following areas: managed care goals, objectives, and overview; efforts or initiatives to reduce disparities in health care; targets for included CMS core performance measures; quality of care improvement efforts; delivery system reforms; best or promising practices; challenges or opportunities with data collection systems; and recommendations for on-going quality improvement. All feedback will be collated and incorporated into the updated version of the strategy. Once the document has been reviewed by the AHS Integrated Operations and Planning Team (IOPT) and AHS Executive Committee, it will be 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. *Compliance*

The Managed Care Medical Committee made updates to its charter and approved a new work plan. The work plan sets a schedule for reviewing and updating current practices, such as prior authorizations, clinical practice guidelines and provider network. During a meeting scheduled for April 2014, the Managed Care Medical Committee will review three documentation standards, including clinical documentation, mental health documentation, and dental documentation.

The Managed Care Compliance Director and Unit began preparations for the EQRO audit in June 2014. The Unit is reviewing its previous corrective actions and responses to audit recommendations to ensure that the DVHA fully met all of our Managed Care requirements. The DVHA met with the AHS to discuss audit timelines and expectations.

The Compliance Director continued to meet with our IGA partners, including the AHS, to develop updates to IGA documents. A new version of the IGA template used by the DVHA is now circulating among managers in the department and the AHS. This template will be used to clarify expectations and responsibilities around services delegated to the DVHA's partnering departments. The new IGA template contains clear statutory citations for all delegated activities and more explicit monitoring and reporting expectations. The DVHA plans to share the new IGA template with partnering departments early in Q3 FFY 2014.

XI. Demonstration Evaluation

During this quarter, the AHS QIM met with members of Vermont's System Innovation Model (SIM) grant to develop its evaluation plan. While Medicaid is only one of the participating payers, it was thought that there might be some efficiencies realized by leveraging the Global Commitment waiver evaluation efforts with those of the SIM grant. As the requirements/details of the SIM grant evaluation plan become clearer, so will the opportunities for coordination/integration. With the possibility of incorporating Long Term Care (LTC) in the GC waiver becoming more of a reality – attention is also being paid to how this change might impact the current evaluation plan. The AHS QIM will 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 2013.

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, includes State-funded Marketplace Subsidies Program Report

Attachment 3: Complaints Received by Health Access Member Services

Attachment 4: Medicaid Managed Care Entity Grievance and Appeal Reports

Attachment 5: Office of Health Care Ombudsman Report

Attachment 6: State Fiscal Year 2013 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 Department of VT Health Access 312 Hurricane Lane, Suite 201 Williston, VT 05495	802-879-5901 (P) 802-879-5952 (F) mark.larson@state.vt.us

Date Submitted to CMS: May 23, 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	\$ 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	\$ 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						\$ 2,162,772	\$ 288,230,320					
WY8 SUM	\$ 1,191,700,038	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 33,842,100	\$ 2,037,093					\$ 35,879,193	\$ 1,199,549,732		\$ 6,260,794	\$ 1,205,810,526	\$ 8,450,684,486	\$ 609,071,343
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	\$ 319,939,651		\$ 1,214,631	\$ 321,154,282	\$ 8,955,886,798	\$ 793,119,374
Cumulative																				
0314	\$ 288,542,475	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 2,159,834						\$ 2,159,834	\$ 290,702,309					
0614	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -						\$ -	\$ -					
0914	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -						\$ -	\$ -					
1214	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -						\$ -	\$ -					
WY9b SUM	\$ 288,542,475	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 2,159,834	\$ -	\$ -	\$ -	\$ -	\$ 2,159,834	\$ 288,542,475		\$ 1,050,062	\$ 289,592,537	\$ 10,290,338,883	\$ 1,837,978,922
Cumulative																				
0315	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -						\$ -	\$ -					
0615	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -						\$ -	\$ -					
0915	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -						\$ -	\$ -					
1215	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -						\$ -	\$ -					
WY10 SUM	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -		\$ -	\$ -	\$ -	\$ -
Cumulative																				
0316	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -						\$ -	\$ -					
0616	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -						\$ -	\$ -					
0916	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -						\$ -	\$ -					
1216	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -						\$ -	\$ -					
WY11 SUM	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -		\$ -	\$ -	\$ -	\$ -
Cumulative																				
	\$ 8,207,662,142	\$ 10,166,327	\$ (16,042,281)	\$ 79,876,130	\$ 41,153,315	\$ 19,453,990	\$ 4,878,725	\$ 48,036,100	\$ 7,849,694	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 8,403,034,141	\$ -	\$ 49,325,820	\$ 8,452,359,961	\$ 13,209,265,211	\$ 4,756,905,250



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The Department of Vermont Health Access
Caseload and Expenditure Report - All AHS Medicaid Spend
 All AHS YTD '14
 Thursday, May 01, 2014

	SFY '14 Budget Adjustment			SFY '14 Actuals thru Mar. 31, 2014			% of Approp. Spent to Date
	Caseload	Expenses	PMPM	Caseload	Expenses	PMPM	
ABD Adult	14,660	\$ 185,030,520	\$ 1,051.77	15,790	\$ 131,205,059	\$ 923.28	70.91%
ABD Dual	17,351	\$ 200,918,225	\$ 964.95	17,306	\$ 130,665,150	\$ 838.92	65.03%
General Adult	11,550	\$ 84,215,797	\$ 607.60	12,053	\$ 60,832,276	\$ 560.76	72.23%
VHAP *	37,921	\$ 100,020,181	\$ 386.93	25,739	\$ 102,394,034	\$ 442.01	102.37%
VHAP ESI *	764	\$ 462,511	\$ 99.99	597	\$ 846,315	\$ 157.48	182.98%
Catamount *	13,208	\$ 35,764,708	\$ 459.64	11,303	\$ 48,358,899	\$ 475.39	135.21%
ESIA *	772	\$ 497,443	\$ 108.33	682	\$ 661,435	\$ 107.81	132.97%
New Adult **	34,834	\$ 92,812,770	\$ 444.07	37,228	\$ 31,999,134	\$ 286.52	34.48%
Exchange Premium Assistance **	40,748	\$ 6,586,587	\$ 26.94	6,571	\$ 999,790	\$ 38.04	15.18%
Exchange Cost Sharing **	15,094	\$ 1,484,460	\$ 16.39	2,136	\$ 100,163	\$ 15.63	6.75%
ABD Child	3,712	\$ 92,534,006	\$ 2,077.42	3,583	\$ 66,704,099	\$ 2,068.66	72.09%
General Child	55,646	\$ 240,214,462	\$ 359.74	55,745	\$ 168,658,459	\$ 336.17	70.21%
Underinsured Child	874	\$ 2,154,907	\$ 205.44	978	\$ 1,553,437	\$ 176.53	72.09%
CHIP	4,174	\$ 10,431,858	\$ 208.26	3,965	\$ 7,703,060	\$ 215.87	73.84%
-							
Pharmacy Only	12,510	\$ 5,393,070	\$ 35.93	12,727	\$ 4,640,166	\$ 40.51	86.04%
Choices for Care	3,884	\$ 206,699,425	\$ 4,434.86	3,966	\$ 151,331,625	\$ 4,240.05	73.21%
Total Medicaid	177,027	\$ 1,265,220,931	\$ 595.59	164,433	\$ 908,653,101	\$ 614.00	71.82%

* Caseload for sunsetting programs are point-in-time values for the BAA.

