

State of Vermont
Agency of Human Services

Global Commitment to Health
11-W-00194/1

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

Quarterly Report for the period
October 1, 2011 – December 31, 2011

February 29, 2012

Background and Introduction

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

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

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

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

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

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

One of the Terms and Conditions of the Global Commitment Waiver requires the State "to submit progress reports 60 days following the end of each quarter. ***This is the fourth quarterly report for waiver year seven, covering the period from October 1, 2011 through December 31, 2011.***

Enrollment Information and Counts

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

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

Enrollment counts are person counts, not member months.

Demonstration Population	Current Enrollees Last Day of Qtr 12/31/2011	Previously Reported Enrollees Last Day of Qtr 9/30/2011	Variance 06/30/11 to 09/30/11
Demonstration Population 1:	47,219	46,711	1.09%
Demonstration Population 2:	43,578	43,586	-0.02%
Demonstration Population 3:	9,502	9,770	-2.74%
Demonstration Population 4:	N/A	N/A	N/A
Demonstration Population 5:	1082	1071	1.03%
Demonstration Population 6:	3,258	3,244	0.43%
Demonstration Population 7:	34,941	35,407	-1.32%
Demonstration Population 8:	10,120	7,853	28.87%
Demonstration Population 9:	2,632	2,525	4.24%
Demonstration Population 10:	N/A	N/A	N/A
Demonstration Population 11:	11,200	11,132	0.61%

This new fiscal quarter data reflects an update in methodology. Variances, particularly in Demonstration Populations 8 and 9, reflect this methodology update. All populations are primarily identified by aid category code, which is the most accurate and up to date reflection of the Medicare and FPL status.

Green Mountain Care Outreach / Innovative Activities

As the State of Vermont works towards the creation of a health benefits exchange and its ultimate goal of a single-payer system, we are simultaneously determining what our outreach strategies will be going forward in an evolving marketplace. During the first quarter we have not initiated new outreach strategies, but have maintain an up-to-date web presence and assisted individuals to access coverage under Green Mountain Care. We partnered with the Vermont Department of Labor at two lay offs to assist 35 people to access Green Mountain Care. The DVHA fleshed out concepts for an inter-department web portal for all health-related agencies and inquiries from the public. We also established a communications work group across agencies to determine what our unified message and outreach strategies will be.

In efforts to inform the general public about these changes, the DVHA created a public outreach event on health care reform by working with both the Lake Champlain Regional Chamber of Commerce and

the Vermont Association of Human Resource Association, two of the largest business associations in the state. The State's Director of Health Care Reform presented to over 220 members from the business community, which in turn gave input into the creation of the future Health Insurance Exchange.

Enrollment and legislative action:

As of the end of December there were 12,070 individuals enrolled in the premium assistance program components of Green Mountain Care (Catamount Health and Employer-Sponsored Insurance).

As required by the Vermont Appropriations Act of State Fiscal Year 2011, Vermont requested an appropriation in the State Fiscal Year 2012 Budget Proposal to implement a palliative care program that would allow Medicaid children with life-limiting illnesses to receive concurrent curative and palliative care. The legislature approved the request for one position and funds to implement this program. The Agency of Human Services submitted a waiver amendment request to CMS in April 2010, and the request was approved in December. DVHA has hired a palliative care nurse case manager to develop and implement the program. Act 48, a bill that authorizes Vermont's Health Benefits Exchange under the Affordable Care Act was passed by the legislature and signed into law by the Governor in May 2010. DVHA has completed its first year of planning for the Exchange, and details of its work during this past year can be found on the Exchange web page at:

<http://dvha.vermont.gov/administration/health-benefits-exchange>. DVHA's application for a Level 1 Establishment grant for FFY 12 was approved at the end of November. DVHA issued an RFP for the second year of Exchange planning and development, and is currently negotiating contracts with vendors.

Vermont's Center for Disease Control and Prevention (CDC) Grant Award/ Oral Health Coalition Convened

The Vermont Department of Health (VDH)/Office of Oral Health was awarded a CDC state-based oral disease and prevention program three year grant (9/30/10 – 9/30/13). The grant provides Vermont the opportunity to focus on and participate in the process regarding: 1) oral health infrastructure, development and sustainability, 2) updating the State Oral Health Plan, 3) Community Water Fluoridation efforts, and 4) access to and utilization of preventive interventions such as school-linked sealant programs.

This grant funding also allowed for the formation of a broad-based Vermont Oral Health Coalition in early 2011, facilitated through the VDH, Office of Oral Health. Vermont recognizes that good oral health is a shared responsibility of individuals and families, the private sector, and federal, state, and local government. As a small state, the potential for collaboration among many organizations is great; the Vermont Oral Health Coalition will serve as an opportunity to work together to reexamine current strategies, and conceptualize new ideas about improving the oral health and general health of Vermonters.

The Dental Dozen

Many Vermonters face challenges in receiving appropriate oral health care due to the limited number of practicing professionals, the affordability of services and a lack of emphasis on the importance of oral health care. Challenges frequently are more acute for low-income Vermonters, including those Vermonters participating in the State's public health care programs. The Dental Dozen recognizes oral health as a fundamental component of overall health and moves toward creating parity between oral health and other health care services.

In 2007/8, the DVHA, in conjunction with the Vermont Department of Health (VDH), implemented 12 targeted initiatives listed below to provide a comprehensive, balanced approach to improve oral health and oral health access for all Vermonters. The DVHA continues to monitor several of these initiatives, including, physician claims for oral health risk assessments, assignments of dental homes for children, and reported missed appointments/late cancellations. Updates as of December 31, 2011 are summarized below:

Initiative #1: Ensure Oral Health Exams for School-age Children - VDH, DVHA and the Department of Education (DOE) collaborated to reinforce the importance of oral health exams and encourage preventive care. Brochures were provided to schools for distribution in October, 2008 to educate parents and children on the importance of fluoride, sealants and regular checkups.

Initiative #2: Increase Dental Reimbursement Rates - DVHA committed to increase Medicaid reimbursement rates over a three-year period to stabilize the current provider network, encourage new dentists to enroll as Medicaid providers and encourage enrolled dentists to see more Medicaid beneficiaries. Rates were increased by \$637,862 in SFY 2008 and by \$1,412,441 for SFY 2009. Rates were not increased for SFY 2010 due to budgetary constraints; however, dentists were held harmless from a 2% provider rate reduction experienced by many other Medicaid providers.

Initiative #3: Reimburse Primary Care Physicians for Oral Health Risk Assessments - In February, 2008, DVHA began reimbursing Primary Care Providers (PCPs) for performing Oral Health Risk Assessments (OHRAs) to promote preventive care and increase access for children from ages 0-3. An action plan was developed to educate/train physicians on performing OHRAs, including online web links. From February '08 – June '11, there were 4021 OHRAs claimed and approximately 3 of every 10 OHRAs claimed was from a physician.

Initiative #4: Place Dental Hygienists in Each of the 12 District Health Offices – Dental hygienists in district offices can be a valuable resource in providing fluoride varnish treatments, dental health education, early risk assessment and helping to connect children with a dental home. A successful pilot project resulted in the start of placement of 3 part-time dental hygienists in District Health Offices. This effort was scaled back due to budget constraints; current funding now covers one half-time dental hygienist in the Newport, Vermont district office. If resources improve and funding is allocated, this program remains well planned/tested and would be ready to expand.

Initiative #5: Selection/Assignment of a Dental Home for Children – Starting in May, 2008, DVHA introduced the capability to select/assign a primary dentist for a child, allowing for the same continuity of care as assigning a Primary Care Physician (PCP) for health improvement. Most new enrollees now select a dental home, emphasizing the importance of keeping oral health care on par with regular physicals and health checkups. If enrollees do not select a dental home, member services will assign one whenever possible, unless an enrollee formally declines this option. Through December, 2011, 77,150 eligible children (ages 0-17) have been identified since the program began in early 2008; of these, 72% voluntarily selected a dental home, approximately 14% were assigned dental homes by member services, and approximately 14% of enrollees declined.

Initiative #6: Enhance Outreach - DVHA and VDH conducted outreach and awareness activities to support understanding of the Dental Dozen and help ensure the success of the initiatives. In SFY 2009, work continued to promote benefits available to dental providers, highlight incentives designed to bring and keep more dentists in Vermont and continue outreach with schools, parents and children. Also, a retired Vermont dentist, with grant assistance, is helping recruit and retain more dentists.

Initiative #7: Codes for Missed Appointments/Late Cancellations – In 2008, DVHA introduced a code to report missed appointments and late cancellations. The negative impact of missed appointments and late cancellations is three-fold: 1) the originally scheduled beneficiary does not receive care, 2) that appointment could have gone to another beneficiary, and 3) dental office productivity and income is reduced. The DVHA is collecting/evaluating this data with the intent of exploring processes to reduce missed appointments and late cancellations in the future.

Initiative #8: Automation of the Medicaid Cap Information for Adult Benefits - DVHA introduced a system upgrade to allow enrolled dentists to access Medicaid cap information for adult benefits automatically. This system has proven to be a convenient and well-received tool for providers. Currently, the annual cap for adult benefits is set at \$495 and DVHA tracks provider use of this upgrade.

Initiative #9: Loan Repayment Program – In SFY 2008, Vermont awarded \$195,000 in loan repayment incentives to dentists in return for a commitment to practice in Vermont and serve low income populations; thirteen awards ranged from \$5,000 to \$20,000. Funding remained at \$195,000 for SFY 2009. Funding was set at \$125,000 for both SFY 2010 and 2011. Fifteen awards were distributed in SFY 2010 and 14 awards were allocated for SFY 2011. No awards exceed \$20,000. Follow-on awards will be allocated in February, 2012.

Initiative #10: Scholarships - Scholarships, administered through the Vermont Student Assistance Corporation, are awarded to encourage new dentists to practice in Vermont. A combined allocation of \$40,000 for SFY 2008/09 was distributed for the 2008-2009 academic year. There was \$20,000 available for 2010 and another \$20,000 for 2011.

Initiative #11: Access Grants - In SFY 2008, VDH awarded a total of \$70,000 as an incentive for dentists to expand access to Medicaid beneficiaries. In order to receive a grant, dentists must meet specific goals for increased access. In SFY 2008, seven grants ranged from \$5,000 to \$20,000. Funding remained at \$70,000 for SFY 2009 and for SFY 2010. Follow-on funding will be targeted to ensure adequate recruitment measures are in place to ensure and enhance access.

Initiative #12: Supplemental Payment Program – In SFY 2008, DVHA began distributing \$292,836 annually to recognize and reward dentists serving high volumes of Medicaid beneficiaries. For SFY 2009, a distribution of \$146,418 was made in October, 2008 and another distribution of \$146,418 was made in the spring of 2009, for an annual total of \$292,836. The program has continued on the same cycle and dollar amount for SFY 2010/11/12. Typically, 35-40 dentists qualify for semi-annual payouts.

Expenditure Containment Initiatives

Vermont Chronic Care Initiative for Quarter 1 of FFY 2012

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

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

The VCCI supports and aligns with other State health care reform efforts. VCCI has now expanded its services to all age groups and prioritize their outreach activities to target beneficiaries with the greatest need based on urgency and ability to impact their behavior. VCCI will continue to partner with providers, hospitals, community agencies and other Agency of Human Services (AHS) departments to support a patient-focused model of care committed to enhanced self-management skills, healthcare systems improvement, and efficient coordination of services in a climate of increasingly complex health care needs and scarce resources.

