

*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**  
**April 1, 2012 – June 30, 2012**

**September 10, 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 31<sup>st</sup> 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 third quarterly report for waiver year seven, covering the period from April 1, 2012 through June 30, 2012.***

## 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.

<b>Demonstration Population</b>	<b>Current Enrollees Last Day of Qtr 6/30/2012</b>	<b>Previously Reported Enrollees Last Day of Qtr 3/31/2012</b>	<b>Variance 03/31/12 to 06/30/12</b>
Demonstration Population 1:	47,744	47,403	0.72%
Demonstration Population 2:	43,891	44,042	-0.34%
Demonstration Population 3:	9,576	9,600	-0.25%
Demonstration Population 4:	N/A	N/A	N/A
Demonstration Population 5:	1003	1007	-0.40%
Demonstration Population 6:	3,174	3,173	0.03%
Demonstration Population 7:	35,815	35,745	0.20%
Demonstration Population 8:	10,414	10,312	0.99%
Demonstration Population 9:	2,637	2,644	-0.26%
Demonstration Population 10:	N/A	N/A	N/A
Demonstration Population 11:	11,801	11,448	3.08%

## **Green Mountain Care Outreach / Innovative Activities**

During the third quarter, DVHA continued to maintain established outreach work, including an up-to-date web presence to promote Green Mountain Care to uninsured individuals. The Health Benefit Exchange team began aggressive work on the comprehensive outreach and education plan for the Exchange, and we will share this plan, consistent with Exchange development and encompassing current Green Mountain Care members, in the fourth quarter.

### ***Enrollment and legislative action:***

As of the end of July there were 16,190 individuals enrolled in the premium assistance program components of Green Mountain Care (Catamount Health and Employer-Sponsored Insurance).

In May, the Governor signed Act 171, a law refining Act 48 and advance Exchange implementation. The goals of the law, "An Act Relating to Health Care Reform Implementation," were to clarify the definition of a small employer as 50 employees in 2014, define the role of brokers in the Exchange, merge the individual and small group markets, and require individuals and small groups to purchase insurance through the Exchange.

DVHA continued exchange planning (see here: <http://dvha.vermont.gov/administration/health-benefits-exchange>) through hiring staff, expanding contractor work, and merging the Medicaid and Exchange Advisory Boards into one unified body. The Exchange team completed the CCIIO Planning Review in May. DVHA applied for a Level Two Establishment Grant on June 30 and is awaiting a response on funding for exchange planning, development and early operations.

## **Expenditure Containment Initiatives**

### **Vermont Chronic Care Initiative for Quarter 3 of FFY 2012**

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

The VCCI uses a holistic approach of evaluating both the physical and behavioral conditions, as well as the socioeconomic issues, that often are barriers to health improvement. The DVHA's VCCI emphasizes evidence-based, planned, integrated and collaborative care for beneficiaries who exhibit high-prevalence chronic disease states, high-expense utilization, high medication utilization, and/or high emergency room and inpatient utilization. Ultimately, the VCCI aims to improve health outcomes by supporting better self-care and lowering health care expenditures through appropriate utilization of health care services. 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 added 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 staff are primarily co-located within high volume Medicaid provider offices and local hospital Emergency Departments, and are integrated with existing VCCI care coordination staff. They lead the way for the Blueprint for Health Community Health Teams (CHT's) which are now operational and integrating with the VCCI in these additional communities. A year after the C4C launch in Franklin County, our VCCI team was named the 'Community Partner of the Year' (2011) at the annual meeting of Northwestern Counseling and Support Services (NCSS) - a core partner serving individuals with mental health conditions.

In January 2012, DVHA further expanded our VCCI operations' to include the development of a Pediatric Palliative Care Program that will link with other AHS services for children and families. This initiative will be launched at the pilot level in Chittenden County early in state FY 2013 and progressively expand statewide throughout FY 2013.

#### 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. 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 3 of FFY 2012)**

- DVHA continues to transition away from traditional disease management and telephone management of high risk beneficiaries and is preparing for expansion of our practice 'integration' efforts with high volume practices and Hospital ED's.
- In the April state budget adjustment, the VCCI received authorization to add additional staff including 2 field staff nursing positions, 2 managerial staff and an administrative assistant to support our increasing expansion efforts and to assure alignment with the Blueprint and Healthcare Reform goals.
- DVHA, working with APS Healthcare, is continue to leverage data for both individual and population based health improvements working with provider practices to deliver health registries outlining gaps in evidence based care; and assigning high risk members to VCCI staff for case management s indicated to prevent hospital admission and readmission rates. A CAD registry was targeted for launch for July 2012.
- The VCCI has been engaged with an MCE 'Project Improvement Plan' for systolic heart failure with an aggressive statewide effort targeting providers and patients to increase adherence to evidence based pharmacology for patients at risk planned for the last quarter of FFY 2012. A repeat HF registry and associated patient health briefs are scheduled for August 2012.
- DVHA has partnered with several high volume hospitals to secure data feeds (FTP site) on ED usage in order to actively identify and assess patterns of high ED usage; and outreach select individuals to more effectively manage care on more 'real time' basis vs. pending claims data. Three sites were operational in the 3<sup>rd</sup> quarter.
- DVHA is expanding its VCCI scope to now include Pediatric Palliative Care based on legislative request and GC waiver authorization (12/2011). The program developmental stages are coming to a close with early pilot implementation stage anticipated for the last quarter of the FFY 2012.
- The APS data indicates that from April 1, 2012 through June 30, 2012 VCCI maintained an average monthly caseload of 775 beneficiaries and 1,357 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			

The Buprenorphine Practice guidelines are reviewed and updated every two years and DVHA is in the process of revising them.

The total for the 3 quarters (October 2011- June, 2012) is \$144,003.70 (Figure 2).