** Caseload for new programs are point in time values for the BAA and are not included in total Medicaid caseload count due to the expected transition from sunsetting programs to new programs



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DVHA YTD '14
 Thursday, May 01, 2014

	SFY '14 Budget Adjustment			SFY '14 Actuals thru Mar. 31, 2014			% of Approp. Spent to Date
	Caseload	Expenses	PMPM	Caseload	Expenses	PMPM	
ABD Adult	14,660	\$ 111,814,690	\$ 635.59	15,790	\$ 79,997,666	\$ 562.94	71.54%
ABD Dual	17,351	\$ 50,384,851	\$ 241.98	17,306	\$ 36,776,184	\$ 236.12	72.99%
General Adult	11,550	\$ 76,593,458	\$ 552.61	12,053	\$ 55,120,722	\$ 508.11	71.97%
VHAP *	37,921	\$ 96,400,670	\$ 372.92	25,739	\$ 95,804,169	\$ 413.57	99.38%
VHAP ESI *	764	\$ 462,511	\$ 99.99	597	\$ 844,721	\$ 157.19	182.64%
Catamount *	13,208	\$ 35,764,708	\$ 459.64	11,303	\$ 48,358,899	\$ 475.39	135.21%
ESIA *	772	\$ 497,443	\$ 108.33	682	\$ 661,435	\$ 107.81	132.97%
New Adult **	34,834	\$ 90,067,832	\$ 432.05	37,228	\$ 30,088,506	\$ 269.41	33.41%
Exchange Premium Assistance **	40,748	\$ 6,586,587	\$ 26.94	6,571	\$ 999,790	\$ 38.04	15.18%
Exchange Cost Sharing **	15,094	\$ 1,484,460	\$ 16.39	2,136	\$ 100,163	\$ 15.63	6.75%
ABD Child	3,712	\$ 33,110,973	\$ 743.35	3,583	\$ 27,830,346	\$ 863.09	84.05%
General Child	55,646	\$ 131,835,785	\$ 197.43	55,745	\$ 96,161,845	\$ 191.67	72.94%
Underinsured Child	874	\$ 708,670	\$ 67.56	978	\$ 608,211	\$ 69.11	85.82%
CHIP	4,174	\$ 7,601,478	\$ 151.75	3,965	\$ 5,749,174	\$ 161.11	75.63%
Pharmacy Only	12,510	\$ 5,393,070	\$ 35.93	12,727	\$ 4,233,864	\$ 36.96	78.51%
Choices for Care	3,884	\$ 206,699,425	\$ 4,434.86	3,966	\$ 151,331,625	\$ 4,240.05	73.21%
Total Medicaid	177,027	\$ 855,406,614	\$ 402.67	164,433	\$ 634,667,321	\$ 428.86	74.19%

* Caseload for sunseting programs are point-in-time values for the BAA.

** Caseload for new programs are point in time values for the BAA and are not included in total Medicaid caseload count due to the expected transition from sunseting programs to new programs

Glossary of Terms

PMPM – Per Member Per Month

MEG – Medicaid Eligibility Group

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

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

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

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

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

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

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

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

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 between 133-300% FPL

Exchange Vermont Cost Sharing - Individuals enrolled in qualified health plans (QHP) with incomes between 200-300% FPL

Underinsured Child – Beneficiaries age 18 or under with household income 225-300% (as of 1/1/14, 237-312%) FPL with other insurance

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

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

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

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

Questions, Complaints and Concerns Received by Health Access Member Services December 29, 2013 – April 5, 2014

December 29 – January 4:

- CSC received several feedback emails from DVHA along with requests via email for a call back. All feedback issues were researched, and CSRs called those who had requested a call back to help resolve their issue. Findings were reported to the DVHA Contract Monitor. The CSC has researched and responded to issues sent from HAEU.
- Prescription Drug Plan: CSRs utilized references to confirm bill amounts and explain the benefits of VPharm. Calls were escalated to HAEU when necessary.

January 6 – January 11:

- CSC received several feedback emails from DVHA along with requests via email for a call back. All feedback issues were researched, and CSRs called those who had requested a call back to help resolve their issue. Findings were reported to the DVHA Contract Monitor. The CSC has researched and responded to issues sent from HAEU.
- Duplicate premium bills: CSRs explained options to customers who received bills for both their VHC and GMC programs and escalated callers as appropriate.

January 13 – January 18:

- CSC received several feedback emails from DVHA along with requests via email for a call back. All feedback issues were researched, and CSRs called those who had requested a call back to help resolve their issue. Findings were reported to the DVHA Contract Monitor. The CSC has researched and responded to issues sent from HAEU.
- The Portal was unavailable for the better part of the day on 1/15/2014, causing high levels of frustration from callers hoping to enroll for Feb. 1 VHC coverage.
- Medicaid not showing active: CSRs referred to Catamaran and HPE and provided outreach when necessary.
- Difficulty with Medicaid co-pays. CSRs offered GAC.

January 20 – January 25:

- Medicaid reapplication forms: CSRs escalated calls to HAEU.
- VPharm payments: CSRs confirmed payment and advised caller of payment timeframes.
- MAXIMUS notified DVHA of increased calls from GMC customers receiving closure for non-review notices when the system shows that all information required for review



has been received. CSRs confirmed that it did not appear that the caller needed to send further information, sent an SR to HAEU and advised the caller to call back within the week if they have not received notice of continued coverage.

January 27 – February 1:

- Premium Invoicing: CSRs advised callers if their payments have been received and where they can mail bills. Calls were escalated to HAEU when necessary.
- Review closure notices: CSRs confirmed whether information was received and advised accordingly.
- RXclaims showing as inactive: CSRs advised callers that if they are found newly eligible for Medicaid it does not immediately show in RXclaims. CSRs rushed prescriptions through the system when necessary.