In July 2010, DVHA also expanded its direct care coordination capacity in two areas of the state through the Challenges for Change initiative. The two trial areas were selected based on, among other factors, high disease prevalence and high health system utilization. The initiative adds three additional DVHA care coordination staff (two RNs and 1 Licensed Clinical Social Worker) in each of the two areas (Rutland and Franklin Counties). The staffs are co-located within doctors' offices and local hospitals, and are integrated with existing VCCI care coordination staff and lead the way for the Blueprint for Health Community Health Teams which now integrate with the VCCI efforts in these communities. In Franklin County, our VCCI team was named the 'Community Partner of the Year' at the annual meeting of Northwestern Counseling and Support Services (NCSS) a core partner serving individuals with mental health conditions, DVHA has also expanded its care coordination services which will include children's palliative care.

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

HRSA designates Health Professional Shortage Areas (HPSAs), which are designated based on requests that states and others submit that demonstrate these areas meet the criteria for having too few health professionals to meet the needs of the population. Franklin County is recognized as a HPSA.

The National Health Service Corps (NHSC) is a network of primary medical, dental and behavioral health care professionals and sites that serve the most medically underserved regions of the country. To support their service, NHSC clinicians receive financial support in the form of loan repayment and scholarships, as well as educational training and networking opportunities. As a result, VCCI was able to hire a Licensed Clinical Social Worker to our workforce in Franklin County who is a participant of NHSC. This type of support is and will be instrumental in our VCCI recruiting efforts in some rural areas.

APS Contract

Since 2007, DVHA has contracted with APS Healthcare for assistance with providing disease management assessment and intervention services to Vermont Medicaid beneficiaries with chronic health conditions. DVHA currently is in the fourth year of its contract with APS and with the newest amendment has made a decision to move away from traditional disease management and instead is expanding its care coordination services provided by DVHA nurse case managers and social workers. DVHA has found this approach more effective with its highest cost/highest risk beneficiaries. As DVHA expands this approach, it requires a different kind of support than covered in the existing contract with APS. APS presented a cost neutral proposal to provide services to DVHA that are better aligned with DVHA's current needs. Specifically, APS proposed to provide an enhanced information technology and sophisticated decision-support system to assist DVHA's care coordinators target the most costly and complex beneficiaries, adjusted with new information as frequently as daily. This enhanced system builds upon the case management and tracking system DVHA staff have been using since 2007. In addition, APS will provide support to DVHA's care coordinators working within provider offices as part of the Blueprint Community Health Teams. APS has guaranteed a 2:1 return on investment by implementing these enhancements, which equates to roughly \$5 million dollars and will bear 100% of the investment for system enhancements if the agreed upon savings are not realized (i.e., full risk contract based upon agreed upon savings methodology). As a result, DVHA invoked its option to extend the contract with APS for two additional years, ending June 30, 2013.

The VCCI program now features key components of a statewide technology infrastructure to improve care coordination for Vermonters with chronic illness and high utilization of health care services, and to eliminate avoidable costs of care. This infrastructure solution is based on the following: innovative technology for care management; delivery of evidence-based interventions by Care Coordinators within the Department of Vermont Health Access (DVHA); pharmacy analysis and prescriber feedback; technical assistance/training on the use of the technology and information products; and collaborative support for provider and beneficiary interventions.

The chronic care case management system used by DVHA, APS Care Connection™, will continuously identify the highest cost/highest risk (HC/HR) beneficiaries to target for care coordination interventions. The APS Percolator™, which uses evidence-based algorithms to identify and stratify the Medicaid beneficiary population and their providers for interventions, includes indicators such as:

- Admissions for Ambulatory Care Sensitive Conditions.
- Visits to multiple physicians indicating lack of engagement in a medical home.
- Polypharmacy, low medication adherence ratios, and inappropriate prescribing.
- Emergency Department visits for non-emergent reasons, using the New York University algorithms to identify these services.
- Other visits to Emergency Departments.
- Acute admissions and readmissions.

APS will provide the technical and clinical staffing to maintain Care Connection and the Percolator. APS also will provide technical assistance, training, clinical and claims data advisory support to Care Coordinators employed by DVHA, and conduct interventions with providers delivering services to high cost, high risk beneficiaries. APS will provide extensive health informatics reporting, analysis and recommendations to DVHA.

The DVHA Care Coordinators with the support of APS will receive a list and/or receive referrals of high cost, high risk beneficiaries generated by the Percolator using data from a variety of sources (e.g.,

claims, pharmacy, self report, staff interactions, program goals, etc.). This listing will identify potential highest priority cases for that day and recommend evidence-based interventions to support Care Coordinator workflow. Care Coordinators will use Care Connection to document beneficiary assessments, interventions, and other aspects of the plan of care for each beneficiary.

The care connection™ will also be enhanced by generating Patient Health Briefs for both the APS Clinical Practice Specialists and Care Coordinators to identify urgent concerns with care and both will also utilize *Patient Registries* to identify patients with chronic disease and gaps in care. These tools are in early stages of development and a work in progress. We have also utilized the patient registries for both diabetes and asthma and are now targeting heart failure. VCCI will consult with the Clinical Pharmacist and they will also identify gaps in medication adherence and issues with poly-pharmacy, as well as promote best prescribing practices.

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

Highlights of the Vermont Chronic Care Initiative (Quarter 1 of FFY 2012)

- All analysis from UVM's VCCI evaluation has been completed on the clinical performance improvement project (PIP) on Heart Failure. The PIP will be implemented during the 1st quarter of FFY 2011. Interventions are being developed and implemented for year 2 of the PIP
- DVHA is transitioning away from traditional disease management and expanding its care coordination services provided by DVHA Nurse Case Managers and Medical Social Workers, Licensed Clinical Social Worker and Licensed Drug and Alcohol Counselor.
- DVHA has an enhanced information technology and sophisticated decision-support system through its contract with APS which targets the most costly and complex beneficiaries, adjusted with new information as frequently as daily.
- DVHA has enhanced its specialty services by adding a Licensed Clinical Social Worker and a Licensed Alcohol and Drug Counselor to the VCCI team; and has received NHSC recognition in Franklin County.
- DVHA care coordinators expanded meetings and electronic data exchange systems with hospital emergency departments (EDs) for increased collaboration regarding emergency room utilization among VCCI beneficiaries.
- DVHA care coordinators in the Challenges for Change Pilot for both Rutland and St. Albans have established high penetration in EDs and in various Primary Care Physician co-location sites in those counties.
- DVHA is expanding its VCCI scope to now include Palliative Care.

- The data indicates that from October 1, 2011 through December 31, 2011 VCCI maintained an average monthly caseload of 663 beneficiaries and 404 unique members were served. Unique members are beneficiaries who have been assigned to VCCI staff and have had a Social Needs, Behavioral Risk or Transitions of Care Assessment completed.

Buprenorphine Program

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

(Figure 1)

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

On January 1, 2010, DVHA notified all buprenorphine providers and implemented an automated payment system for the CPTOD. All claims are now submitted directly to HP Enterprise Services and processed through the MMIS, enabling the DVHA to more accurately budget and track expenditures. The billing requirements are aligned with the treatment complexity levels outlined in the Buprenorphine Provider Agreements and the Buprenorphine Practice Guidelines. The Buprenorphine Practice guidelines are reviewed and updated every two years and DVHA is in the process of revising these guidelines this quarter.

The total for the 1st quarter (October 2011- December 31, 2011) is \$44,807.80 (Figure 2).

(Figure 2)

Buprenorphine Program Payment Summary FFY 2012	
FIRST QUARTER	
Oct-11	\$14,415.76
Nov-11	\$ 15,136.66
Dec-11	\$ 15,255.38
Quarter Total	\$44,807.80

340B DRUG DISCOUNT PROGRAM

Background

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

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

Covered entities include:

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

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

340B PROGRAM IN VERMONT

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

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

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

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

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

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

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

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

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

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

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

Safeguards for Overprescribing

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

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

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

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

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

340B Reimbursement and Calculation of Incentive Payment

Determination of Dispensing Fee and Savings Sharing Amounts

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

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

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

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

Summary

Because of federal laws prohibiting "duplicate discounts" on Medicaid drug pricing related to the interaction of 340B and manufacturer rebate programs, Medicaid participation in 340B has been limited both in Vermont and nationally. Vermont has put in place an innovative, first in the nation methodology to maximize Medicaid participation in 340B pricing for Medicaid beneficiaries served by eligible prescribers at 340B enrolled covered entities. This methodology can enable substantial expansion participation in 340B. Using the Global Commitment authority, DVHA provides incentive

payments to providers for their 340B participation that recognizes the additional administrative burden of the program. Because of the beneficial 340B pricing, both Vermont and CMS benefit from higher 340B covered entity-employed prescriber and Medicaid beneficiary participation in the program. For the first half of 2011, Vermont has realized approximately \$400,000 in savings through Medicaid participation of a relatively small number of eligible covered entities. DVHA is focused on outreach and education of all Vermont covered entities to encourage enrollment in the 340B discount program.

Mental Health – Vermont Futures Planning

Vermont State Hospital – Replacement Planning

Given the abrupt closure of the Vermont State Hospital due to flooding from Tropical Storm Irene, Vermont has the unique opportunity to reduce its reliance on institutional care and further build its community based system of care for persons with mental health conditions. The Department of Mental Health, consistent with the plan advanced by Governor Peter Shumlin and available Medicaid and Medicare funding resources, has a unique opportunity to take significant steps forward in promoting a more person-centered, flexible and community based system with all the elements for a comprehensive and integrated system of care.

Access to acute, psychiatric in-patient care remains a critical part of the overall mental health system. Individuals needing inpatient mental health care should not be sitting in emergency rooms for many hours or even days awaiting a hospital admission. At this juncture, DMH believes that it can achieve the right balance of essential inpatient beds. The Vermont State Hospital was licensed for 54 beds. The night of the flood there were 52 patients at the facility, about half could have been discharged if the proper community setting was available. At any given time approximately 25-30 individuals at VSH could have been effectively served in other treatment environments.

The current DMH plan seeks to create 36 inpatient beds to serve individuals who would otherwise have been treated at VSH. This plan anticipate long term agreements with two hospitals to provide more than half of these beds: the Brattleboro Retreat (14 beds) and Rutland Regional Medical Center (6 beds). In addition, DMH plans to develop a new state managed facility of 16 beds (but designed to be expanded to 25 if needed). During this period of renovations necessary at Rutland Regional Medical Center and the Brattleboro Retreat to accommodate this population, DMH will also contract with Fletcher Allen Health Care for 7-12 beds for acute in-patient care until a new state hospital is built.

Furthermore, the Department is investigating the possibility of creating additional temporary state hospital bed capacity in a former nursing home facility in the central Vermont area. If this temporary hospital can be licensed and certified, it will take great pressure off the hospital system until the new state hospital is built. Throughout this process, the existing psychiatric inpatient service capacity provided by Fletcher-Allen Health Care, Central Vermont Medical Center, and the Windham Center will remain part of the ongoing continuum of inpatient care service options. This geographic distribution of acute inpatient services will provide individuals with in-patient options closer to home which can be very important to their recovery and discharge planning needs.

DMH is actively planning with the Rutland and Brattleboro facilities to estimate renovations costs necessary to provide higher acuity services during this period of decreased inpatient bed capacity. The Brattleboro Retreat renovations are likely to be approximately \$4 million and RRMC's renovations will likely be approximately \$6 million. Given that these renovations are coming about in direct

response to immediate service needs and the loss of VSH, DMH and the state expect that FEMA will cover the costs of these renovations. A Certificate of Need will be required for both projects with renovation commencing with CON and legislative approval. DMH is requesting an Emergency Certificate of Need to replace the state hospital, with the hospitals as co-applicants.

Long term agreements with the hospitals will include provisions for a “no-reject” system, reimbursement based on acuity and enhanced programming/staffing, and access to peer supports. One favorable element is that in these settings, care can be covered in part by Medicare, and even more so by Medicaid. This will result in a significant savings to the state general fund, even while services are expanded.