(Figure 2)

Buprenorphine Program Payment Summary FFY 2012	
<b>FIRST QUARTER</b>	
Oct-11	\$14,415.76
Nov-11	\$ 15,136.66
Dec-11	\$ 15,255.38
<b>1<sup>st</sup> Quarter Total</b>	<b>\$44,807.80</b>
<b>SECOND QUARTER</b>	
Jan - 2012	\$11,626.56
Feb - 2012	\$16,199.22
March- 2012	\$11,473.18
<b>2<sup>nd</sup> Quarter Total</b>	<b>\$39,298.96</b>
<b>THIRD QUARTER</b>	
April - 2012	\$12,678.38
May - 2012	\$27,532.72
June - 2012	\$19,685.84
<b>3<sup>rd</sup> Quarter Total</b>	<b>\$59,896.94</b>
<b>Grand Total</b>	<b>\$144,003.70</b>

## 340B DRUG DISCOUNT PROGRAM

### Background

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

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

Covered entities include:

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

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

### 340B PROGRAM IN VERMONT

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

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

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

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

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

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

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

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

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

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

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

### Safeguards for Overprescribing

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

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

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

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

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

### 340B Reimbursement and Calculation of Incentive Payment

#### Determination of Dispensing Fee and Savings Sharing Amounts

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

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

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

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

#### Summary

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

**approximately \$385,000** 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*

During the third quarter, major mental health reform legislation was formally passed at Act 79 during the 2012 Legislative Session. Act 79 proposes sweeping changes to the state's public mental health system through significant investments in community support services and authorizes up to 25 acute hospital beds be developed at a new state-run hospital to be built in Central Vermont. An additional 28 inpatient beds to serve individuals who would otherwise have been treated at the former Vermont State Hospital is also authorized via legislation while the new hospital is in development.

Facility renovations at the Brattleboro Retreat (14 beds), Rutland Regional Medical Center (6 beds), and an interi psychiatric hospital (8 beds) in a former nursing home in Morrisville were authorized by the legislature and through Certificate of Need approval late this quarter by the Department of Financial Regulation. This increased bed capacity will serve individuals in need of acute psychiatric, involuntary care services while new facility site planning and construction moves forward over the next two years.

### *Community System Development*

Act 79 authorizes significant investments in a more robust publicly funded mental health services system for Vermont as outlined in previous quarterly reports. Fiscal Year 13 funding will allow implementation of service expansion in:

- emergency and outreach crisis services;
- intensive residential recovery and crisis bed support programs;
- outpatient services and better alignment with physical healthcare initiatives;
- housing supports and stabilization; and
- peer support services.

During this quarter, outreach activities such as “Police Meet Mental Health” brought together law enforcement, advocacy organizations, and mental health service providers to identify county-wide needs and to begin service collaboration planning and development. The creation of reliable alternative transportation options for persons in involuntary care is an active component of planning and is being pursued with local sheriff's departments and the Department of Mental Health and should be in place over the next quarter. Act 79 also called for independent external consultant review of Vermont's new plan for mental health services and to make recommendations for any changes, data collections, and financing methodology. A report will be forthcoming to the Department over the next quarter. Departmental care management activities continue to develop for purposes of facilitating both timely access to necessary levels of inpatient and community-based care, as well as movement through the publicly funded mental health system of care. Opportunities to care manage other publicly funded mental health inpatient admissions for individuals receiving community designated agency mental health services is in development. This initiative will work in tandem with comparable initiatives being undertaken by the Department of Vermont Health Access. Over the next quarter the Department of Mental Health will be formalizing data collection and reporting capabilities consistent with Act 79 provisions regarding: access

to emergency room and inpatient services, mobile outreach supports, crisis bed and intensive residential recovery bed utilization, alternative transportation availability, housing stability, and adverse event and emergency involuntary procedures. Outcomes and cost-savings to the service system will be reported back to the legislature as outlined within this new law.

### **Integrated Family Services**

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

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

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

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

- Local clinicians moving from a day per week of separate and conflicting paperwork requirements to one set representing approximately 2-3 hours of paperwork time, immediate freeing up more time for direct family services

- A more immediate response to families who ask for help who prior to this grant were “not sick enough” to meet funding criteria
- Unified local efforts to offer a single on site response to families bringing together multiple state and federal programs that would otherwise be offered at differing times and places.

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

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

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

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

### **Financial/Budget Neutrality Development/Issues**

Effective with the January 1, 2011 waiver renewal, AHS began paying DVHA a monthly PMPM estimate using the existing rates on file, in accordance with the new Special Terms and Conditions. This monthly payment reflects the State’s monthly need for Federal funds based on estimated Global Commitment

expenditures for the month. Beginning with the QE0311 filing, AHS has reconciled the Federal claims from the estimated monthly PMPM payments to the underlying actual Global Commitment expenditures incurred via the usual reconciliation draw process on a quarterly basis.

AHS 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 agreement with Aon expired on March 31, 2012. AHS selected Milliman, Inc. as its new actuarial services vendor for the FFY13 and FFY14 periods, and entered into a contractual arrangement with Milliman effective April 1, 2012. 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. Throughout QE0612, AHS has worked with Milliman on development of the FFY13 rate ranges, which as of July 31, 2012 are nearly finalized; AHS anticipates selecting the FFY13 rates and sending the revised IGA to CMS no later than September 1, 2012.