February 3 – February 8:

- Dual VHC/GMC enrollment: CSR's sent ACH form and requested closure of GMC plan.
- Premium refund requests: CSR's submitted SR indicating refund request, and supervisors forwarded to COP's to have refund issued.
- Automatic Withdrawal: CRS's assisted caller set up automatic withdrawal for premium payments.
- Billing issues due to overlapping segments in Access: CSR's submitted SR indicating the error, and supervisors forwarded to COP's for resolution.
- PC Plus enrollment issues due to unavailable managed care screens. CSR's submitted SR indicating error, while supervisors logged the information to enter at a later date.
- Co-pays for new Medicaid members: CSR's referred to a provided script and gave available resources.

February 10 – February 15:

- Medicaid savings plan closure notices: CSRs advised if MSP would be continuing and, if not, why it is closing.

February 17 – February 22:

- Review reminders: CSR's verified information and advised callers to allow processing time.
- PDP premiums for Medicaid members: CSR's advised callers to allow 3 to 4 months for systems to align and reviewed HPE to verify payments have been made. Callers were further advised to inform their PDP that they are on VT SPAP.
- Review closure notices because client received incorrect review application: CSR's send service requests to HAEU, and escalated when necessary.

February 24 – March 1:

- Late premium payments: CSR's entered a CATN or transfered the caller based on when the premium was received.
- PDP premiums for VPharm clients: CSR's verified if premiums had been paid and advised callers of processing time frames.
- Managed care enrollment screens were established in ACCESS for cases originating in the VHC portal. MAXIMUS staff began entering a backlog of approximately 1,300 PCP choices.
- Based on the availability of enrollment screens, MAXIMUS staff resumed outreaching potential enrollees by phone to solicit a PCP choice.
- The MAXIMUS mail room received a file of approximately 3,000 enrollment forms due to a back log of pending cases. MAXIMUS and the SoV agreed to mail these forms at a rate of approximately 300 per day to prevent unnecessarily contributing to high call volumes and CSR workload.

March 3 – March 8:

- Late premium payments: CSRs explained time frames for reinstatement.
- PDP premiums for VPharm clients: CSRs verified if premiums had been paid and advised callers of processing time frames.
- CHAP customers requesting refund after applying through VHC: CSRs submitted a level 3 SR.
- Premium refunds for people who transitioned from GMC to VHC: CSRs escalated a level 3 SR and supervisors sent to COPS.
- Overlapping VHC and Medicaid coverage: CSRs escalated a level 3 SR and supervisors sent to COPS.

March 9 – March 15:

- Second reminder closures: CSRS confirmed whether or not the application was received and advised if more information was necessary.
- Premium refund requests: CSRs submitted SR indicating refund request.

March 17 – March 22:

- Review Applications: CSRs reviews the caller's account and advised accordingly.
- Closure Notices: CSRs reviewed the caller's account and advised accordingly.



March 24 – March 29:

- Review Notices: CSRs advised which application to complete and assisted with application when necessary.
- VPharm Premiums: CSRs advised if payment had been received.
- Dr. Dynasaur premiums generated in both the CRM and ACCESS: CSRs reviewed the caller's account and escalated to HAEU when necessary.

March 30 – April 5:

- Dr. Dynasaur premiums generated in both CRM and ACCESS when bill has been paid: CSRs advised to follow through with VHC invoices and disregard GMC Dr. Dynasaur bills.
- Payment confirmation: CSRs verified status of premium and advised accordingly.
- Overlapping coverage: CSRs escalated the call to level 3 SR and supervisors sent to COPS.

**Grievance and Appeal Quarterly Report
Medicaid MCE All Departments Combined Data
January 1, 2014 – March 31, 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 (DAIL), and the Department of Health (VDH). Also included in the MCE are the Designated Agencies (DA) and Specialized Service Agencies (SSA) that provide service authorizations for DMH and DAIL. Each entity should have at least one assigned grievance and appeal coordinator who enters data into the MCE database. This report is based on data compiled on April 3, 2014, from the centralized database for grievances and appeals that were filed from January 1, 2014 through March 31, 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, 83% were filed by beneficiaries, and 17% were filed by a representative of the beneficiary. Of the 11 grievances filed, DMH had 75%, DAIL had 17%, and VDH had 8%. There were no grievances filed for the DVHA, or DCF during this quarter.

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

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.

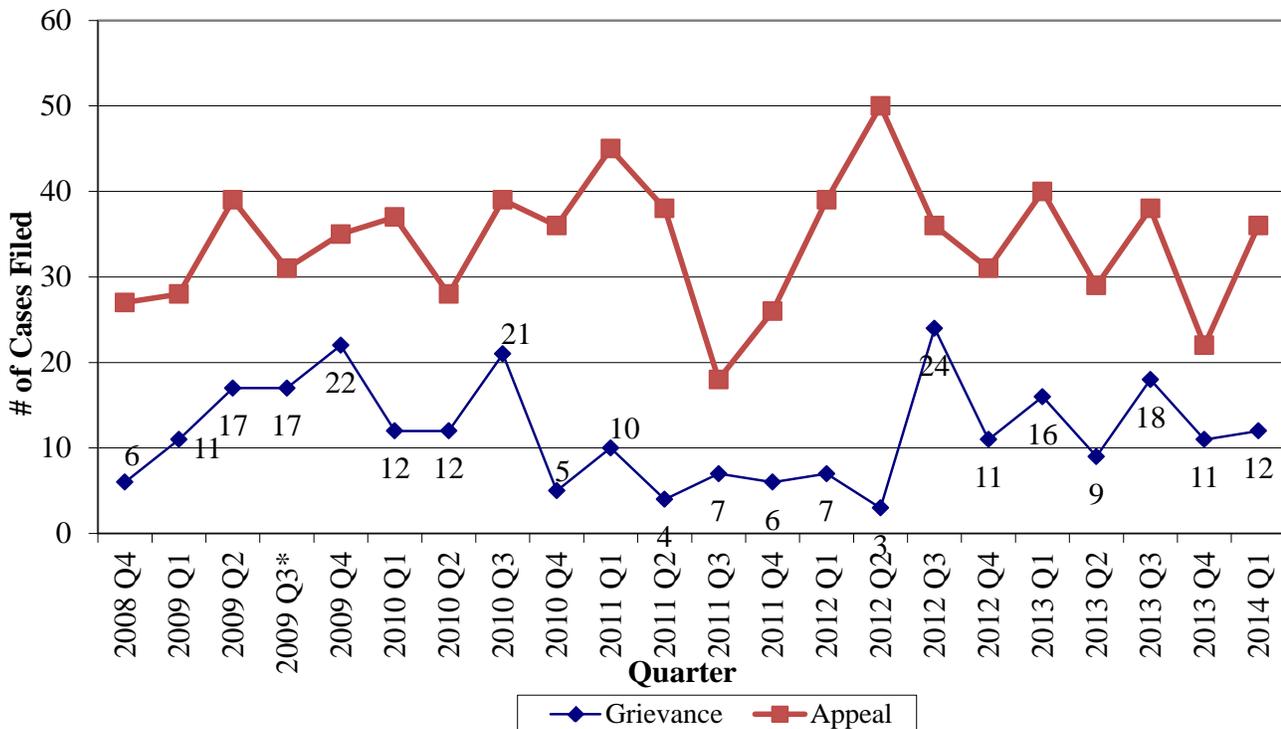
During this quarter, there were 36 appeals filed with the MCE; 5 requested an expedited decision, with three of them meeting the criteria. Of these 36 appeals, 14 were resolved (39% of filed appeals), 20 were still pending (56%), 2 were withdrawn (5%). In six cases (43% of those resolved), the original decision was upheld by the person hearing the appeal, 5 cases (36% of those resolved) were approved by the applicable department/DA/SSA before the appeal meeting, three cases (21%) the original decision was reversed.