Community System Development

Services of the Vermont State Hospital that had been paid for only with state general funds can now be matched in large part with federal Medicaid and Medicare dollars when provided in alternative care settings and the community. This change results in an additional \$20 million that can be made available to support a more balanced and effective system of care in Vermont.

Vermont’s mental health care system has been working to provide evidence based and innovative practices to help people with recovery, to live independently, to work, and to fully participate in their communities. In the coming fiscal year, DMH will invest significant resources into the state’s community-based mental health services in the following ways:

Expand and Improve emergency, crisis, and residential supports - There is wide consensus that emergency services and support need to be more consistent, flexible and mobile. Services need to be able to respond to people in supportive ways, where they are, and be available 24/7 every day. Services need to integrate their work with local law enforcement, hospital emergency rooms and peer services where they exist. Alternative forms of transportation need to be available.

Also, additional residential programs and crisis bed capacity, intended to prevent or divert hospitalization when appropriate, are needed. Additional crisis beds in areas lacking such resources will be developed in the upcoming year. These support programs will be immediately available to individuals in crisis who can be successfully served in an alternative treatment setting to hospitalization. Toward ongoing support and stabilization, new residential recovery facilities in the southern and northern-central portions of Vermont are in development as well. Proposals for locations and services have been received by DMH and are in the early stages of development and Certificate of Approval review. These facilities will serve people who no longer need acute in-patient care but are not yet ready for full independent living. These program environments will assist individuals in their recovery by providing a safe and secure setting and therapeutic services aimed at returning persons served to their communities.

Flexible Outpatient Services - Develop a stronger out patient service in the DA’s, with a strong emphasis on identifying and responding to people at risk. Services must be flexible and person-centered to respond to the real needs and choices of the individuals. There must be case management to meet the needs of people who do not meet other eligibility criteria.

DMH will work closely with DVHA and the Blueprint for Health to more specifically identify high cost Medicaid beneficiaries with mental illnesses who are not currently served by other intensive programs. Likely investment areas include flexible case management services, integrated mental health and primary care services, and increasing the availability of health care services in the DA

network.

Housing Subsidies - Research has shown that stable housing is one of the most important elements in preventing crisis and in supporting recovery. Yet, persons with mental health conditions often find themselves struggling to maintain stable housing and even worse, are at high risk for homelessness. DMH proposes to use allocated funds in the upcoming fiscal year to establish housing subsidies to ensure stable housing. Housing assistance should be provided as much as possible in the “housing first” model, in which housing is provided without pre-qualification or agreements to accept certain services in order to receive assistance. However, when desired, DMH through its DA network will deploy services from minimal case management to full wrap-around plans to keep the individual successfully housed.

Peer Services - In keeping with its longstanding commitment to stakeholder inclusion in the development of new services, DMH established a peer services workgroup with a task of recommending growth and development of peer support. In the upcoming fiscal year with additional funding allocation as appropriated, DMH will continue its work with peers to implement recommendations put forward:

- Add funding to existing peer services organizations to expand their capacity and strengthen their organizations;
- Fund a state wide “warm line” run by peers to provide support and help people obtain services they need and choose;
- Develop a coordinating entity, preferably within an existing organization, to coordinate peer efforts at training, organizing, transportation alternatives and other activities; and
- Add funding for new peer services

Alyssum, Vermont’s first peer-run crisis alternative program, has been in operation during this past quarter, is the most recent addition to the state’s continuum of mental health service options.

Through its participation in its five-year SAMHSA-funded *Mental Health Transformation Grants*, Vermont is moving forward in the development of a new credentialed peer workforce that will provide outreach and support services for young adults (ages 18-34) with or at risk of serious mental illness. Although this grant experienced a 55% reduction in federal funding in this last quarter, pilot sites established will remain operational and serving many individuals who choose not to access professional mental health services. This work continues to occur in tandem with the development of new and alternative services in the community.

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 began working with its existing actuarial consultant, Aon, in April 2011, to develop actuarially sound capitation rate ranges for the FFY12 period, and delivered the selected FFY12 rates to CMS on August 23, 2011 (one week prior to the required September 1 due date). AHS began utilizing the

FFY12 rates in calculating the monthly PMPM payments on October 1, 2012. AHS posted an actuarial consultant RFP in July, 2011, in accordance with State contracting guidelines that required this contract to be rebid. The existing agreement with Aon is set to expire on March 31, 2012. AHS has selected Milliman, Inc. as its new actuarial services vendor for the FFY13 and FFY14 periods, effective April 1, 2012 and the parties are currently negotiating contract terms. Milliman previously had a successful relationship with AHS, having provided the actuarially certified PMPM rate ranges for Global Commitment for the FFY06, FFY07, and FFY08 periods.

Member Month Reporting

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

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

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

Demonstration Population (DP)	Month 1	Month 2	Month 3	Total for Quarter Ending 1st Qtr FFY '12	Total for Quarter Ending 4th Qtr FFY '11	Total for Quarter Ending 3rd Qtr FFY '11	Total for Quarter Ending 2nd Qtr FFY '11	Total for Quarter Ending 1st Qtr FFY '11	Total for Quarter Ending 4th Qtr FFY '10	Total for Quarter Ending 3rd Qtr FFY '10	Total for Quarter Ending 2nd Qtr FFY '10	Total for Quarter Ending 1st Qtr FFY '10	Total for Quarter Ending 4th Qtr FFY '09	Total for Quarter Ending 3rd Qtr FFY '09	Total for Quarter Ending 1st Qtr FFY '09	Total for Quarter Ending 4th Qtr FFY '08	Total for Quarter Ending 3rd Qtr FFY '08	Total for Quarter Ending 2nd Qtr FFY '08	Total for Quarter Ending 1st Qtr FFY '08
	10/31/2011	11/30/2011	12/30/2011																
DP 1:	46,948	47,133	47,219	141,300	139,591	138,493	137,968	136,144	134,256	132,168	131,930	131,513	129,656	128,203	125,825	123,997	122,281	121,926	120,113
DP 2:	44,463	44,054	43,578	132,095	130,715	130,868	131,340	131,167	131,402	131,865	130,746	129,075	128,698	128,590	122,210	121,981	123,283	122,118	120,309
DP 3:	9,902	9,650	9,502	29,054	29,396	29,431	29,787	29,874	30,068	30,244	29,567	29,352	29,428	28,628	26,555	26,452	25,723	24,676	24,821
DP 4:	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
DP 5:	1,120	1,123	1,082	3,325	3,246	3,310	3,237	3,423	3,444	3,701	3,614	3,546	3,410	3,568	3,832	3,850	3,767	3,542	3,767
DP 6:	3,112	3,334	3,258	9,704	9,888	9,795	9,769	9,226	9,073	8,972	8,495	8,218	8,088	7,480	8,208	7,428	7,357	6,208	6,084
DP 7:	35,677	35,215	34,941	105,833	105,932	108,184	107,915	105,131	103,915	103,194	98,576	92,217	89,158	87,116	75,277	74,301	73,966	72,336	65,803
DP 8:	10,004	10,050	10,120	30,174	23,287	24,639	23,499	23,180	23,155	22,707	22,462	22,254	21,905	23,165	22,032	21,715	23,100	22,697	22,445
DP 9:	2,621	2,622	2,632	7,875	7,512	7,634	7,722	7,887	7,848	7,914	7,770	7,673	7,634	7,665	7,649	7,626	7,838	7,919	7,929
DP 10:	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
DP 11:	11,083	11,181	11,200	33,464	33,207	32,732	31,046	31,397	30,986	31,445	29,728	28,278	26,444	24,717	19,465	16,136	12,525	7,997	1,641

This new fiscal quarter data reflects an update in methodology.

Variations, particularly in Demonstration Populations 8 and 9, reflect this methodology update. All populations are primarily identified by aid category code, which is the most accurate and up to date reflection of the Medicare and FPL status.

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

Consumer Issues

The AHS and DVHA have several mechanisms whereby consumer issues are tracked and summarized. The first is through the Managed Care Entity, Health Access Member Services. This is a contracted function for providing information on health care programs, assisting with the eligibility process, and helping beneficiaries to understand the benefits and responsibilities of their particular programs. The complaints received by Member Services are based on anecdotal weekly reports that the contractor provides to DVHA (see Attachment 3). Member services works to resolve the issues raised by beneficiaries, and their data helps DVHA look for any significant trends. The weekly reports are seen by several management staff at DVHA and staff asks for further information on complaints that may appear to need follow-up to ensure that the issue is addressed. When a caller is dissatisfied with the resolution that Member Services offers, the member services representative explains the option of filing a grievance and assists the caller with that process. It is noteworthy that Member Services receives an average approximately 25,000 calls a month. We believe that the low volume of complaints and grievances is an indicator that our system is working well.

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

The third mechanism to track consumer issues is the report for the Office of Health Care Ombudsman (HCO) is a comprehensive report of all contacts with beneficiaries (see Attachment 4). These include inquiries, requests for information, and requests for assistance. HCO's role is to assist individuals to navigate health care insurance systems, and help to resolve eligibility and coverage problems. The data is not broken down into requests for assistance as opposed to complaints.

Quality Assurance/Monitoring Activity

External Quality Review Organization

During this quarter, the External Quality Review Organization (EQRO) reviewed the MCE's Performance Improvement Project (PIP) submission form and produced a final report. The EQRO conducted the validation consistent with the CMS protocol, *Validating Performance Improvement Projects: A Protocol for Use in Conducting Medicaid External Quality Review Activities*, final protocol, Version 1.0, May 1, 2002. The validation covered steps I – VII (i.e., review of the selected study topic, study questions, and study indicators, identification of the study population, and data collection procedures, and analyze and interpret study results). The validation results indicated an overall score of 100 percent across all evaluation elements and a finding of high confidence in the results of the PIP for steps I-VII. Also during this quarter, the EQRO produced a final report detailing the findings of their Performance Measure Validation activities. During this year's review, the EQRO validated a set of 9 performance measures calculated by the MCO. The EQRO conducted the validation activities as outlined in the CMS publication, *Validating Performance Measures: A Protocol for Use in Conducting External Quality Review Activities*, final protocol, Version 1.0, May 1, 2002. The performance measures were reported and validated for the measurement period of January 1, 2010, and ended December 31, 2010. All performance measures were calculated using HEDIS specifications for the corresponding year. All 9 measures were assigned a validation finding of fully compliant with AHS specifications. Also during this quarter, the EQRO produced a final report detailing the findings of their review of compliance with managed care regulations activities. The EQRO conducted a review of MCE compliance with federal Medicaid managed care Structure and Operations regulations and their associated AHS IGA/contract requirements. The EQRO followed the guidelines in the February 11, 2003, CMS protocol, *Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs): A Protocol for Determining Compliance With Medicaid Managed Care Proposed Regulations* at 42 CFR Parts 400, 430, et al, for the pre-on-site and on-site review activities. DVHA obtained a total percentage of compliance score of 90 percent across the 89 requirements. Finally, the EQRO produced a final Technical Report that combines the results of all three external quality review activities and identifies strengths and challenges associated with the three activities as well as making recommendations to improve the timeliness, access, and quality of services provided by the MCO.