### 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 15<sup>th</sup> of the preceding month.

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

Demonstration Population	Month 1 4/30/2012	Month 2 5/31/2012	Month 3 6/30/2012	Total for Quarter Ending 3rd Qtr FFY '12	Total for Quarter Ending 2nd Qtr FFY '12	Total for Quarter Ending 1st Qtr FFY '12	Total for Quarter Ending 4th Qtr FFY '11	Total for Quarter Ending 3rd Qtr FFY '11	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
Demonstration Population 1:	47,544	47,664	47,744	142,952	142,365	141,300	139,591	138,493	137,968	136,144	134,256	132,168	131,930	131,513
Demonstration Population 2:	44,353	44,293	43,891	132,537	132,285	132,095	130,715	130,868	131,340	131,167	131,402	131,865	130,746	129,075
Demonstration Population 3:	9,762	9,738	9,576	29,076	28,869	29,054	29,396	29,431	29,787	29,874	30,068	30,244	29,567	29,352
Demonstration Population 4:	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Demonstration Population 5:	1,017	992	1,003	3,012	2,999	3,325	3,246	3,310	3,237	3,423	3,444	3,701	3,614	3,546
Demonstration Population 6:	3,126	3,236	3,174	9,536	9,646	9,704	9,888	9,795	9,769	9,226	9,073	8,972	8,495	8,218
Demonstration Population 7:	35,785	35,928	35,815	107,528	106,610	105,833	105,932	108,184	107,915	105,131	103,915	103,194	98,576	92,217
Demonstration Population 8:	10,234	10,291	10,414	30,939	30,730	30,174	23,287	24,639	23,499	23,180	23,155	22,707	22,462	22,254
Demonstration Population 9:	2,627	2,610	2,637	7,874	7,889	7,875	7,512	7,634	7,722	7,887	7,848	7,914	7,770	7,673
Demonstration Population 10:	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Demonstration Population 11:	11,687	11,687	11,801	35,175	33,674	33,464	33,207	32,732	31,046	31,397	30,986	31,445	29,728	28,278

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

### Consumer Issues

The AHS and DVHA have several mechanisms whereby consumer issues are tracked and summarized. The first is through the Managed Care Entity, Health Access Member Services. This is a contracted function for providing information on health care programs, assisting with the eligibility process, and helping beneficiaries to understand the benefits and responsibilities of their particular programs. The complaints received by Member Services are based on anecdotal weekly reports that the contractor provides to DVHA (see Attachment 2). Member services works to resolve the issues raised by beneficiaries, and their data helps DVHA look for any significant trends. The weekly reports are seen by several management staff at

DVHA and staff asks for further information on complaints that may appear to need follow-up to ensure that the issue is addressed. When a caller is dissatisfied with the resolution that Member Services offers, the member services representative explains the option of filing a grievance and assists the caller with that process. It is noteworthy that Member Services receives an average approximately 25,000 calls a month. We believe that the low volume of complaints and grievances is an indicator that our system is working well.

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

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

## **Quality Assurance/Monitoring Activity**

### **External Quality Review Organization**

During this quarter, the AHS Quality Improvement Manager (QIM) continued to work with DVHA as they prepared for the 2012 external quality review activities. First, the AHS worked with DVHA to complete the PIP summary form. This included participating in a conference call between DVHA and the EQRO to determine how best to report changes in PIP activities undertaken during the past year on the newly approved form. This year, the External Quality Review Organization (EQRO) evaluated the technical methods of the Performance Improvement Project (PIP) (i.e., the study design and implementation/evaluation) associated with the baseline data reported. The new project will be validated up to and including step nine (i.e., assess for real improvement). Also during this quarter, the EQRO scored the initial DVHA submission. Results were as follows: percentage score of evaluation elements met – 80%; percentage score of critical elements met – 100%; overall validation status – Met. The AHS Quality Improvement Manager will work with DVHA to address the points of clarification identified by the EQRO during the initial review. DVHA will make any necessary changes and resubmit during the next quarter. If necessary, AHS will participate in a technical assistance call with the EQRO and DVHA to discuss any preliminary findings. Second, AHS worked with DVHA to help them prepare for this year's compliance review. During this quarter, the compliance review tool was completed. All documents were posted to the EQRO FTP site by the due date. The EQRO confirmed that all requested documents were received and that the on-site visit is scheduled for early next quarter. Finally, AHS worked with DVHA to complete the performance measure review materials. During this quarter, the AHS Quality Improvement Manager and DVHA representatives agreed to a final list of measures that will be subject to EQRO review during the next quarter. It is anticipated that initial measures and rates will be ready for EQRO review by the beginning of next quarter.

### Quality Assurance Performance Improvement Committee (QAPI)

During this quarter, the members of the Quality Assurance and Performance Improvement (QAPI) Committee focused on development of the Quality Work Plan and prepared for the External Quality Review audit. The quarterly meeting was rescheduled to July, 2012 and ongoing communication between members continued. The updated Quality Plan was approved by all members and the QAPI Committee began developing the Quality Work Plan. Representatives from each IGA partner participated in a training on the quality improvement model adopted by AHS. These representatives initiated quality improvement projects throughout the Medicaid Program which will be monitored by the QAPI Committee through the Quality Work Plan. The 2012 External Quality Review Audit will focus on three compliance standards from 42 CFR: Practice Guidelines, Quality Assessment & Performance Improvement Program, and Health Information Systems. Members of the QAPI Committee assisted in the review of compliance evidence in preparation for the audit. The QAPI Committee chair also met with the AHS Quality Improvement Manager to review the compliance activities. The AHS examined compliance activities with the DVHA Quality Director in three areas: practice guidelines, QAPI program, and health information systems. During this time, the diabetes and Bupenorphrine practice guidelines were discussed. These guidelines have been in place for the past 5 years and the idea of selecting additional guidelines was talked about. Conversations around the QAPI program centered on the activities related to the Quality Work Plan (including IGAs). Finally, the Federal and State Medicaid Manage Care health information system requirements were examined. The two systems that are subject to these requirements are the MMIS and the grievance and appeal data base. Policies and related procedures were discussed as a way to prepare for the upcoming review. Finally, during this quarter, one recommendation was made to the AHS Quality Manager for a corrective action plan related to one IGA partner's compliance with standards for coordination & continuity of care and appropriateness of care for special health needs populations. Through a collaborative effort a plan was developed to bring the IGA partner into compliance with no formal corrective action plan being necessary.

### Quality Strategy

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

### Demonstration Evaluation

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

### Reported Purposes for Capitated Revenue Expenditures

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

- Reduce the rate of uninsured and/or underinsured in Vermont;
- Increase the access of quality health care to uninsured, underinsured, and Medicaid beneficiaries;

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

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

## **Enclosures/Attachments**

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

Attachment 1: Catamount Health Enrollment 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

Our first attachment would normally be the Catamount Health Enrollment Report, but because of a legislative change to the reporting requirements, which are currently in process, this report will be updated and attached to the next quarterly report.