Of the 14 appeals that were resolved this quarter, 100% were resolved within the statutory time frame of 45 days; 100% were resolved within 30 days. The average number of days it took to resolve these cases was 10 days. Acknowledgement letters of the receipt of an appeal must be sent within five days; the average was three days, with three of them being late.

Of the 36 appeals filed, 21 were filed by beneficiaries (61%), 12 were filed by a representative of the beneficiary (33%), and 2 (6%) were filed by the provider. Of the 36 appeals filed, DVHA had 39%, DAIL had 56%, and DMH had 5%.

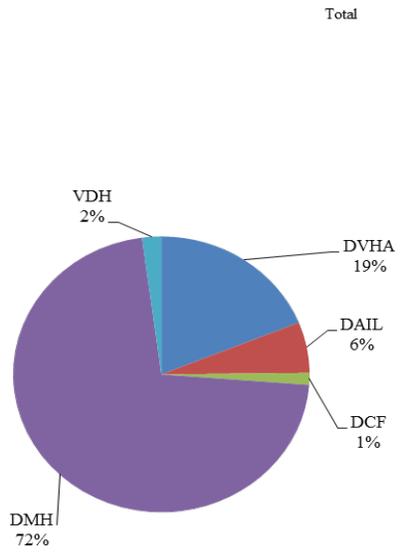
Beneficiaries can file an appeal and a fair hearing at the same time, and they can file a fair hearing if their appeal is not decided in their favor. There were seven fair hearing filed this quarter.

Medicaid MCE Grievances & Appeals

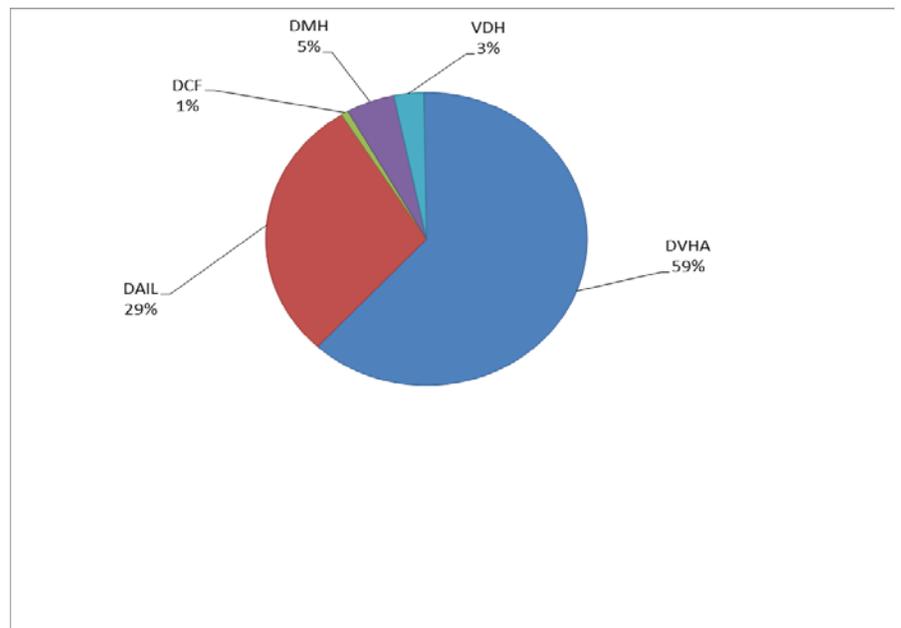


MCE Grievance & Appeals by Department From October 1, 2008 through March 31, 2014

Grievances



Appeals



VERMONT LEGAL AID, INC.

OFFICE OF HEALTH CARE ADVOCATE

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BURLINGTON, VERMONT 05402
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BURLINGTON
RUTLAND
ST. JOHNSBURY

OFFICES:

MONTPELIER
SPRINGFIELD

QUARTERLY REPORT

January 1, 2014 – March 31, 2014

to the

Agency of Administration

submitted by

Trinka Kerr, Chief Health Care Advocate

April 21, 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:** 1,185 calls
 - **DVHA beneficiaries:** 472 calls or **40%** of total calls
 - **Commercial plan beneficiaries:** 270 calls or **23%**
 - **Uninsured Vermonters:** 164 calls or **14%**
 - **Vermont Health Connect:** 540 calls or **46%** (this data report draws from the above data sets)
 - **Reportable Activities (Summary & Detail):** 191 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 1,185 calls this quarter. We divided these calls into five issue categories. The figures below are based on the All Calls data. See the other data reports for a similar breakdown based on the insurance status of the caller, or whether the call was related to a Vermont Health Connect (VHC) issue. The percentage and number of calls in each issue category based on the caller's primary issue was as follows:

- **18.14%** (215) of our total calls were regarding **Access to Care**;
- **16.62%** (197) were regarding **Billing/Coverage**;
- **4.47%** (53) were questions regarding **Buying Insurance**;
- **8.61%** (102) primarily involved **Consumer Education**;
- **32.24%** (382) were regarding **Eligibility** for VHC programs and Medicare; and
- **19.92%** (236) 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 382 cases had Eligibility for state health care programs as the primary issue, there were actually a total of 929 calls in which we spent a significant amount of time assisting consumers regarding eligibility for health insurance. In each section of this narrative we record 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 VHC programs fell into all three insurance status categories.