Quality Assurance Performance Improvement Committee (QAPI)

During this quarter, the Quality Assurance and Performance Improvement Committee held two meetings and continued ongoing communication between meetings. The Committee reviewed the compliance activities of the MCE in six areas: practice guidelines, utilization management, provider selection, coordination & continuity of care, authorization of services and grievances & appeals. The MCE has adopted practice guidelines for the management of diabetes and prescribing of buprenorphine. The Committee reviewed the MCE Operating Procedures for adopting and managing practice guidelines. No recommendations for changes were made. The QAPI Committee chair also met with the AHS Quality Improvement Manager to discuss the aforementioned activities. The draft *Utilization Management Program Description* was reviewed and edited by the Committee. This document was submitted to the AHS Quality Improvement for review. Once the document is finalized the Committee will work with the DVHA Quality Committee on developing the utilization management work plan. To ensure compliance with the requirement for provider selection, the Committee reviewed the MCE's operating principles and procedures for enrolling and auditing of providers. Sample audits were provided to the Committee. To ensure compliance with the requirements for coordination & continuity of care, authorization of services and grievances & appeals, the Committee reviewed the results of the MCE Toolkit for Monitoring Delegated Administrative Activities (Toolkit). The Toolkit was developed by the MCE and approved by the Committee as a mechanism to monitor compliance of MCE delegated activities to the IGA partners. Monitoring occurs on a regular schedule and the results are reviewed by the Committee and then reported to the AHS Quality Manager. Should areas of improvement be identified by the Committee, a recommendation for a corrective action plan will be made to the AHS Quality Manager. During this quarter, no recommendations were made to the AHS Quality Manager for corrective action plans.

Also during this quarter the MCE received the report of the 2010 – 2011 EQRO's audit of the Managed Care Regulations. The MCE presented the Corrective Action Plan to the Committee. Members from the DVHA policy unit presented the plan for improving the grievance and appeal procedures which will include a more formalized auditing of the IGA partners. The Committee approved the plan. At the end of this quarter the Committee began the process of updating the MCE Quality Plan and developing a Quality Work Plan. The Committee continues to report on its activities to the AHS Quality Manager and provides documentation of the compliance activities.

Quality Strategy

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

Demonstration Evaluation

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

Reported Purposes for Capitated Revenue Expenditures

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

- Reduce the rate of uninsured and/or underinsured in Vermont;

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

Please see Attachment 6 for a summary of Managed Care Entity Investments, with applicable category identified, for State fiscal year 2011.

Enclosures/Attachments

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

Attachment 1: Catamount Health Enrollment Report

Attachment 2: Budget Neutrality Workbook

Attachment 3: Complaints Received by Health Access Member Services

Attachment 4: Medicaid Managed Care Entity Grievance and Appeal Reports

Attachment 5: Office of VT Health Access Ombudsman Report

Attachment 6: DVHA Managed Care Entity Investment Summary

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Date Submitted to CMS: February 29, 2012

ATTACHMENTS



Department of Vermont Health Access
 SFY 12 Catamount Health Actual Revenue and Expense Tracking
 Tuesday, January 17, 2012

	SFY '12 Appropriation			Consensus Estimates for SFY to Date			Actuals thru 12/31/11			
	<=200%	>200%	Total	<=200%	>200%	Total	<=200%	>200%	Total	% of SFY to-Date
TOTAL PROGRAM EXPENDITURES										
Catamount Health	37,583,124	14,894,418	52,477,542	17,935,695	7,108,602	25,044,298	17,082,504	8,512,043	25,594,547	102.20%
Catamount Eligible Employer-Sponsored Insurance	1,549,861	1,093,183	2,643,044	765,526	539,958	1,305,483	548,387	252,277	800,664	61.33%
Subtotal Program Spending	39,132,985	15,987,601	55,120,586	18,701,221	7,648,560	26,349,781	17,630,891	8,764,320	26,395,211	100.17%
DVHA Administration	1,296,449	530,244	1,826,693	648,225	265,122	913,347	648,225	265,122	913,347	100.00%
DCF Administration	874,743	357,767	1,232,510	437,371	178,884	616,255	437,371	178,884	616,255	100.00%
Subtotal Administration Spending	2,171,192	888,011	3,059,203	1,085,596	444,006	1,529,602	1,085,596	444,006	1,529,602	100.00%
TOTAL GROSS PROGRAM SPENDING	41,304,177	16,875,612	58,179,789	19,786,817	8,092,566	27,879,383	21,600,967	10,632,497	32,233,464	115.62%
TOTAL STATE PROGRAM SPENDING	17,406,765	7,111,866	24,518,631	8,285,532	3,388,682	11,674,214	7,833,058	3,817,920	11,650,978	99.80%
TOTAL OTHER EXPENDITURES										
Immunizations Program	2,500,000	-	2,500,000	1,250,000	-	1,250,000	1,250,000	-	1,250,000	100.00%
VT Dept. of Labor	-	401,993	401,993	-	200,997	200,997	-	200,997	200,997	100.00%
Marketing and Outreach	500,000	-	500,000	250,000	-	250,000	250,000	-	250,000	100.00%
Blueprint	1,846,713	-	1,846,713	923,357	-	923,357	923,357	-	923,357	100.00%
TOTAL OTHER SPENDING	4,846,713	401,993	5,248,706	2,423,357	200,997	2,624,353	2,423,357	200,997	2,624,353	100.00%
TOTAL STATE OTHER SPENDING	2,042,405	401,993	2,444,398	1,021,202	200,997	1,222,199	1,014,296	200,997	1,215,292	99.43%
TOTAL ALL STATE SPENDING	19,449,170	7,513,859	26,963,029	9,306,735	3,589,678	12,896,413	8,847,354	4,018,916	12,866,270	99.77%
TOTAL REVENUES										
Catamount Health Premiums	5,118,571	4,933,526	10,052,097	2,526,656	2,435,313	4,961,969	2,633,764	2,577,301	5,211,065	105.02%
Catamount Eligible Employer-Sponsored Insurance Premiums	356,157	441,156	797,314	175,917	215,987	391,905	167,277	135,628	302,905	77.29%
Subtotal Premiums	5,474,728	5,374,682	10,849,411	2,702,573	2,651,301	5,353,874	2,801,041	2,712,929	5,513,970	102.99%
Federal Share of Premiums	(3,167,512)	(3,109,618)	(6,277,130)	(1,571,306)	(1,541,495)	(3,112,800)	(1,628,719)	(1,582,584)	(3,211,303)	103.16%
TOTAL STATE PREMIUM SHARE	2,307,216	2,265,064	4,572,280	1,131,268	1,109,806	2,241,074	1,172,322	1,130,345	2,302,667	102.75%
Cigarette Tax & Floor Stock			10,648,500			5,324,250			6,107,545	114.71%
Employer Assessment			9,800,000			4,900,000			5,272,000	107.59%
Interest			-		-	-			1,902	0.00%
Shared Savings by > 300%			1,277,100			580,500			628,297	108.23%
TOTAL OTHER REVENUE			21,725,600			10,804,750			11,381,447	105.34%
TOTAL STATE REVENUE			26,297,880			13,045,824			13,684,114	104.89%
State-Only Balance			(665,149)			149,410			817,844	
Carryforward			-			-			-	
CATAMOUNT FUND (DEFICIT)/SURPLUS			(665,149)			149,410			817,844	
General Fund BAA to GC on Behalf of Catamount			2,612,336			1,306,168			1,306,168	100.00%
ALL FUNDS THAT SUPPORT CATAMOUNT (DEFICIT)/SURPLUS			1,947,187			1,455,578			2,124,012	

Green Mountain Care Enrollment Report
 DECEMBER 2011

TOTAL ENROLLMENT BY MONTH

	Jul-07	Nov-07	Jul-08	Dec 10	Jan 11	Feb 11	Mar 11	Apr 11	May 11	June 11	July 11	Aug 11	Sept 11	Oct 11	Nov 11	Dec 11
Adults:																
VHAP-ESIA	-	35	672	899	899	905	918	890	876	850	818	825	807	823	823	847
ESIA	-	21	336	764	783	785	801	801	804	782	782	759	755	751	720	714
CHAP	-	320	4,608	9,898	9,820	9,967	10,200	10,375	10,477	10,434	10,461	10,669	10,542	10,647	10,742	10,509
Catamount Health	-	120	697	2,498	2,545	2,718	2,810	2,622	2,852	2,386	2,921	2,964	2,960	2,992	3,061	3,072
Total	-	496	6,313	14,059	14,047	14,375	14,729	14,688	15,009	14,452	14,982	15,217	15,064	15,213	15,346	15,142
Adults:																
VHAP	23,725	24,849	26,441	36,669	37,093	37,194	37,820	37,383	36,988	37,412	36,569	35,953	36,886	36,465	36,021	36,445
Other Medicaid	69,764	69,969	70,947	39,414	40,384	40,462	40,799	40,794	40,094	39,962	39,897	39,773	40,530	38,935	40,308	40,631
Children:																
Dr. Dynasaur	19,738	19,733	19,960	21,120	21,113	21,080	21,064	21,171	20,821	20,027	20,077	20,029	20,269	20,284	20,255	20,248
SCHIP	3,097	3,428	3,396	3,539	3,499	3,657	3,605	3,622	3,612	3,721	3,789	3,790	3,843	3,924	3,960	4,052
Other Medicaid*	Included	Included	Included	38,265	38,355	38,460	38,675	38,523	37,666	38,103	37,948	37,841	38,394	37,556	37,971	38,069
Total	116,324	117,979	120,744	139,007	140,444	140,853	141,963	141,493	139,181	139,225	138,280	137,386	139,922	137,164	138,515	139,445
TOTAL ALL	116,324	118,355	127,057	153,066	154,491	155,228	156,692	156,181	154,190	153,677	153,262	152,603	154,986	152,377	153,861	154,587

KEY:

* Prior to November 2008, the numbers for Other Medicaid included both children and adults enrolled in this eligibility category

VHAP-ESIA = Eligible for VHAP and enrolled in ESI with premium assistance

ESIA = Between 150% and 300% and enrolled in ESI with premium assistance

CHAP = Between 150% and 300% and enrolled in Catamount Health with premium assistance

Catamount Health = Over 300% and enrolled in Catamount Health with no premium assistance

VHAP = Enrolled in VHAP with no ESI that is cost-effective and/or approvable

Dr. Dynasaur = Enrolled in Dr. Dynasaur

SCHIP = Enrolled in SCHIP

Totals do not include programs such as Pharmacy, Choices for Care, Medicare Buy-in

Data on the range and types of ESI plans has not been included in this report, but will be included as soon as the data is available.