## **State Contact(s)**

Fiscal:	Jim Giffin, CFO VT Agency of Human Services 103 South Main Street Waterbury, VT 05671-0201	802-871-3005 (P) 802-871-3001 (F) <a href="mailto:jim.giffin@state.vt.us">jim.giffin@state.vt.us</a>
Policy/Program:	Suzanne Santarcangelo, Director AHS Health Care Operations, Compliance, and Improvement VT Agency of Human Services 103 South Main Street Waterbury, VT 05671-0203	802-871-3265 (P) 802-871-3001 (F) <a href="mailto:suzanne.santarcangelo@state.vt.us">suzanne.santarcangelo@state.vt.us</a>
Managed Care Entity:	Mark Larson, Commissioner Department of VT Health Access 312 Hurricane Lane, Suite 201 Williston, VT 05495	802-879-5901 (P) 802-879-5952 (F) <a href="mailto:mark.larson@state.vt.us">mark.larson@state.vt.us</a>

**Date Submitted to CMS: September 10, 2012**

**ATTACHMENTS**



Department of Vermont Health Access  
SFY 12 Catamount Health Actual Revenue and Expense Tracking  
Monday, March 19, 2012

	SFY '12 BAA		Consensus Estimates for SFY to Date		Actuals thru 2/29/12		% of SFY to-Date
	<=200%	>200%	<=200%	>200%	<=200%	>200%	
<b>TOTAL PROGRAM EXPENDITURES</b>	<b>24,009,872</b>	<b>9,515,962</b>	<b>33,525,834</b>	<b>33,525,834</b>	<b>22,827,315</b>	<b>11,291,097</b>	<b>34,118,411</b>
Catamount Health	36,286,486	14,381,770	50,668,256	50,668,256	733,038	319,421	1,052,460
Catamount Eligible Employer-Sponsored Insurance	1,549,861	1,093,183	2,643,044	2,643,044	23,560,353	11,610,518	35,170,871
Subtotal Program Spending	37,836,347	15,474,953	53,311,300	53,311,300	908,466	309,309	1,217,795
DVHA Administration	1,296,449	530,244	1,826,693	1,826,693	612,976	208,698	821,673
DCF Administration	874,743	357,767	1,232,510	1,232,510	1,521,462	518,006	2,039,469
Subtotal Administration Spending	2,171,192	888,011	3,059,203	3,059,203	27,966,296	13,552,896	41,518,991
<b>TOTAL GROSS PROGRAM SPENDING</b>	<b>40,007,539</b>	<b>16,362,964</b>	<b>56,370,503</b>	<b>56,370,503</b>	<b>10,533,230</b>	<b>5,023,086</b>	<b>15,556,316</b>
<b>TOTAL STATE PROGRAM SPENDING</b>	<b>16,860,123</b>	<b>6,895,742</b>	<b>23,755,865</b>	<b>23,755,865</b>	<b>11,124,637</b>	<b>4,549,863</b>	<b>15,674,500</b>
<b>TOTAL OTHER EXPENDITURES</b>	<b>11,124,637</b>	<b>4,549,863</b>	<b>15,674,500</b>	<b>15,674,500</b>	<b>1,666,667</b>	<b>-</b>	<b>1,666,667</b>
Immunizations Program	2,500,000	-	2,500,000	2,500,000	333,333	-	333,333
Marketing and Outreach	500,000	-	500,000	500,000	1,231,142	-	1,231,142
Blueprint	1,846,713	-	1,846,713	1,846,713	3,231,142	-	3,231,142
<b>TOTAL OTHER SPENDING</b>	<b>4,846,713</b>	<b>-</b>	<b>4,846,713</b>	<b>4,846,713</b>	<b>1,356,958</b>	<b>-</b>	<b>1,356,958</b>
<b>TOTAL STATE OTHER SPENDING</b>	<b>2,042,405</b>	<b>2,042,405</b>	<b>1,361,603</b>	<b>1,361,603</b>	<b>11,890,188</b>	<b>5,023,086</b>	<b>16,913,275</b>
<b>TOTAL ALL STATE SPENDING</b>	<b>18,902,528</b>	<b>6,895,742</b>	<b>25,798,270</b>	<b>25,798,270</b>	<b>12,485,240</b>	<b>4,549,863</b>	<b>17,036,103</b>
<b>TOTAL REVENUES</b>	<b>10,052,097</b>	<b>10,052,097</b>	<b>10,052,097</b>	<b>10,052,097</b>	<b>3,564,780</b>	<b>3,445,668</b>	<b>7,010,448</b>
Catamount Health Premiums	5,118,571	4,933,526	797,314	797,314	223,317	172,558	395,875
Catamount Eligible Employer-Sponsored Insurance Premiums	356,157	441,156	797,314	797,314	3,783,087	3,618,226	7,405,323
Subtotal Premiums	5,474,728	5,374,682	10,849,411	10,849,411	(2,197,066)	(2,114,269)	(4,311,331)
Federal Share of Premiums	(3,167,512)	(3,109,618)	(6,277,130)	(6,277,130)	1,391,031	1,503,961	3,094,992
<b>TOTAL STATE PREMIUM SHARE</b>	<b>2,307,216</b>	<b>2,265,064</b>	<b>4,572,280</b>	<b>4,572,280</b>	<b>6,544,333</b>	<b>6,544,333</b>	<b>7,573,358</b>
Cigarette Tax & Floor Stock	9,816,500	9,816,500	9,816,500	9,816,500	8,074,000	8,074,000	109,859%
Employer Assessment	9,800,000	9,800,000	9,800,000	9,800,000	2,863	2,863	0.00%
Interest	-	-	-	-	777,043	777,043	87.64%
Shared Savings by > 300%	1,393,200	1,393,200	1,393,200	1,393,200	15,650,221	15,650,221	105.88%
<b>TOTAL OTHER REVENUE</b>	<b>21,009,700</b>	<b>21,009,700</b>	<b>14,780,915</b>	<b>14,780,915</b>	<b>18,745,213</b>	<b>18,745,213</b>	<b>105.35%</b>
<b>TOTAL STATE REVENUE</b>	<b>25,681,980</b>	<b>25,681,980</b>	<b>17,792,925</b>	<b>17,792,925</b>	<b>1,831,938</b>	<b>1,831,938</b>	<b>105.35%</b>
State-Only Balance	(216,289)	(216,289)	766,822	766,822	-	-	-
Carryforward	(216,289)	(216,289)	766,822	766,822	-	-	-
<b>CATAMOUNT FUND (DEFICIT)/SURPLUS</b>	<b>(216,289)</b>	<b>(216,289)</b>	<b>766,822</b>	<b>766,822</b>	<b>1,831,938</b>	<b>1,831,938</b>	<b>105.35%</b>
General Fund BAA to GC on Behalf of Catamount	2,612,336	2,612,336	1,741,557	1,741,557	1,523,863	1,523,863	87.50%
<b>ALL FUNDS THAT SUPPORT CATAMOUNT (DEFICIT)/SURPLUS</b>	<b>2,396,047</b>	<b>2,396,047</b>	<b>2,498,379</b>	<b>2,498,379</b>	<b>3,355,801</b>	<b>3,355,801</b>	<b>87.50%</b>