A. Record level call volume: the HCA received 42% more calls this quarter compared to 2013, primarily due to continued implementation problems with Vermont Health Connect.

The state launched its health benefit exchange, Vermont Health Connect (VHC), on October 1, 2013, as required by the federal Affordable Care Act (ACA). Despite continued improvements in VHC's functionality, significant implementation difficulties persisted this quarter. As a result, our call volume hit record high levels. Call volume increased by 25% over last quarter.

We received 1,185 calls this quarter, compared to 950 last quarter. This compares to 835 calls in the first quarter of 2013. Thus, our SFY Q 3 call volume was 42% higher than last year's. Because 46% of our calls this quarter were related to VHC, it seems safe to assume that this big increase was directly attributable to problems with the exchange.

Our 436 call volume in March set an all time record for any month. To understand what this means, we checked the call volume after a previous big program change, the launch of Medicare Part D in January 2006. We received 313 calls that January, which was the all time record at that time. Historically, it has been unusual for our call volume to exceed 300 calls in any month.

Call volume in each month this quarter hit a new record for that month. January's volume was 44% higher than January 2013, February's was just 7% higher, but March's volume was a whopping 66% higher than March 2013. The March call volume increase was mainly due to the end of this year's VHC Open Enrollment Period, which occurred on March 31, 2014.

Our call volume probably would have been even higher but for the fact that VHC still did not send out the legally required written Notices of Decision (NODs) to applicants during this quarter. The HCA phone number is on DVHA NODs and is one of the main ways that consumers find out about our services. We complained earlier about the lack of notices. Our understanding is that VHC now has the capability to send out NODs and is just beginning to do so. The additional delay in NODs this past quarter was in part due to concern that sending the notices would generate even more calls and further overwhelm the VHC call center during the last weeks of the Open Enrollment Period.

B. Vermont Health Connect, the Department for Children and Families, and Blue Cross Blue Shield of Vermont have made heroic efforts to make sure consumers get the care they need.

Many consumers are experiencing severe problems getting enrolled correctly. VHC, DCF and BCBS have all worked tirelessly and closely with the HCA to make sure Vermonters who have problems with their coverage are not going without medical care that they need as a result. The HCA contacts VHC, DCF and BCBS daily on behalf of individual consumers. Sometimes it can take weeks or months to get some problems fixed (especially those related to the lack of the change of circumstance functionality), but if a consumer has an urgent medical need it seems that together we have been finding ways to get people on coverage. We appreciate everyone's efforts and willingness to collaborate with us.

C. The top issues generating calls

This section includes both primary and secondary issues. The most common issues raised by callers were requests for information about VHC and applying for VHC programs, Medicaid eligibility, complaints about VHC, and communication problems with the Department for Children and Families (DCF), which includes the Health Access Eligibility Unit (HAEU).

Problems with access to prescription drugs jumped this quarter, which appeared to be primarily due to insurance eligibility problems.

All Calls (1,185, compared to 949 last quarter)

1. Information about VHC 231 (compared to 167 last quarter)
2. VHC complaints 230 (this is a new code)
3. Information about DVHA programs 139 (156 last quarter)
4. Communication Problems with DCF 138 (83 last quarter)
5. MAGI Medicaid eligibility 131 (89 last quarter)
6. Complaints about Providers 118 (88 last quarter)
7. Access to Prescription Drugs 112 (74 last quarter)
8. Buying QHPs through VHC 111 (51 last quarter)
9. VHC website/technology 108 (this is a new code)
10. Medicaid (non-MAGI) eligibility 104 (102 quarter)

DVHA Beneficiary Calls (472, compared to 417 last quarter)

1. Complaints about Providers 73 (48 last quarter)
2. Information about DVHA programs 60 (62 last quarter)
3. Access to Prescription Drugs 60 (35 last quarter)
4. Information about VHC 54 (65 last quarter)
5. Communication Problems with DCF 52 (38 last quarter)
6. MAGI Medicaid eligibility 50 (42)
7. Medicaid (non-MAGI) eligibility 46 (50 last quarter)
8. Affordability of health care 40 (50 last quarter)
9. VHC complaints 37 (this is a new code)
10. Provider billing problems 26 (11 last quarter)

Commercial Plan Beneficiary Calls (270, compared to 146 last quarter)

1. VHC complaints 125 (12 last quarter)
2. Information about VHC 87 calls (52 last quarter)
3. Buying QHPs through VHC 53 (21 last quarter)
4. VHC website/technology 53 (this is a new code)
5. Premium billing 43 (11)
6. VHC invoice problem 29 (this is a new code)
7. Affordability of health care 27 (24)
8. Communication problem with DCF 25 (9 last quarter)
9. Communication problem with plan 25 (8 last quarter)
10. Change of circumstance 25 (this is a new code)

Vermont Health Connect Calls (540, compared to 249 last quarter)

1. VHC complaints 230 (37 last quarter)
2. Information about VHC 228 (164 last quarter)
3. MAGI Medicaid eligibility 127 (85 last quarter)
4. Buying QHPs through VHC 110 (49 last quarter)
5. VHC website/technology 108 (this is a new code)
6. Communication Problems with DCF 105 (27 last quarter)

7. Premium Tax Credit eligibility 79 (31 last quarter)
8. Information about applying for DVHA programs 72 (51 last quarter)
9. Medicaid eligibility 63 (27)
10. Premium billing 60 (7 last quarter)

D. Hotline call volume by type of insurance:

The HCA received 1,185 total calls this quarter. Callers had the following insurance status:

- **DVHA programs** (Medicaid, VHAP, Premium Assistance, VPharm, or both Medicaid and Medicare aka dual eligibles) insured **40%** (472 calls), compared to 44% (417) last quarter;
- **Medicare**¹ (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 **23%** (269), compared to 31% (295) last quarter;
- **Commercial plans** (employer sponsored insurance, individual or small group plans, and Catamount Health plans) insured **23%** (270), compared to 15% (146) last quarter; and
- **Uninsured** callers made up **14%** (164) of the calls, compared to 12% (114) last quarter.
- In the remainder of calls the insurance status was either unknown or not relevant.

E. Dispositions of closed cases

All Calls

We closed 1,114 cases this quarter, compared to 936 last quarter.