Green Mountain Care Enrollment Report

December 2011 Demographics

Income	VHAP-ESIA*	ESIA*	CHAP*	TOTAL
0-50%	16	4	553	573
50-75%	31	1	93	125
75-100%	98	-	118	216
100-150%	400	16	351	767
150-185%	292	255	3995	4,542
185-200%	10	198	2384	2,592
200-225%	-	116	1447	1,563
225-250%	-	87	961	1,048
250-275%	-	32	461	493
275-300%	-	5	146	151
Total	847	714	10,509	12,070

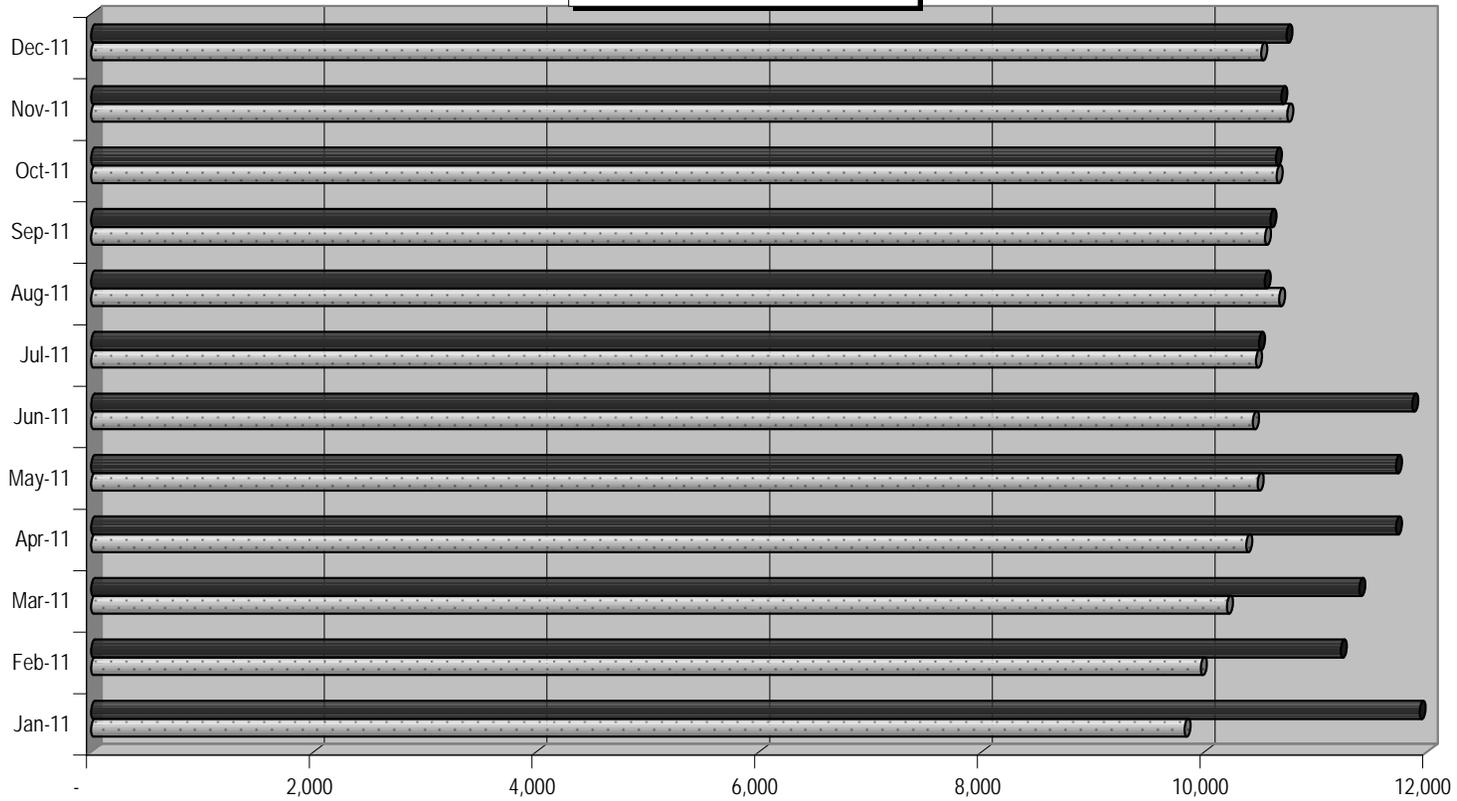
Age	VHAP-ESIA	ESIA	CHAP	TOTAL
18-24	62	64	2,062	2,188
25-35	263	175	1,974	2,412
36-45	302	229	1,642	2,173
46-55	183	183	2,406	2,772
56-64	37	63	2,424	2,524
65+	-	-	1	1
Total	847	714	10,509	12,070

Green Mountain Care Enrollment Report (continued)
December 2011 Demographics

Gender	VHAP-ESIA	ESIA	CHAP	TOTAL
Male	298	262	4557	
Female	549	452	5952	
Total	847	714	10,509	12,070

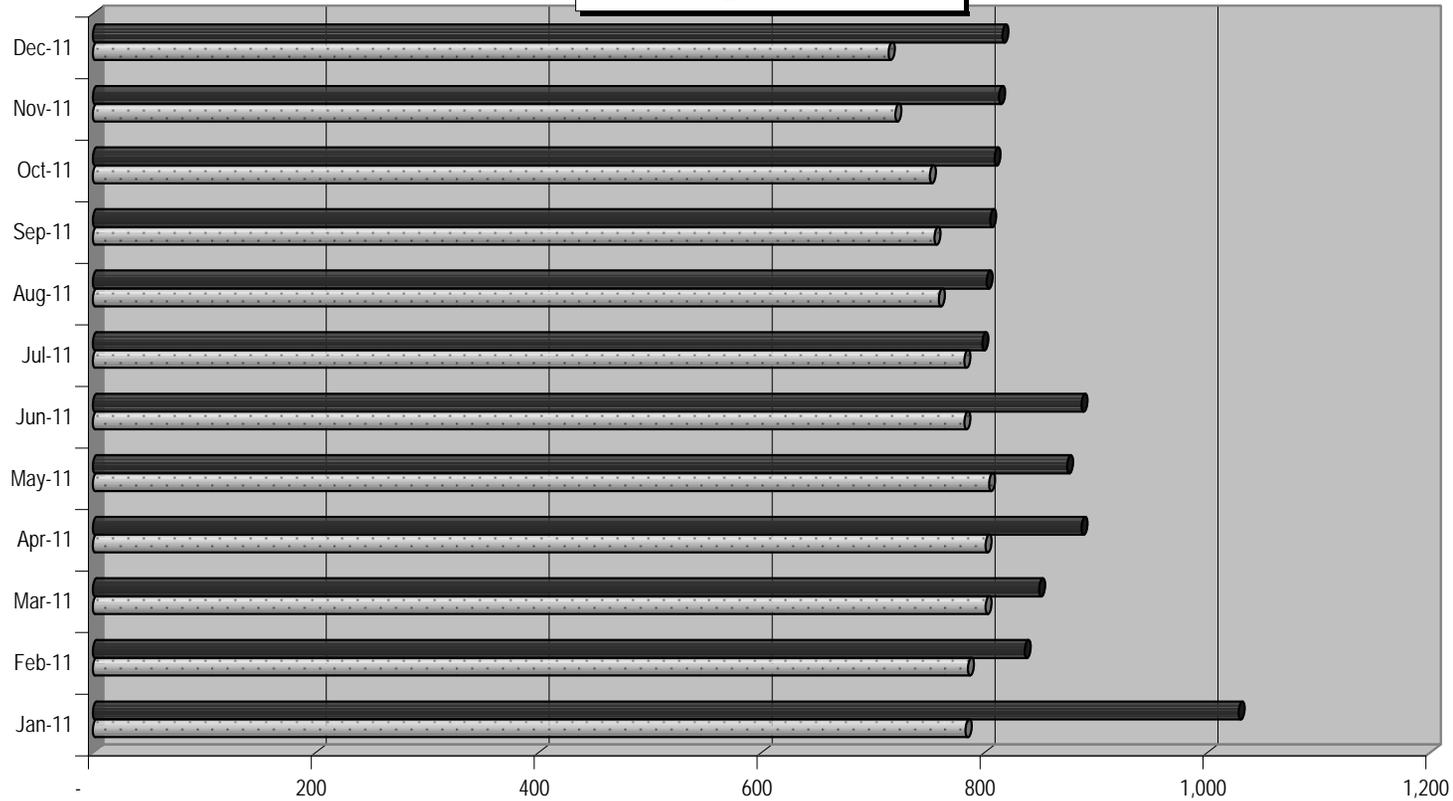
County	VHAP-ESIA	ESIA	CHAP	TOTAL
Addison	45	39	622	706
Bennington	82	65	687	834
Caledonia	22	16	687	725
Chittenden	205	174	1986	2,365
Essex	10	4	139	153
Franklin	84	48	668	800
Grand Isle	14	8	111	133
Lamoille	44	64	505	613
Orange	39	38	525	602
Orleans	52	44	617	713
Other	-	-	1	1
Rutland	95	71	1101	1,267
Washington	65	58	971	1,094
Windham	38	35	867	940
Windsor	52	50	1022	1,124
Total	847	714	10,509	12,070

Catamount Health Assistance Program
 Enrollment



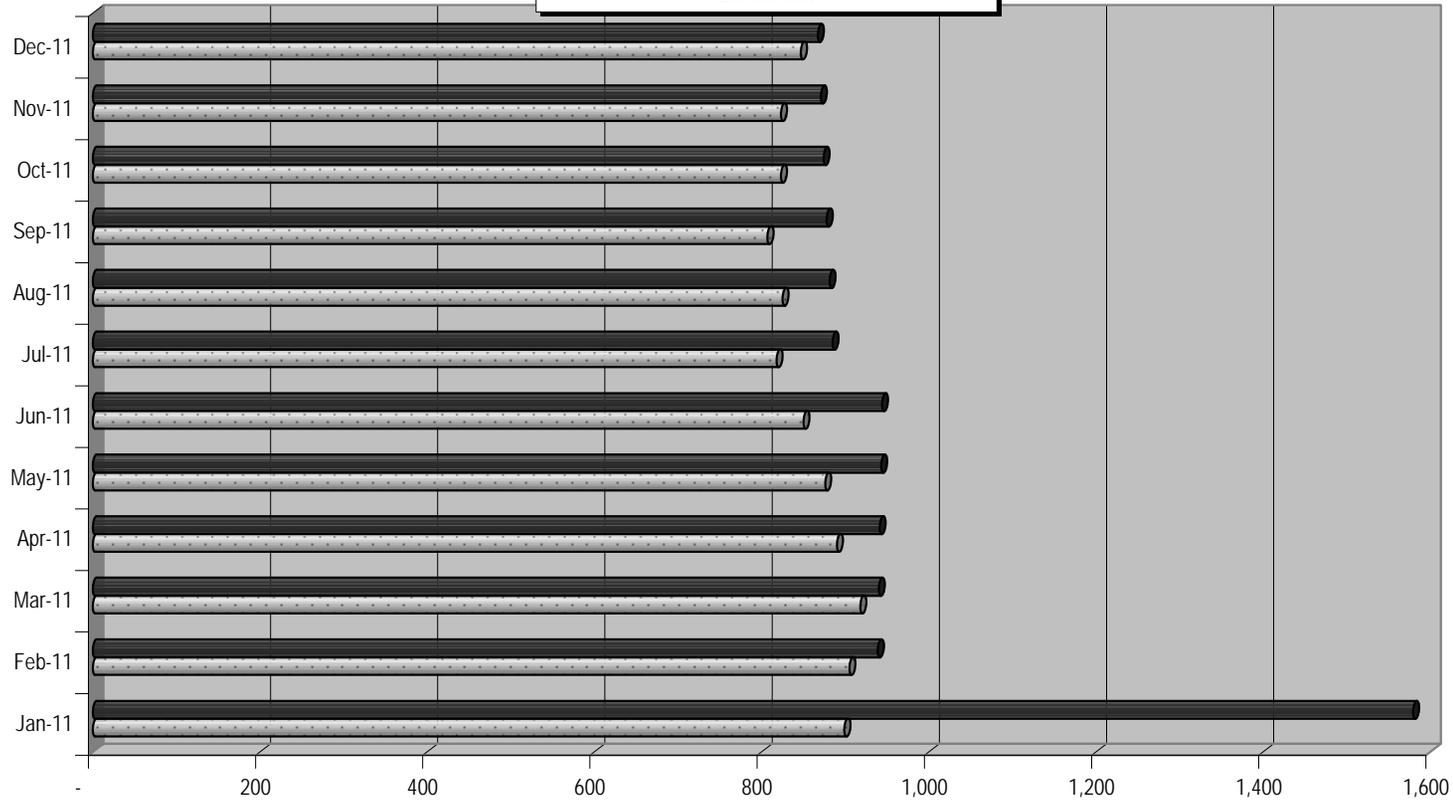
	Jan-11	Feb-11	Mar-11	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11
■ Projected	11,932	11,224	11,389	11,720	11,720	11,866	10,490	10,541	10,591	10,640	10,688	10,735
▨ Actual	9,820	9,967	10,200	10,375	10,477	10,434	10,461	10,669	10,542	10,647	10,742	10,509