Green Mountain Care Enrollment Report  
FEBRUARY 2012

TOTAL ENROLLMENT BY MONTH

	Jul 07	Nov 07	Jul 08	Feb 11	Mar 11	Apr 11	May 11	June 11	July 11	Aug 11	Sept 11	Oct 11	Nov 11	Dec 11	Jan 11	Feb 11
<b>Adults:</b>																
VHAP-ESIA	-	35	672	905	918	890	876	850	818	825	807	823	823	847	829	832
ESIA	-	21	336	785	801	801	804	782	782	759	755	751	720	714	709	717
CHAP	-	320	4,608	9,967	10,200	10,375	10,477	10,434	10,461	10,669	10,542	10,647	10,742	10,509	10,736	11,020
Catamount Health	-	120	697	2,718	2,810	2,622	2,852	2,386	2,921	2,964	2,960	2,992	3,061	3,072	3,129	3,189
<b>Total</b>	-	496	6,313	14,375	14,729	14,688	15,009	14,452	14,982	15,217	15,064	15,213	15,346	15,142	15,403	15,758
<b>Children:</b>																
VHAP	23,725	24,849	26,441	37,194	37,820	37,383	36,988	37,412	36,569	35,953	36,886	36,465	36,021	36,445	36,810	36,761
Other Medicaid	69,764	69,969	70,947	40,462	40,799	40,794	40,094	39,962	39,897	39,773	40,530	38,935	-40,308	40,631	40,535	40,630
<b>Dr Dynasaur</b>	19,738	19,733	19,960	21,080	21,064	21,171	20,821	20,027	20,077	20,029	20,269	20,284	20,255	20,248	20,222	20,083
SCHIP	3,097	3,428	3,396	3,657	3,605	3,622	3,612	3,721	3,789	3,790	3,843	3,924	3,960	4,052	3,679	3,728
Other Medicaid*	Included	Included	Included	38,460	38,675	38,523	37,666	38,103	37,948	37,841	38,394	37,556	37,971	38,069	38,500	38,541
<b>Total</b>	116,324	117,979	120,744	140,853	141,963	141,493	139,181	139,225	138,280	137,386	139,922	137,164	138,515	139,445	139,746	139,743
<b>TOTAL ALL</b>	116,324	118,355	127,057	155,228	156,692	156,181	154,190	153,677	153,262	152,603	154,986	152,377	153,861	154,587	155,149	155,501

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.