- 30% (330 cases) were resolved by brief analysis and advice;
- 26% (291) were resolved by brief analysis and referral;
- 22% (242) of the cases were complex interventions, which involves complex analysis, usually direct intervention, and more than two hours of an advocate's time (complex cases rose 32% this quarter);
- 19% (214) were resolved by direct intervention, including calling an insurance company, calling providers, writing letters, gathering supporting medical documentation, etc.;
- <1% (2) of the cases were resolved in the initial call, down from 50 calls last quarter.
- In the remaining cases, clients withdrew, resolved the issue on their own, or had some other outcome
- Appeals: 20 cases involved help with appeals: 4 commercial plan appeals, 12 Fair Hearings, 1 DVHA internal MCO appeal and 4 Medicare. With all the problems VHC was having, we expected a sharp increase in appeals. However, because VHC was

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

aware of the high number of errors in processing eligibility, it resolved most complaints outside of the appeal system.

DVHA Beneficiary Calls

We closed 455 DVHA cases this quarter, compared to 424 last quarter.

- 26% (118 cases) were resolved by brief analysis and advice;
- 30% (137) were resolved by brief analysis and referral;
- 19% (85) were considered complex intervention, which involves complex analysis, usually direct intervention, and more than two hours of an advocate's time;
- 24% (107) were resolved by direct intervention on the caller's behalf, including advocacy with DVHA and providers, writing letters, and gathering medical information;
- No DVHA beneficiary calls were resolved in the initial call, down from 24 last quarter.
- In the remaining cases, clients withdrew, resolved the issue on their own, or had some other outcome.
- Appeals: 13 cases involved appeals: 12 Fair Hearings and 1 internal MCO appeal.

Commercial Plan Beneficiary Calls

We closed 239 cases involving individuals on commercial plans,, compared to 134 last quarter.

- 35% (84 cases) were resolved by brief analysis and advice;
- 18% (43) were resolved by brief analysis and referral;
- 22% (53) were considered complex intervention, which involves complex analysis, usually direct intervention, and more than two hours of an advocate's time;
- 21% (51) 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, down from 7 last quarter..
- In the remaining cases clients withdrew, resolved the issue on their own, or had some other outcome.
- Appeals: 4 cases involved appeals.

F. Case outcomes

All Calls

The HCO helped 115 people get enrolled in insurance plans and prevented 17 insurance terminations or reductions. We obtained coverage for services for 29 people. We got 32 claims paid, written off or reimbursed. We assisted 13 people complete applications and estimated VHC insurance program eligibility for 53 more. We provided other billing assistance to 31 individuals. We obtained hospital patient assistance for 5 people. We provided 602 individuals with advice and education. We obtained other access or eligibility outcomes for 75 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. In total, this quarter the **HCA saved individual consumers \$39,505.67** in cases opened this quarter. The amount of savings for state fiscal year 2014 up to March 31, 2014, is **\$159,122.61**.

G. Case examples

Here are a few examples of how we helped Vermonters this quarter:

1. Ms. A could not get post-surgery medication because her insurance had been incorrectly terminated for nonpayment of premium. Ms. A went to the emergency room because she was having severe abdominal pain, and was rushed into surgery. After she came home from the hospital, her husband went to pick up her prescriptions. The pharmacist told him that Ms. A had no insurance coverage. Because he could not afford the full cost of the medication, Mr. A left the pharmacy empty handed. He called VHC Member Services, but could not get through, so he called the HCA. The HCA advocate determined that Mr. A's VHAP coverage had been improperly closed for nonpayment, as Mr. A had in fact paid the premium. The advocate was able to get the processing of the payment expedited and get the As' VHAP reinstated so that Mr. A could get his wife the medication she needed. By getting their coverage reinstated, the HCA saved the As over \$5,000: the cost of her prescriptions, the hospitalization and the surgery.
2. Mr. B and his family were incorrectly denied Medicaid. Mr. B and his wife were very low income and were on VHAP and their children were on Dr. Dynasaur. Knowing that the VHAP program was ending, Mr. B applied for other coverage in December by calling the VHC Customer Support Center. After two hours on the phone, the customer service representative told him the family was not eligible for Medicaid or Dr. Dynasaur and would have to buy a Qualified Health Plan for the family to continue coverage. The CSR did not adequately explain the subsidies they might get to reduce the cost of the premium. Very discouraged, Mr. B concluded that they could not afford insurance. However, he was very worried because his wife had a chronic health condition and needed coverage. He called the HCA in January and asked for our help. The HCA advocate determined that VHC had not calculated the family's income correctly under the new rules. The advocate contacted VHC multiple times in order to get the income calculation corrected. In the end, both parents were found eligible for Medicaid and the children for Dr. Dynasaur.
3. Vermont Health Connect refused to refund a large erroneous payment. While paying his bills, Mr. C inadvertently placed a check to another payee into his VHC premium payment envelope. The check was for \$4,000, a very significant sum to the household; his premium was only about \$48. Even though the \$4,000 check was not made out to VHC, VHC cashed it and applied it to the Mr. C's account. When Mr. C realized what had happened, he called VHC immediately and asked that the check be refunded. He was informed it was not possible for VHC to make any refunds. The customer service

representative explained that the only option was to have the check applied as a credit to future health care premiums. This would have been an advance payment covering seven years of premiums! Mr. A then called the HCA . The HCA advocate contacted VHC and initially was also told that VHC did not have the capability to make refunds. She persisted and eventually VHC did refund the check. The HCA saved Mr. C \$3,952.

4. Ms. D, a refugee on VHAP, was incorrectly denied Medicaid. Ms. D called the HCA after she was found ineligible for Medicaid when she applied through VHC. Immigrants who have not lived in the U.S. legally for at least five years are not eligible for Medicaid. However, there are exceptions to this rule, including having refugee status. The VHC application does not include questions that would enable VHC to determine whether a non-citizen meets an exception to the five year bar. The HCA advocate recognized that Ms. D fell into this exception and contacted VHC to explain that Ms. D was eligible for Medicaid. VHC subsequently put her on Medicaid and back-dated her coverage to the date of her application.

H. Recommendations to DVHA

1. *The change of circumstance functionality must be made operational soon.*

This is the biggest problem we see. We know VHC is well aware of this issue and working on it, but it is a huge problem, affecting thousands of people and wreaking havoc. We would be remiss if we didn't mention it.

2. *The glitches in the invoice and payment system must be fixed and the functionality to easily make refunds developed and deployed.*

We continue to hear from consumers who say they are not getting invoices, are not getting correct invoices, and whose premium payments are not being processed in a timely manner. It is very difficult for the HCA to pinpoint what the exact problems are, because these problems are not happening to everyone. In addition, VHC must have the capacity to refund incorrect payments. Aside from the rare situations like case example #3 above, we are also hearing from individuals who are receiving incorrect subsidies and thus paying significantly more in premiums than they should have to. They should be able to get refunds.