Employer Sponsored Insurance Assistance Enrollment



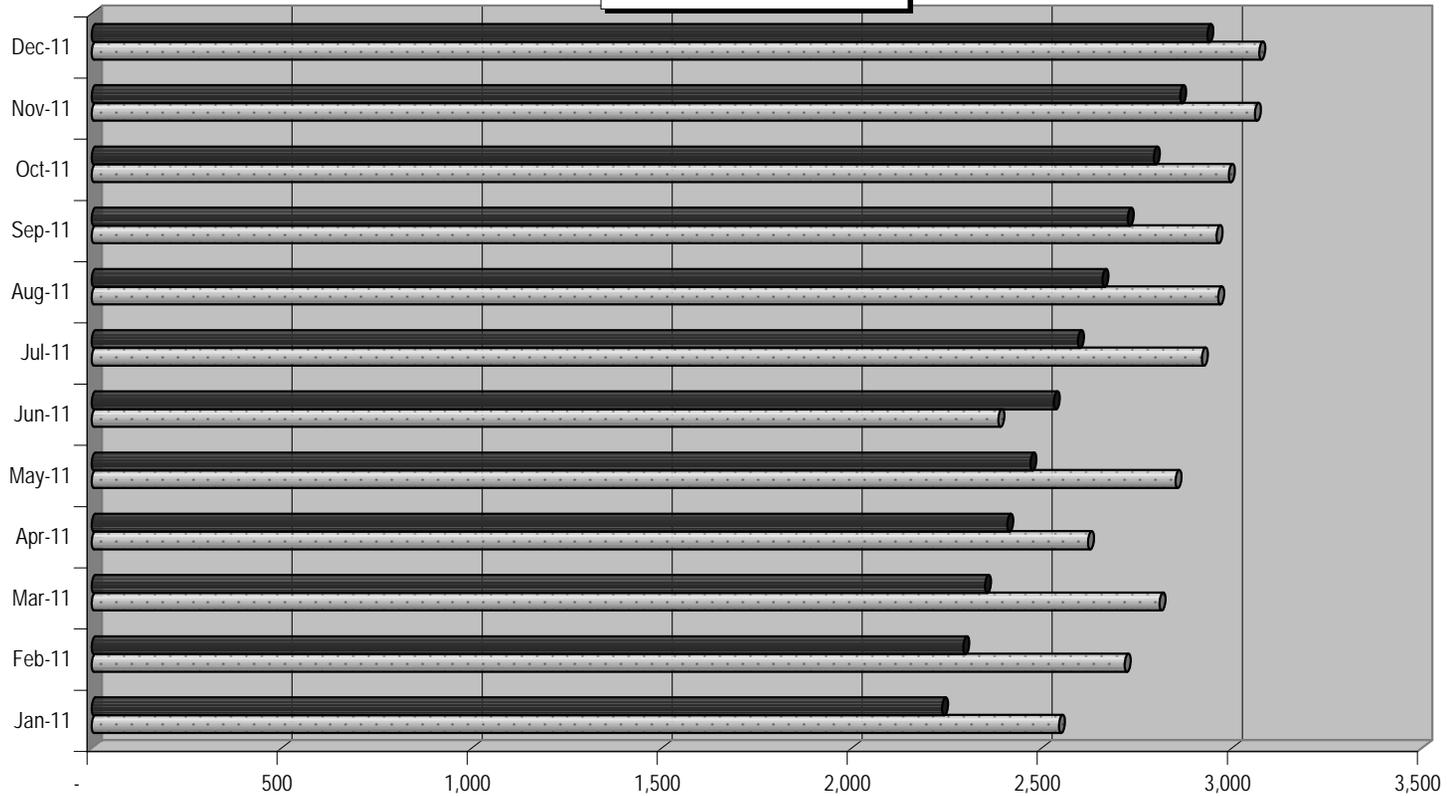
	Jan-11	Feb-11	Mar-11	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11
■ Projected	1,028	836	849	887	874	887	798	802	805	809	813	816
□ Actual	783	785	801	801	804	782	782	759	755	751	720	714

VHAP - Employer Sponsored Insurance Assistance
 Enrollment



	Jan-11	Feb-11	Mar-11	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11
■ Projected	1,579	939	940	941	943	944	885	881	878	874	871	867
□ Actual	899	905	918	890	876	850	818	825	807	823	823	847

Catamount Health - Unsubsidized Enrollment



	Jan-11	Feb-11	Mar-11	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11
■ Projected	2,238	2,293	2,351	2,410	2,470	2,532	2,595	2,660	2,726	2,794	2,864	2,936
▨ Actual	2,545	2,718	2,810	2,622	2,852	2,386	2,921	2,964	2,960	2,992	3,061	3,072

Global Commitment Expenditure Tracking

QE	Quarterly Expenditures										Net Program PQA	Net Program Expenditures as reported on 64	non-MCO Admin Expenses	Total columns J:K for Budget Neutrality calculation					
	PQA: WY1	PQA: WY2	PQA: WY3	PQA: WY4	PQA: WY5	PQA: WY6	PQA: WY7	PQA: WY8	PQA: WY9	Cumulative per 1/1/11 STCs				Waiver Cap	Variance to Cap under/(over)				
1205	\$ 178,493,793											\$ 178,493,793							
0306	\$ 189,414,365	\$ 14,472,838										\$ 14,472,838	\$ 203,887,203						
0606	\$ 209,647,618	\$ (14,172,165)										\$ (14,172,165)	\$ 195,475,453						
0906	\$ 194,437,742	\$ 133,350										\$ 133,350	\$ 194,571,092						
WY1 SUM	\$ 771,993,518	\$ 434,023										\$ 434,023	\$ 782,159,845	\$ 4,620,302	\$ 786,780,147	\$ 841,266,663	\$ 54,486,516		
1206	\$ 203,444,640	\$ 8,903										\$ 8,903	\$ 203,453,543						
0307	\$ 203,804,330	\$ 8,894,097										\$ 8,894,097	\$ 212,698,427						
0607	\$ 186,458,403	\$ 814,587	\$ (68,408)									\$ 746,179	\$ 187,204,582						
0907	\$ 225,219,267	\$ -	\$ -									\$ -	\$ 225,219,267						
WY2 SUM	\$ 818,926,640	\$ 9,717,587	\$ (68,408)									\$ 9,649,179	\$ 802,884,359	\$ 6,464,439	\$ 809,348,797	\$ 1,684,861,317	\$ 88,732,372		
Cumulative																			
1207	\$ 213,871,059	\$ -	\$ 1,010,348									\$ 1,010,348	\$ 214,881,406						
0308	\$ 162,921,830	\$ -	\$ -									\$ -	\$ 162,921,830						
0608	\$ 196,466,768	\$ 14,717	\$ -	\$ 40,276,433								\$ 40,291,150	\$ 236,757,918						
0908	\$ 228,593,470	\$ -	\$ -	\$ -								\$ -	\$ 228,593,470						
WY3 SUM	\$ 801,853,126	\$ 14,717	\$ 1,010,348	\$ 40,276,433								\$ 41,301,498	\$ 881,729,256	\$ 6,457,896	\$ 888,187,152	\$ 2,604,109,308	\$ 119,793,211		
Cumulative																			
1208	\$ 228,768,784	\$ -	\$ -									\$ -	\$ 228,768,784						
0309	\$ 225,691,930	\$ (16,984,221)	\$ 38,998,635	\$ (4,144,041)								\$ 17,870,373	\$ 243,562,303						
0609	\$ 204,169,638	\$ -	\$ 686,851	\$ 5,522,763								\$ 6,209,614	\$ 210,379,252						
0909	\$ 235,585,153	\$ -	\$ 30,199	\$ 34,064,109								\$ 34,094,308	\$ 269,679,461						
WY4 SUM	\$ 894,215,505	\$ -	\$ (16,984,221)	\$ 39,715,685	\$ 35,442,831							\$ 58,174,295	\$ 935,368,819	\$ 5,495,618	\$ 940,864,437	\$ 3,606,430,571	\$ 181,250,037		
Cumulative																			
1209	\$ 241,939,196	\$ -	\$ -	\$ 5,192,468								\$ 5,192,468	\$ 247,131,664						
0310	\$ 246,257,198	\$ -	\$ -	\$ 531,141	\$ 4,400,166							\$ 4,931,306	\$ 251,188,504						
0610	\$ 253,045,787	\$ -	\$ -	\$ 248,301	\$ 5,260,537							\$ 5,508,838	\$ 258,554,625						
0910	\$ 252,294,668	\$ (115,989)	\$ (261,426)	\$ 3,348,303								\$ 2,970,888	\$ 255,265,556						
WY5 SUM	\$ 993,536,849	\$ -	\$ -	\$ (115,989)	\$ 5,710,484	\$ 13,009,006						\$ 18,603,501	\$ 1,012,990,839	\$ 5,949,605	\$ 1,018,940,444	\$ 4,700,022,174	\$ 255,901,196		
Cumulative																			
1210	\$ 262,106,988	\$ -	\$ -	\$ 6,444,984								\$ 6,444,984	\$ 268,551,972						
0311	\$ 257,140,611	\$ -	\$ -	\$ -	\$ (121,416)							\$ -	\$ 257,140,611						
0611	\$ 277,708,043	\$ -	\$ -	\$ -	\$ 5,528,143							\$ (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	\$ 1,045,338,873	\$ 6,071,553	\$ 1,051,410,426	\$ 5,865,213,737	\$ 369,682,333		
Cumulative																			
1211	\$ 253,147,037	\$ -	\$ -	\$ -	\$ (531,744)							\$ (531,744)	\$ 252,615,293						
0312	\$ -	\$ -	\$ -	\$ -	\$ -							\$ -	\$ -						
0612	\$ -	\$ -	\$ -	\$ -	\$ -							\$ -	\$ -						
0912	\$ -	\$ -	\$ -	\$ -	\$ -							\$ -	\$ -						
WY7 SUM	\$ 253,147,037	\$ -	\$ -	\$ -	\$ (531,744)	\$ -						\$ (531,744)	\$ 253,147,037	\$ 1,348,845	\$ 254,495,882	\$ 7,113,290,903	\$ 1,363,263,617		
Cumulative																			
1212	\$ -	\$ -	\$ -	\$ -	\$ -							\$ -	\$ -						
0313	\$ -	\$ -	\$ -	\$ -	\$ -							\$ -	\$ -						
0613	\$ -	\$ -	\$ -	\$ -	\$ -							\$ -	\$ -						
0913	\$ -	\$ -	\$ -	\$ -	\$ -							\$ -	\$ -						
WY8 SUM	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Cumulative																			
1213	\$ -	\$ -	\$ -	\$ -	\$ -							\$ -	\$ -						
WY9 SUM	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Cumulative																			
	\$ 5,574,136,565	\$ 10,166,327	\$ (16,042,281)	\$ 79,876,130	\$ 41,153,315	\$ 19,453,990	\$ 4,874,983	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 5,750,027,286	\$ 8,955,886,798	\$ 3,205,859,512		



State of Vermont
Department of Vermont Health Access
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Agency of Human Services

**Complaints Received by Health Access Member Services
 October 1, 2011 – December 31, 2011**

Eligibility forms, notices, or process	18
ESD Call-center complaints (IVR, rudeness, hold times)	8
Use of social security number as identifiers	0
General premium complaints	8
Catamount Health Assistance Program premiums, process, ads, plans	20
Coverage rules	4
Member services	3
Eligibility rules	6
Eligibility local office	5
Prescription drug plan complaint	0
Copays/service limit	0
Pharmacy coverage	0
Provider issues (perceived rudeness, refusal to provide service, prices) (variety of provider types)	2
Provider enrollment issues	0
Chiropractic coverage change	0
Shortage of enrolled dentists	0
Green Mountain Care Website	0
DVHA	0
<hr/>	
Total	74





**Grievance and Appeal Quarterly Report
Medicaid MCE All Departments Combined Data
October 1, 2011 – December 31, 2011**

The MCE is composed of various administrative areas within the Agency of Human Services (AHS). These include: the Department of Vermont Health Access (DVHA), the Department for Children and Families (DCF), the Department of Mental Health (DMH), the Department of Disabilities, Aging and Independent Living (DAIL), and the Department of Health (VDH). Also included in the MCE are the Designated Agencies (DA) and Specialized Service Agencies (SSA) that provide service authorizations for DMH and DAIL. Each entity should have at least one assigned grievance and appeal coordinator who enters data into the MCE database. This report is based on data compiled on January 1, 2012 from the centralized database for grievances and appeals that were filed from October 1, 2011 through December 31, 2011.