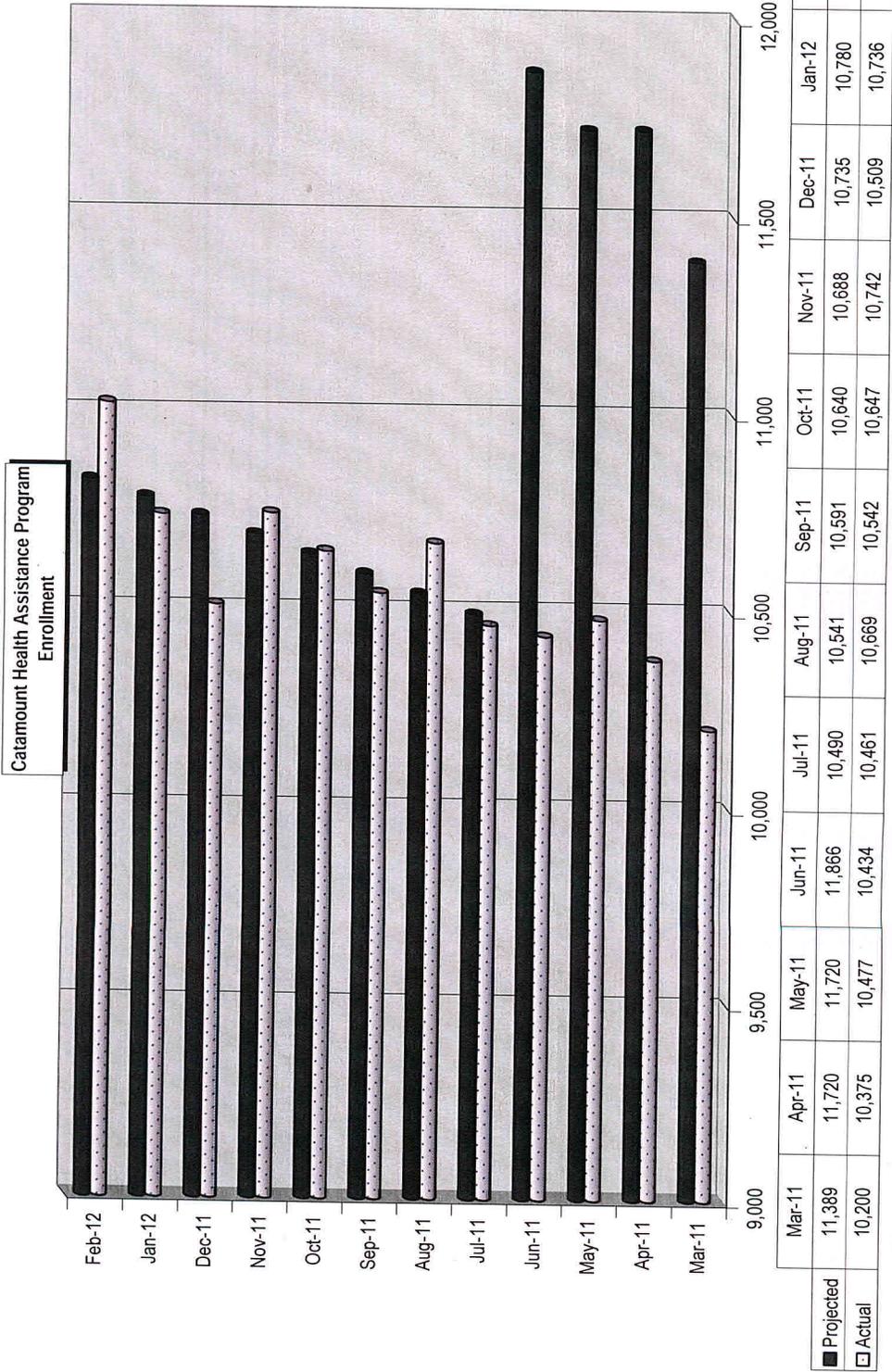
Green Mountain Care Enrollment Report				
February 2012 Demographics				
Income	VHAP-ESIA*	ESIA*	CHAP*	TOTAL
0-50%	23	3	624	650
50-75%	22	1	83	106
75-100%	81	1	111	193
100-150%	418	16	342	776
150-185%	285	227	3922	4,434
185-200%	3	228	2724	2,955
200-225%	0	107	1552	1,659
225-250%	0	84	996	1,080
250-275%	0	46	516	562
275-300%	0	4	150	154
<b>Total</b>	<b>832</b>	<b>717</b>	<b>11,020</b>	<b>12,569</b>

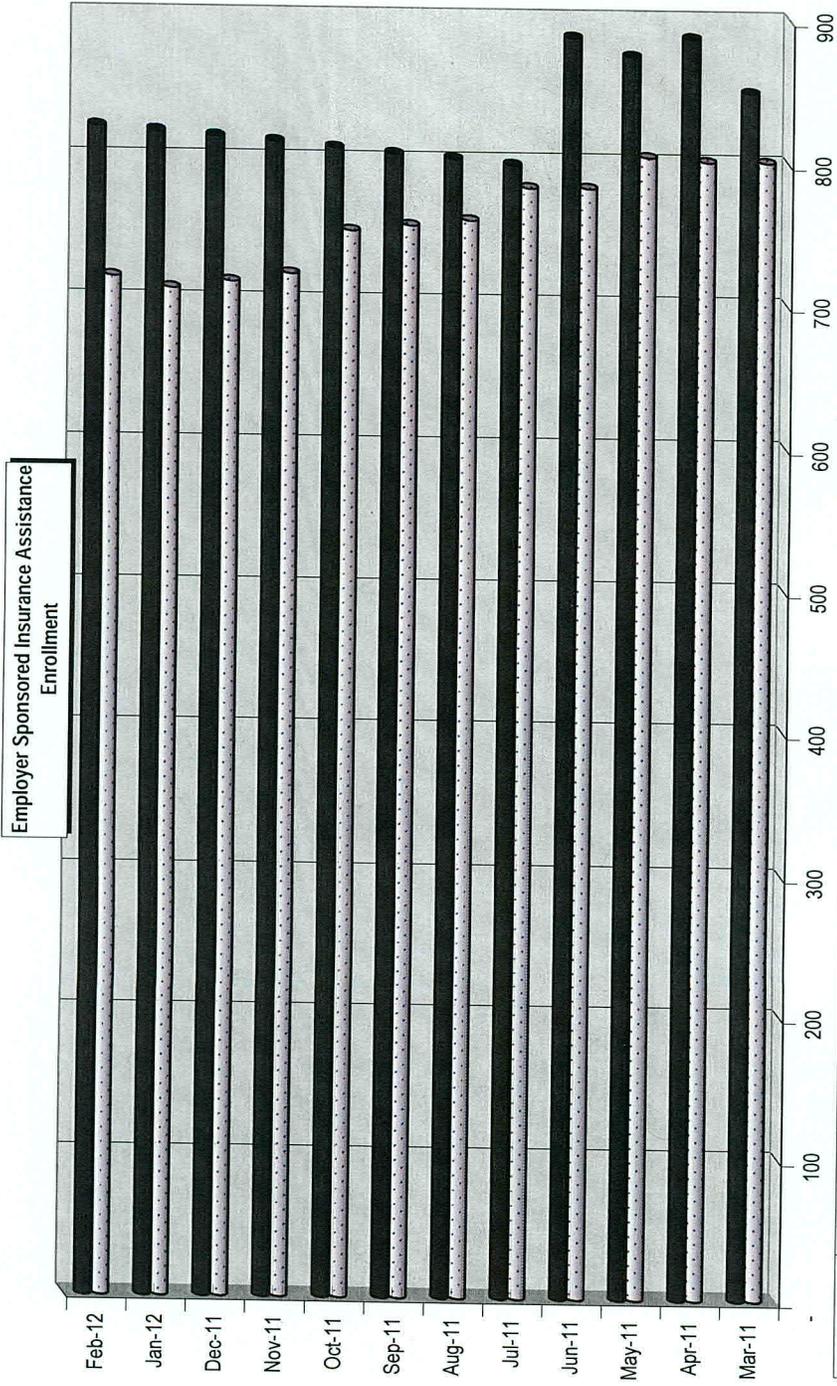
  

Age	VHAP-ESIA	ESIA	CHAP	TOTAL
18-24	40	43	1884	1967
25-35	250	183	2150	2583
36-45	304	223	1683	2210
46-55	193	195	2484	2872
56-64	45	73	2816	2934
65+	-	-	3	3
<b>Total</b>	<b>832</b>	<b>717</b>	<b>11,020</b>	<b>12,569</b>