3. *Maximus and Health Access Eligibility Unit staff need additional training, resource materials and supervision.*

We continued to hear incorrect information from some Maximus customer service representatives and HAEU staff. We also heard the same thing from consumers and navigators. These errors cause confusion and serious problems for consumers. We report these errors to VHC frequently, but sometimes we just try to fix them. We also met about every two weeks

with Maximus and VHC staff to talk through problems we were seeing, and had a separate face-to-face meeting with HAEU and DCF staff. We appreciate the difficulties in running large call centers which must handle complex information, but because the mistakes can be so harmful, there should be an increased effort to improve training, resource materials and quality control.

- 4. The applications must be changed to incorporate questions which garner more nuanced information about citizenship status.*

The HCA received 35 calls related to eligibility problems related to citizenship status, up from 6 last quarter. Of these, 33 were due to VHC's inability to distinguish among the various possible exceptions to the five year bar rule. [See the case example #4 above.]

- 5. Applicants need more information regarding what income is countable and who should be included in the household.*

More information could be provided on the application, on a page of the website, or both. This is especially important while the change of circumstance functionality is not working. Many of the COCs involve mistakes made completing the application in these two areas.

- 6. Communication among all levels of VHC and DCF staff, as well as with the Navigators and the HCA, needs to be improved.*

Often it seems like the various parts of the state working on VHC issues are not talking to each other. As various policy and operational issues are worked through, we are sometimes surprised by who doesn't appear to have received certain information. We have seen some improvement in the information coming to the HCA very recently, which is great.

- 7. Legally proper and timely Notices of Decision need to start going out to all VHC applicants.*

The state is legally required to send NODs when an applicant's eligibility for a health care program or subsidy has been determined. We know the state worked on the NODs for months while the VHC functionality to automatically issue them was developed. We are not sure whether the functionality is fully deployed or that these notices are going out yet for every applicant now. These notices should be going out now.

- 8. Copayments for prescriptions for individuals on Medicaid whose income is less than 75% of the Federal Poverty Level should be eliminated.*

The switch from VHAP to Medicaid has created an unexpected problem for some people. Prior to the implementation of the Affordable Care Act, many Vermonters whose income was less than 150% FPL (185% for parents) were on VHAP and had no copayments for medications. Today people with income below 133% FPL are on expanded Medicaid. Medicaid has copayments for prescriptions of \$1, \$2, or \$3, depending on the cost of the medication.

The HCA has received an increased number of complaints (12) from very low income individuals who, now that they are on Medicaid instead of VHAP, are unable to afford their medications. Most of these callers had income below 75% FPL (about \$730 per month), and some had no income at all. Someone who has applied for SSI and is living on General Assistance may have income as low as \$254 per month. These folks cannot afford these new copayments. Copayments for very low income individuals should be abolished.

I. Table of all calls by month and year

All Cases	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
January	252	178	313	280	309	240	218	329	282	289	417
February	188	160	209	172	232	255	228	246	233	283	302
March	257	188	192	219	229	256	250	281	262	263	436
April	203	173	192	190	235	213	222	249	252	253	
May	210	200	235	195	207	213	205	253	242	228	
June	176	191	236	254	245	276	250	286	223	240	
July	208	190	183	211	205	225	271	239	255	271	
August	236	214	216	250	152	173	234	276	263	224	
September	191	172	181	167	147	218	310	323	251	256	
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	339	
Total	2409	2200	2583	2560	2604	2616	3077	3209	3105	3256	1155

III. Consumer protection activities

A. Rate review work

Insurance carriers filed 14 new rate cases with the Green Mountain Care Board (GMCB) in this calendar quarter. This is the first quarter where the two-step review process with the Department of Financial Regulation and the GMCB has been replaced by a new rate review system. The entire rate review process is now conducted by the GMCB, which also hired a new actuarial firm, Lewis & Ellis, to review the filings. The HCA met with actuaries from the new firm when they visited Vermont in January.

The HCA filed Notices of Appearance in all 14 of the new 2014 filings. We also filed two memoranda covering six of the filings. No contested hearings were held for these cases this quarter. The GMCB decisions are due in April.

In addition to our rate review case work, we reviewed the new GMCB rate review website and suggested changes to some of the content. We identified issues with the way that individuals interested in being notified about new rate filings could sign up for this information.

We also updated materials about rate review on our own website, www.vtlawhelp.org/health, and added more information about how the public can participate in rate review cases.

Finally, the HCA worked to amend the GMCB's policy regarding the treatment of confidential materials in rate review cases. We negotiated with the Board's General Counsel and the attorneys for Blue Cross and Blue Shield of Vermont (BCSBSVT) and MVP to extend the deadline for destroying confidential materials after the appeal deadline and to allow us to keep a record of some hearing materials which contain confidential information. All parties agreed to the deadline extension. The negotiation regarding retaining confidential material is ongoing.

B. Green Mountain Care Board and Vermont Health Care Innovation Project

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 11 GMCB public meetings
- Attended one meeting of the GMCB Advisory Committee
- Met once with General Counsel for the GMCB
- Met twice with the Chair of the GMCB
- Reviewed 3 new certificate of need applications, and the conceptual CON report for Fletcher Allen Health Care's proposed new 120 bed inpatient facility
- Participated in the state's Vermont Health Care Innovation Project (VHCIP) in the following ways:
 - Participated in two meetings as a member of the VHCIP Steering Committee
 - Participated, along with representatives from other projects of Vermont Legal Aid, as "active members" in five of the seven VHCIP work groups: the Payment Models Work Group, the Quality and Performance Measures Work Group, the Disability and Long Term Services and Supports Work Group (formerly the Duals Demonstration Work Group), the Population Health work Group and the Care Models and Care Management Work Group
 - Participated along with representatives from other projects of Vermont Legal Aid, as "interested parties" in two of the seven work groups: the Governor's Workforce Work Group and the Health Information Exchange/Health Information Technology Work Group
 - Attended five meetings of the Core Team
 - Submitted comments to the Quality and Performance Measures Work Group recommending new measures to be considered for the second year of the Accountable Care Organizations (ACO) Shared Savings Programs

- Provided input to the VHCIP staff on the content of its new website
- Submitted recommendations to the VHCIP Project Director, DVHA Director of Payment Reform, and GMCB Director of Payment Reform on patient notices for the Medicaid and commercial ACOs
- Participated in the Patient Experience Survey RFP review
- Submitted comments to the GMCB regarding changes in the health care benefit design for the VHC Qualified Health Plans in 2015
- Submitted comments regarding proposed changes to the Vermont Information Technology Leaders (VITL) consent policy

QHP Plan Design

The HCA submitted brief comments to the GMCB supporting a proposed 2015 plan design adjustment for pediatric dental benefits for the VHC Qualified Health Plans requested by the Department of Vermont Health Access.