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 6 grievances filed with the MCE; 1 was addressed during the quarter, none were withdrawn and one was filed to late. Grievances must be addressed within 90 days of filing. The grievances were addressed in an average of 30 days. Acknowledgement letters of the receipt of a grievance must be sent within five days; the average was 2 days. Of the grievances filed, 83% were filed by beneficiaries, and 17% were filed by a representative of the beneficiary. Of the 6 grievances filed, DMH had 83% and DVHA had 17%. There were no grievances filed for DAIL, DCF or VDH during this quarter.

There is one case that is pending from previous quarters.

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

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

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

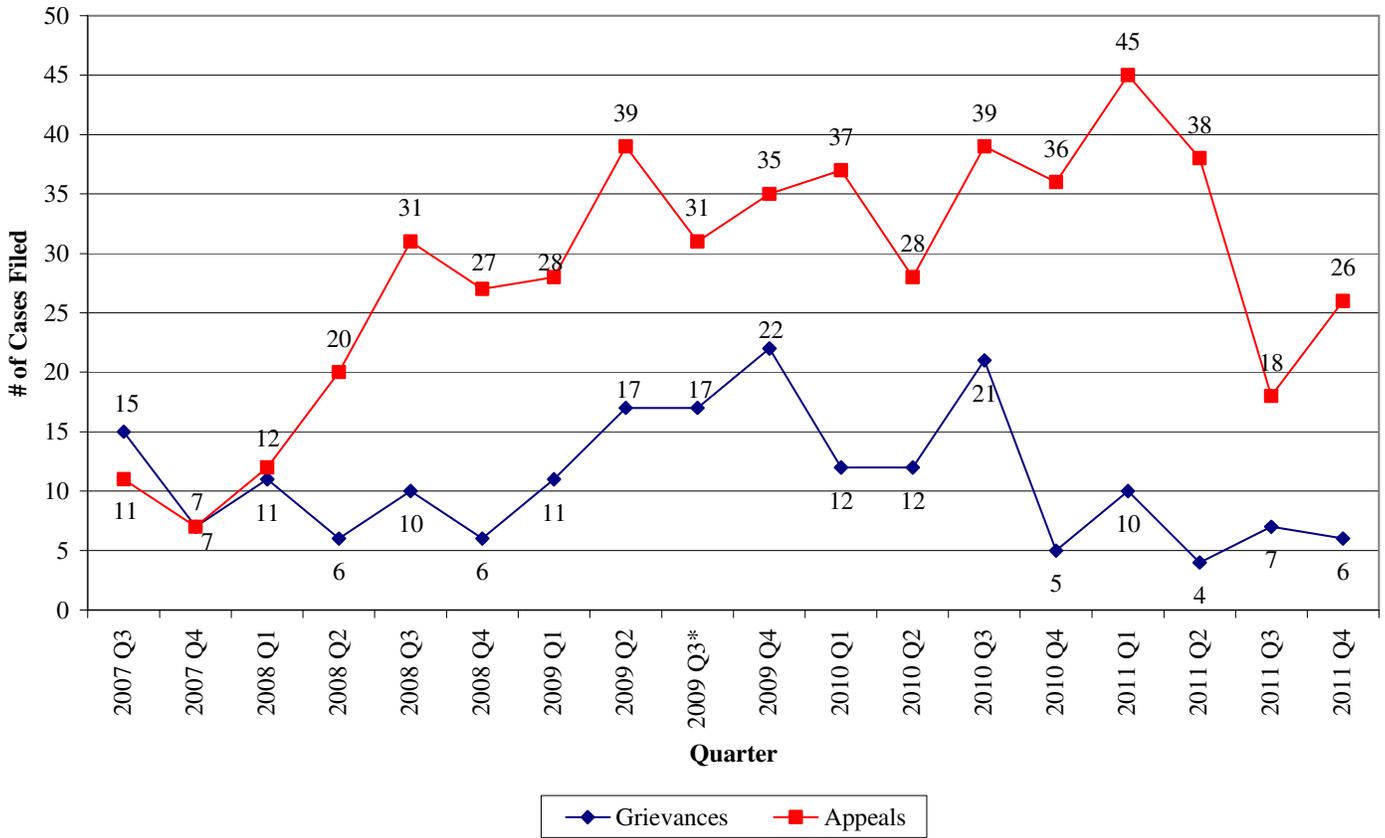
During this quarter, there were 29 appeals filed with the MCE; 3 requested an expedited decision of which 3 met the criteria. Of the other 26 appeals, 13 were resolved (50% of filed appeals), 1 was withdrawn, and 12 were still pending (49%). In 2 cases (15% of those resolved), the original decision was upheld by the person hearing the appeal, six cases (47% of those resolved) were reversed, two cases were approved with modifications and three cases (23% of those resolved) were approved by the applicable department/DA/SSA before the appeal meeting.

Of the 13 appeals that were resolved this quarter, 100% were resolved within the statutory time frame of 45 days; 71% were resolved within 30 days. The average number of days it took to resolve these cases was 18 days. 100% of appeals resolved this quarter were resolved within the maximum time frame of 59 days (the statutory time frame of 45 days plus an allowed 14 day extension). Acknowledgement letters of the receipt of an appeal must be sent within five days; the average was three days.

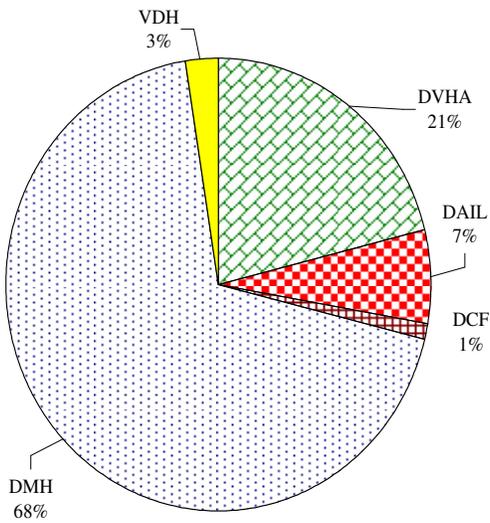
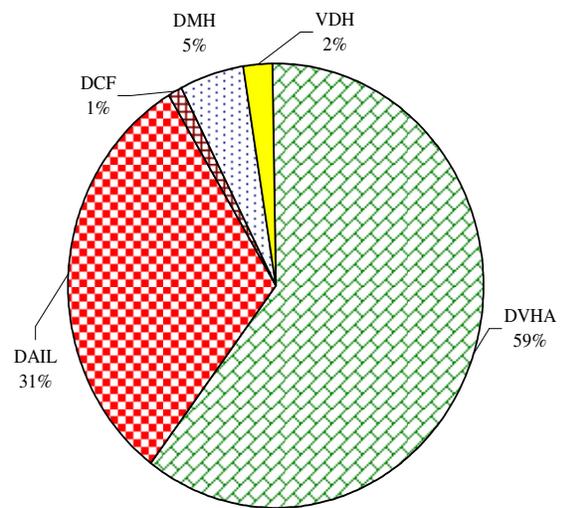
Of the 26 appeals filed, 16 were filed by beneficiaries (61%), 7 were filed by a representative of the beneficiary (27%) and three were filed by an other source (12%). Of the 26 appeals filed, DVHA had 54%, DAIL had 42%, and DMH had 4%.

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

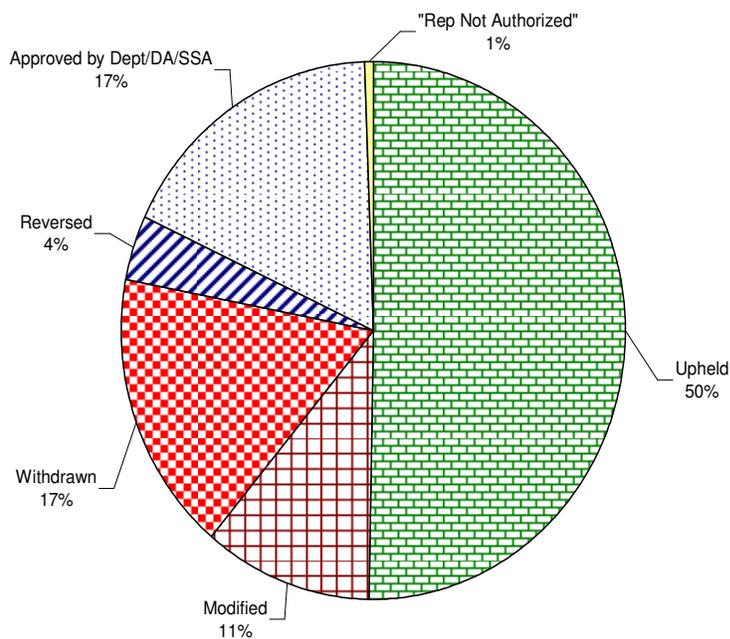
Medicaid MCE Grievances & Appeals



MCE Grievance & Appeals by Department From July 1, 2007 through December 31, 2011

Grievances

Appeals


MCE Appeal Resolutions from July 1, 2007 through December 31, 2011



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(802) 863-2316

QUARTERLY REPORT

October 1, 2011 – December 31, 2011

to the

Department of

**BANKING, INSURANCE, SECURITIES,
and HEALTH CARE ADMINISTRATION**

and the

DEPARTMENT OF VERMONT HEALTH ACCESS

submitted by

Trinka Kerr, Vermont Health Care Ombudsman

I. Overview

This is the Office of Health Care Ombudsman's (HCO) report to the Department of Banking, Insurance, Securities, and Health Care Administration (BISHCA) and the Department of Vermont Health Access (DVHA) for the quarter September 1, 2011 through December 31, 2011. This is the first joint BISHCA and DVHA report.

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

A. Total call volume decreased 13% compared to last quarter.

All Calls

The HCO received 727 calls this quarter, compared to 838 in the July to September quarter. Call volume was also significantly lower than the same quarter in 2010, when we received 889 calls. Call volume fell across all of the issue categories except Consumer Education, which increased 28%. Eligibility calls fell 20%, Access to Care fell 11%, and Billing/Coverage fell 28%. The reason for the decrease is unclear. Last quarter's increase appeared to be related to Tropical Storm Irene, so some of the decrease may be related to the state's systems falling back into place. [See the table at the end of this narrative for further detail related to call volume.]

DVHA Beneficiary Calls

We received 289 (39.75% of all calls) calls from individuals on state programs this quarter, compared to 369 (44% of all calls) last quarter. This is about a 22% decrease.

B. The top ten issues generating calls were:

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

All Calls

- Affordability (87)
- Complaints about Providers (83)
- Eligibility for Medicaid (77)
- Access to Prescription Drugs (75)
- Eligibility for VHAP (72)
- Medicare (both Consumer Education and Eligibility) (66)
- Information about applying for DVHA programs (63)
- Eligibility for Premium Assistance (44)
- Fair Hearings (42)
- Communication Problems with the Department for Children and Families (DCF) (34).