Green Mountain Care Enrollment Report (continued)				
February 2012 Demographics				
Gender	VHAP-ESIA	ESIA	CHAP	TOTAL
Male	293	258	4793	
Female	539	459	6227	
<b>Total</b>	<b>832</b>	<b>717</b>	<b>11,020</b>	<b>12,569</b>
County	VHAP-ESIA	ESIA	CHAP	TOTAL
Addison	44	42	654	740
Bennington	79	72	718	869
Caledonia	24	21	696	741
Chittenden	204	172	2115	2,491
Essex	7	4	148	159
Franklin	79	44	701	824
Grand Isle	14	6	117	137
Lamoille	41	54	536	631
Orange	42	34	528	604
Orleans	52	41	653	746
Other	-	-	3	3
Rutland	89	79	1169	1,337
Washington	66	56	985	1,107
Windham	34	41	921	996
Windsor	57	51	1076	1,184
<b>Total</b>	<b>832</b>	<b>717</b>	<b>11,020</b>	<b>12,569</b>

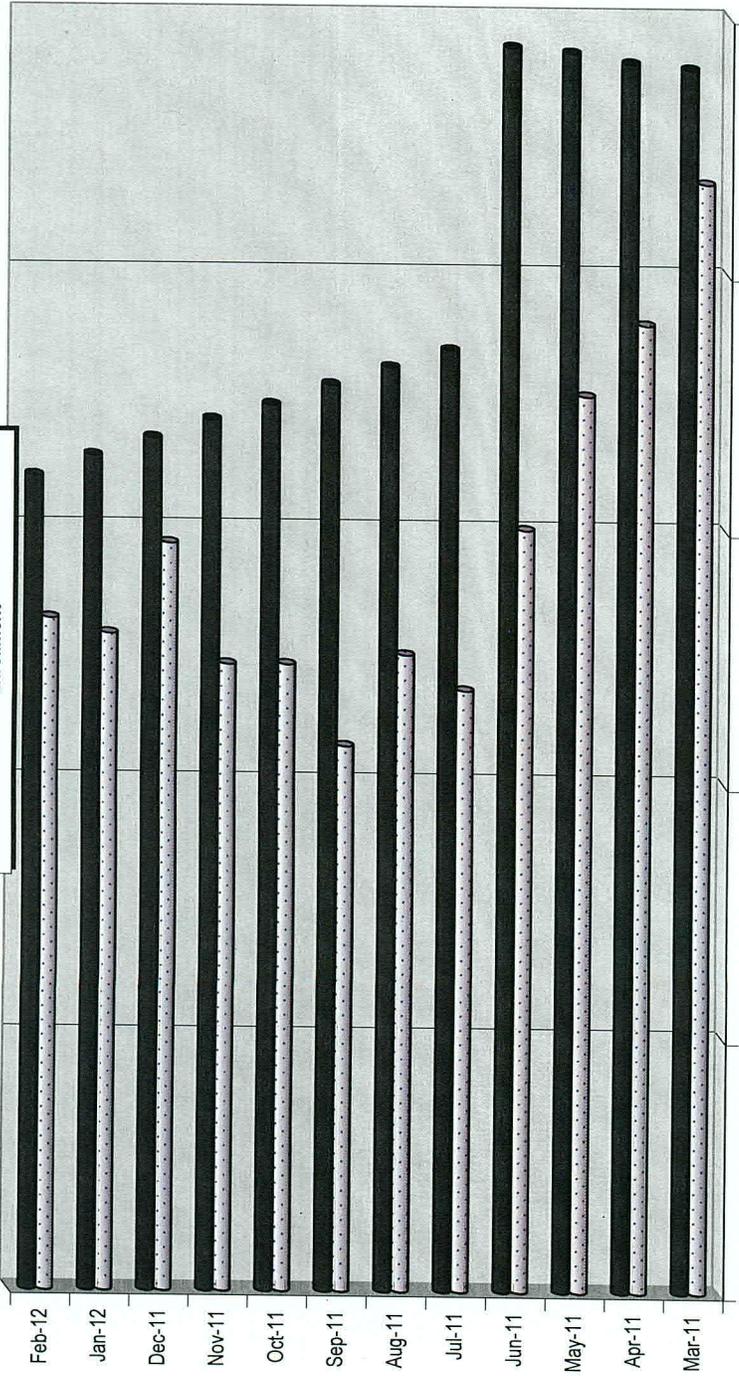




	Mar-11	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12
Projected	849	887	874	887	798	802	805	809	813	816	819	822
Actual	801	801	804	782	782	759	755	751	720	714	709	717



VHAP - Employer Sponsored Insurance Assistance Enrollment



	Mar-11	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12
Projected	940	941	943	944	885	881	878	874	871	867	864	860
Actual	918	890	876	850	818	825	807	823	823	847	829	832