VITL's Consent Policy

VITL is a nonprofit organization that is assisting Vermont health care providers in adopting and using health care information technology to improve patient care. In this quarter, the HCA learned that VITL had proposed a change to its patient consent policy which would allow health care providers to gain access to a patient's protected health information on the Health Information Exchange which VITL manages. VITL changed its policy from requiring individual providers to obtain consent from each of their patients to a global opt-in policy. The global opt-in policy means that patients would be asked to sign one consent form covering all of their current and future providers who join the Health Information Exchanges.

The HCA identified a number of concerns with the policy which affect consumer/patient rights including the scope of the global opt-in consent; the absence of plain language consent forms, revocation forms, and informational materials; and the lack of protections against security breaches of patients' private health information proposed to be stored on the Exchange.

The HCA submitted public comments on the proposed revisions to the consent policy to the Agency of Administration and two sets of public comments to the GMCB. The Agency of Administration adopted some of the changes the HCA recommended regarding clarifying language in the consent policy. The GMCB responded to the HCA's comments by ordering VITL, at the HCA's request, to work with the HCA to develop plain language information materials including consent forms, revocation forms, and supplemental materials.

The HCA developed sample plain language consent forms and revocation forms. Together, the HCA and VITL are in the process of creating the final versions of the consent form, the revocation form, and a companion informational brochure on the Health Information Exchange. VITL's original consent form was written at a reading level of grade 18, which should be understandable to readers with six years post-high-school education. The HCA and VITL's current draft of the consent form is at a seventh grade reading level.

C. Other Activities

- The Chief Health Care Advocate participated in:
 - 3 Medicaid and Exchange Advisory Board (MEAB) meetings
 - 1 Governor’s Consumer Advisory Council meeting
 - 1 Single Payer Advocates meeting
 - 1 Improving Access Work Group meeting (subgroup of the MEAB)
- Continued to discuss and informally comment on the development of the Agency of Human Services Health Benefit Eligibility and Enrollment regulations, which are now going through the formal Administrative Procedures Act process.
- Commented on VHC notices at least 7 times.
- Participated in at least 81 legislative activities, testified 13 times, and submitted 9 documents to legislative committees, mostly related to VHC and S. 252 (on Green Mountain Care).
- Developed and posted two policy papers on our website:
 - *Low Income Taxpayers and the Affordable Care Act*
 - *Accountable Care Organizations – What is the Evidence?*
- Posted new information on our website related to VHC changes for small employers and Catamount and VHAP beneficiaries.
- HCA staff attended one training, the Families USA Health Action 2014 Conference January 23-25, 2014 in Washington, D.C.
- The HCA has also begun to participate in two national e-mail forums organized by The Consumer Union, The Health Cost Forum and a Rate Review Group.
- We also developed a training on VHC eligibility and enrollment for other Vermont Legal Aid projects and staff.

D. Collaboration with other organizations

The HCA worked with the following organizations this quarter:

- ACLU
- Planned Parenthood
- Voices for Vermont’s Children
- Vermont CARES
- Disability Rights Vermont
- VPIRG
- Vermont Campaign for Health Care Security
- Vermont Family Network

IV. Outreach and education

A. Website

Vermont Law Help is a statewide website that is maintained by Vermont Legal Aid and Law Line of Vermont. The site includes a substantial Health section with more than 150 pages of consumer-focused information that is 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.

Vermonters Continued to Seek Information Related to VHC and Health Care Reform

Comparing the health site's Google Analytics with the same quarter last year, we continue to see significant increases in the number of pages being accessed by Vermonters seeking information about and assistance with health care:

- Pageviews of the Health Home Page **increased by 130.61%** (874 vs. 379)
- Pageviews of All Health Pages **increased by 69.23%** (1,760 vs. 1,040)
- Unique pageviews of All Health Pages **increased by 74.92%** (1,130 vs. 646) Unique page views counts only the first view of a page by each user; repeat views of the same page from the same computer are not counted.

17 out of the 25 most-visited pages in the health section provided information related to health insurance topics:

- Vermont Health Connect, health care reform, and Vermont's sunseting health care programs (13)
- Information about all types of health insurance, Medicare, regulation, and employer-sponsored insurance (4)

Health Care Policy Page

This quarter, the HCA launched a new page to share policy papers and comments that represent the HCA's work to represent consumers before the Green Mountain Care Board, the legislature, and state agencies, committees, boards and task forces.

The new Health Care Policy page was the **fourth most visited page in the health section** after the home, Vermont Health Connect and health insurance pages. Visitors spent an average of five minutes, more than four times the site average, viewing the policy page. "Low-Income Taxpayers and the Affordable Care Act for Non-Tax Lawyers" and "Accountable Care Organizations: What is the Evidence?" were the **second and third most-downloaded** out of all PDFs on the entire Vermont Law Help website, with 29 and 15 downloads each, respectively.

Other policy papers and comments posted on the Health Care Policy or Health Insurance Rate Review pages were among the 40 different titles that were downloaded from the Vermont Law Help site.

Client Engagement

The bounce rate reflects the number of visits in which the person leaves the site from the entrance page without engaging with (i.e. clicking on links within) the page. A lower bounce rate represents a higher level of engagement. Continuing the positive trend we have seen since

we began to improve Vermont Law Help's Health section a year ago, the bounce rate was down by 31% this quarter, from an unacceptably high bounce rate of 67% last year to 46% this year. The time spent on a single page has also declined, which is often viewed as a negative statistic. But in this case, it reflects our efforts to create shorter, more focused pages that provide better access to important health care information to consumers with lower reading skills.

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.

SFY13 Final MCO Investments

9/4/13

MCO Investment Expenditures		
Criteria	Department	Investment Description
2	DOE	School Health Services
4	GMCB	Green Mountain Care Board
2	BISHCA	Health Care Administration
2	VVH	Vermont Veterans Home
2	VSC	Health Professional Training
2	UVM	Vermont Physician Training
3	VAAFAM	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
4	DMH	Challenges for Change: DMH
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	CUPS/Early Childhood Mental Health
2	DCF	Therapeutic Child Care
2	DCF	Lund Home
2	DCF	GA Community Action
3	DCF	Prevent Child Abuse Vermont: Shaken Baby
3	DCF	Prevent Child Abuse Vermont: Nurturing Parent
4	DCF	Challenges for Change: DCF
2	DCF	Strengthening Families
2	DCF	Lamoille Valley Community Justice Project
3	DCF	Building Bright Futures
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