DVHA Beneficiary Calls

- Complaints about Providers (37)
- Eligibility for Medicaid (32)
- Access to Prescription Drugs (31)
- Eligibility for VHAP (29)
- Affordability (28)
- Fair Hearings (26)
- Medicare (both Consumer Education and Eligibility) (24)
- Access to Primary Care Doctors (23)
- Information about applying for DVHA programs (21)
- Not Health Related (19)¹
- Transportation (17)

C. The affordability of health care remains an issue.

In calendar year 2011 we received 323 calls, when counting both primary and secondary issues, from consumers saying they could not afford health care, often even when they had insurance. In 2010 we received 258 Affordability calls. We started tracking Affordability as an access issue at the end of 2009, so we don't have complete data for that year.

¹ Once state program beneficiaries find out about the HCO, they often call us about other problems. We refer them to other agencies. Note also that we received 14 calls about Communication Problems with DCF from DVHA beneficiaries and 2 Complaints about State Workers. The Not Health Related calls are often about other DCF programs.

This quarter we had 87 calls from consumers saying they had problems affording health care (looking at primary and secondary issues), compared to 100 last quarter.

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

- Commercially insured: 9 calls in which it was a primary issue (all 9 callers had employer sponsored insurance), 14 as a secondary;
- Medicare: 6 as a primary issue, 24 as a secondary;
- Uninsured: 4 calls as a primary issue, 22 as a secondary; and
- DVHA plans: 2 calls as a primary, 26 as a secondary.

Callers repeatedly told us that they could not afford the following:

- VHAP premiums;
- CHAP premiums;
- Cost-sharing in the Catamount Health plans;
- Medicaid and VPharm copayments for prescription drugs;
- Medicare cost-sharing;
- College insurance;
- Employer Sponsored Insurance deductibles or other cost sharing, including for prescriptions (some commercial plans require 50% coinsurance for prescriptions, for example); and
- Individual or small group plans, either because the premiums were unaffordable, or the deductibles were too high.

D. Access to pain management continues to be a problem.

The HCO continued to get a significant number of difficult calls from individuals who were having trouble getting adequate treatment for pain. We received 23 such calls (primary and secondary issue) this quarter, compared to 37 last quarter. A majority of these calls, 15, were from DVHA beneficiaries. In the previous quarter we received 36 calls.

Although the call volume decreased for pain cases this quarter, we saw a 13% annual increase in such calls. In calendar year 2010 we received 68 calls where access to pain management was the primary reason for the call. In 2011 that number increased to 78.

Due to the shortage of primary care providers, a culture of fear around prescribing pain killers, and the reluctance of many providers to take on patients suffering from chronic pain, there is usually not much we can do for these callers on an individual level.

E. Calls regarding access to substance abuse treatment increased 94% in calendar year 2011 .

We received 9 calls coded as access to substance abuse treatment as the primary issue this quarter. Of these, 4 were from DVHA beneficiaries. The previous quarter we received 12 such calls, and 7 were from DVHA beneficiaries.

However, the HCO received 46 calls in calendar year 2011 related to primary problems accessing substance abuse treatment, which reflects a **94% increase** over 2010. We received only 17 calls in 2010.

Access to substance abuse treatment, especially for opiate addiction, and specifically for methadone and buprenorphine treatment, is of increasing concern.

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

- A table showing monthly totals for All Calls at the end of this narrative, and
- Four data reports based on type of insurance coverage:
 - **All calls/all coverages:** 727 calls;
 - **DVHA beneficiaries:** 289 calls or **40%** of total calls;
 - **Commercial plan beneficiaries:** 119 calls or **16%**; and
 - **Uninsured Vermonters:** 86 callers or **12%**.

II. Call volume by type of insurance:

The HCO received 727 total calls this quarter. Callers had the following insurance status:

- **DVHA programs** (Medicaid, VHAP, VHAP Pharmacy, Premium Assistance, VScript, VPharm, or both Medicaid and Medicare aka dual eligibles) insured **40%** (289 calls), compared to 44% (369) last quarter;
- **Medicare** (Medicare only, Medicare and a Medicare Supplemental Plan aka Medigap, Medicare and Medicaid aka dual eligibles, Medicare and Medicare Savings Program aka Buy-In program, Medicare and Part D, or Medicare and VPharm) insured **36%** (261), compared to 24% (205) last quarter;
 - **17%** of all callers (123) had **Medicare only**;
 - **17%** (126) had both **Medicare coverage and coverage through a state program** such as Medicaid, a Medicare Savings Program aka a Buy-In program, or VPharm; and
 - **Less than 1%** (2) had a Medicare Supplemental plan.
- **Commercial carriers** (employer sponsored insurance, individual or small group plans, and Catamount Health plans) insured **16%** (119), compared to 15% (128) last quarter;
- **12%** (86) identified themselves as **Uninsured**, compared to 8% (66) last quarter;
- **6%** (44) had a **Catamount Health** plan, either at full cost or with Premium Assistance (CHAP), or Catamount ESIA, compared to 3% (26) last quarter; and
- In the remainder of calls the insurance status was either unknown or not relevant.

III. Disposition of cases

All Calls

We closed 745 cases this quarter, compared to 847 last quarter.

- 69% (517 cases) were resolved by advice or referral, compared to 67% (568 cases) last quarter;

- 22% (161) were resolved by direct intervention, including calling an insurance company, calling providers, writing letters, gathering supporting medical documentation, etc., compared to 20% (168 cases) last quarter (these numbers include complex interventions);
- 7% (54) of the cases were complex interventions compared to 6% (47):
- 4% (32) of the cases involved appeals, compared to 3% (24); and
- 1% (10) of the cases were resolved in the initial call compared to 3% (28).

DVHA Beneficiary Calls

We closed 300 DVHA cases this quarter, compared to 364 last quarter:

- 68% (204 calls) were resolved by advice or referral, after an analysis of the problem. Last quarter 65% (236 calls) were resolved in this manner;
- 28% (83 calls) were resolved by direct intervention on the caller's behalf, including advocacy with DVHA and providers, writing letters, and gathering medical information. Last quarter 20% (72 calls) were resolved in this manner (these numbers include complex interventions);
- About 8% (25 calls) were considered complex intervention, which involves complex analysis and more than two hours of an advocate's time, compared to 6% (23 calls) last quarter;
- Less than 1% of calls (2) from DVHA beneficiaries were resolved in the initial call, compared to 4% (14 calls) last quarter;
- In the remaining calls clients either withdrew or resolved the issue on their own.

IV. Outcomes

All Calls

The HCO prevented 14 insurance terminations or reductions and got 34 people onto insurance. We assisted 9 people with applications and estimated the eligibility for state programs for 31 individuals. We got 37 claims paid or written off on behalf of consumers. We provided 476 individuals with advice and education.

DVHA Beneficiary Calls

We prevented 11 terminations or reductions in coverage for DVHA beneficiaries, and got 8 more onto different DVHA programs. We estimated the eligibility for other programs for 10 DVHA beneficiaries. We got 20 claims paid or written off. We provided 187 DVHA beneficiaries with advice or education.

V. Issues

The HCO database allows us to track more than one issue per case, so we can see the total number of calls that involved a particular problem. For example, although only 70 cases had Consumer Education as the primary issue, there were actually a total of 269 calls in which we spent a significant amount of time educating consumers about insurance. See the breakouts of the issue numbers in the data reports for a more detailed look at how many callers had questions about issues other than the primary reason for their call.

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

- **29.85%** (217) of our total calls were regarding **Access to Care**;
- **12.38%** (90) were regarding **Billing/Coverage**;
- **.48%** (4) was questions regarding **Buying Insurance**;
- **9.63%** (70) were **Consumer Education**;
- **24.90 %** (181) were regarding **Eligibility** for state programs, Medicare and Catamount Health plans; and
- **22.42%** (163) were categorized as **Other**, which includes Medicare Part D, communication problems with providers or plans, accessing medical records, changing providers or plans, enrollment problems, etc.

A. Access to Care (29.85% of all calls)

We received 217 calls from individuals for whom the primary issue was difficulty getting specific health care, down from 244 last quarter. The top ten Access to Care issues, out of over 35 codes were, in descending order:

- 39 calls were for problems obtaining Prescription Drugs, not including Medicare Part D, compared to 31 last quarter;
- 18 Transportation to medical appointments, compared to 21;
- 17 Affordability of health care, compared to 31;
- 17 Dental, Dentists or Orthodontic care, compared to 22;
- 17 Durable Medical Equipment (DME), Supplies and Wheelchairs, compared to 14;
- 16 Pain Management, compared to 22;
- 10 Mental Health, compared to 14 (not including Substance Abuse);
- 9 Substance Abuse, compared to 12;
- 8 Eye Care, compared to 9; and
- 8 Quality of Care.

B. Eligibility (24.90%)

We received 181 calls from individuals for whom eligibility for state programs was the primary issue, as compared to 226 last quarter.

- 38 Medicaid, compared to 55;
- 38 VHAP, compared to 46;
- 34 Catamount or Premium Assistance, compared to 23; and
- 15 Medicaid Spend Down.

C. Other (22.42%)

We received 163 calls in this category for which the primary issue was categorized as Other, compared to 173 last quarter.

- 29 Complaints about providers, compared to 37;
- 10 Access to medical records, compared to 5;

- 9 Provider error/medical malpractice, compared to 10;
- 7 Information about the HCO, compared to 6;
- 7 Medicare Modernization Act (MMA, i.e. Medicare Part D), compared to 5; and
- 4 Claims of discrimination based on disability.

D. Billing/Coverage (12.38%)

We received 90 calls related to primary issues with billing, compared to 125 last quarter.

- 20 Hospital billing;
- 9 Claim denials by insurers;
- 8 Medicaid/VHAP billing;
- 8 Medicare billing; and
- 7 Premium billing.

E. Consumer Education (9.63%)

We received 70 calls where we primarily provided consumer education, compared to 54 last quarter.

- 19 Information about applying for DVHA programs;
- 16 Medicare;
- 8 Fair Hearings;
- 3 Debt Collection; and
- 3 Information about the Affordable Care Act.

VI. Table of All Calls by Month and Year

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

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

SFY11 Final MCO Investments

8/23/11

Investment Criteria #	Department	Investment Description
2	DOE	School Health Services
2	BISHCA	Health Care Administration
2	VVH	Vermont Veterans Home
2	VSC	Health Professional Training
2	UVM	Vermont Physician Training
2	AHSCO	Designated Agency Underinsured Services
4	AHSCO	Vermont 2-1-1 Service
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	FQHC Lookalike
4	VDH	Patient Safety - Adverse Events
4	VDH	Coordinated Health Activity, Motivation & Prevention Programs (CHAMPPS)
2	VDH	Substance Abuse Treatment
4	VDH	Recovery Centers
2	VDH	DMH Investment Cost in CAP
4	VDH	Poison Control
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
4	DVHA	Vermont Information Technology Leaders/HIT/HIE
4	DVHA	Vermont Blueprint for Health
1	DVHA	Buy-In
1	DVHA	HIV Drug Coverage
1	DVHA	Civil Union
2	DVHA	Patient Safety Net Services
2	DCF	Family Infant Toddler Program
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 Family Mental Health
2	DCF	Therapeutic Child Care
2	DCF	Lund Home
2	DCF	GA Community Action
3	DCF	Prevent Child Abuse Vermont
4	DCF	Challenges for Change: DCF
2	DAIL	Mobility Training/Other Svcs.-Elderly Visually Impaired
2	DAIL	DS Special Payments for Medical Services
2	DAIL	Flexible Family/Respite Funding
4	DAIL	Quality Review of Home Health Agencies
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	Northern Lights