Global Commitment Expenditure Tracking

Quarterly Expenditures	PQA: WY1	PQA: WY2	PQA: WY3	PQA: WY4	PQA: WY5	PQA: WY6	PQA: WY7	PQA: WY8	PQA: WY9	Net Program PQA	Net Program Expenditures as reported on 64	non-MCO Admin Expenses	Total columns J-K for Budget Neutrality calculation		Variance to Cap under/(over)
													Cumulative Waiver Cap per 1/1/11 STCs	Cumulative	
GE															
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	\$ 841,266,663	\$ 54,486,516	
1206	\$ 203,444,640	\$ 8,903								\$ 8,903	\$ 203,453,543				
0307	\$ 203,804,330	\$ 8,894,087								\$ 8,894,087	\$ 212,688,427				
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	\$ 1,694,128,945	\$ 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	\$ 340,276,433							\$ 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	\$ 2,604,109,308	\$ 119,793,211	
Cumulative															
1208	\$ 228,768,784	\$ -	\$ -							\$ -	\$ 228,768,784				
0309	\$ 225,691,930	\$ (16,984,221)	\$ 338,988,635	\$ (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	\$ 265,595,153	\$ -	\$ 30,199	\$ 34,064,109						\$ 34,094,308	\$ 289,679,461				
WY4 SUM	\$ 894,215,505	\$ (16,984,221)	\$ 339,715,685	\$ 35,442,631						\$ 55,174,295	\$ 935,368,619	\$ 5,495,618	\$ 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)	\$ (251,426)	\$ 3,348,303						\$ 2,970,888	\$ 255,265,566				
WY5 SUM	\$ 993,536,849	\$ -	\$ (115,989)	\$ 5,710,484	\$ 13,009,006					\$ 18,603,501	\$ 1,012,990,839	\$ 5,949,605	\$ 4,700,022,174	\$ 255,901,196	
Cumulative															
1210	\$ 262,105,988	\$ -	\$ -	\$ 6,444,984						\$ 6,444,984	\$ 268,551,972				
0311	\$ 267,140,611	\$ -	\$ -	\$ -						\$ -	\$ 267,140,611				
0611	\$ 277,708,043	\$ -	\$ -	\$ -	\$ (121,416)					\$ (121,416)	\$ 277,586,627				
0911	\$ 243,508,248	\$ -	\$ -	\$ -	\$ 5,528,143					\$ 5,528,143	\$ 249,036,391				
WY6 SUM	\$ 1,040,463,690	\$ -	\$ -	\$ -	\$ 6,444,984	\$ 5,406,727				\$ 11,851,711	\$ 1,045,342,616	\$ 6,071,563	\$ 5,865,213,737	\$ 369,678,591	
Cumulative															
1211	\$ 253,147,037	\$ (531,744)								\$ (531,744)	\$ 252,615,293				
0312	\$ 267,978,672	\$ 3,742	\$ 49,079							\$ 52,821	\$ 268,031,493				
0612	\$ 302,958,610	\$ -	\$ 6,393,928							\$ 6,393,928	\$ 309,352,538				
0912	\$ 824,084,319	\$ -	\$ -	\$ (528,002)	\$ 6,443,006					\$ 5,915,005	\$ 830,527,325	\$ 4,543,112	\$ 7,113,290,903	\$ 782,685,319	
WY7 SUM	\$ 1,648,168,636	\$ (531,744)	\$ 49,079	\$ 6,443,006	\$ 6,443,006					\$ -	\$ 1,648,168,636	\$ 4,543,112	\$ 8,855,886,798	\$ 2,625,281,214	
Cumulative															
1212	\$ -	\$ -	\$ -	\$ -	\$ -					\$ -	\$ -				
0313	\$ -	\$ -	\$ -	\$ -	\$ -					\$ -	\$ -				
0613	\$ -	\$ -	\$ -	\$ -	\$ -					\$ -	\$ -				
0913	\$ -	\$ -	\$ -	\$ -	\$ -					\$ -	\$ -				
WY8 SUM	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -				\$ -	\$ -	\$ -	\$ 8,450,684,486	\$ 2,120,078,902	
Cumulative															
1213	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -				\$ -	\$ -				
0314	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -				\$ -	\$ -				
0614	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -				\$ -	\$ -				
0914	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -				\$ -	\$ -				
WY9 SUM	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -			\$ -	\$ -	\$ 39,602,525	\$ 8,955,886,798	\$ 2,625,281,214	
Cumulative	\$ 6,145,073,847	\$ 10,166,327	\$ (16,042,281)	\$ 79,876,130	\$ 41,153,315	\$ 19,453,990	\$ 4,878,725	\$ 6,443,006	\$ -	\$ 6,291,003,059	\$ 39,602,525	\$ 8,955,886,798	\$ 2,625,281,214		

**Complaints Received by Health Access Member Services  
April 1, 2012 – June 30, 2012**

Eligibility forms, notices, or process	46
ESD Call-center complaints (IVR, rudeness, hold times)	1
Use of social security number as identifiers	0
General premium complaints	11
Catamount Health Assistance Program premiums, process, ads, plans	0
Coverage rules	4
Member services	2
Eligibility rules	6
Eligibility local office	3
Prescription drug plan complaint	2
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	2
<b>Total</b>	<b>79</b>

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

The MCE is composed of various administrative areas within the Agency of Human Services (AHS). These include: the Department of Vermont Health Access (DVHA), the Department for Children and Families (DCF), the Department of Mental Health (DMH), the Department of Disabilities, Aging and Independent Living (DAIL), and the Department of Health (VDH). Also included in the MCE are the Designated Agencies (DA) and Specialized Service Agencies (SSA) that provide service authorizations for DMH and DAIL. Each entity should have at least one assigned grievance and appeal coordinator who enters data into the MCE database. This report is based on data compiled on July 2, 2012, from the centralized database for grievances and appeals that were filed from April 1, 2012 through June 30, 2012.

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

During this quarter, there were 3 grievances filed with the MCE; none were addressed during the quarter and none were withdrawn. Grievances must be addressed within 90 days of filing, so having pending cases at the end of the quarter is to be expected. Acknowledgement letters of the receipt of a grievance must be sent within five days; the average was three days. Of the grievances filed, 67% were filed by beneficiaries and 33% were filed by a representative of the beneficiary. Of the 3 grievances filed, DMH had 67% and DCF had. There were no grievances filed for the DVHA, DAIL, or VDH during this quarter.

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

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

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

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

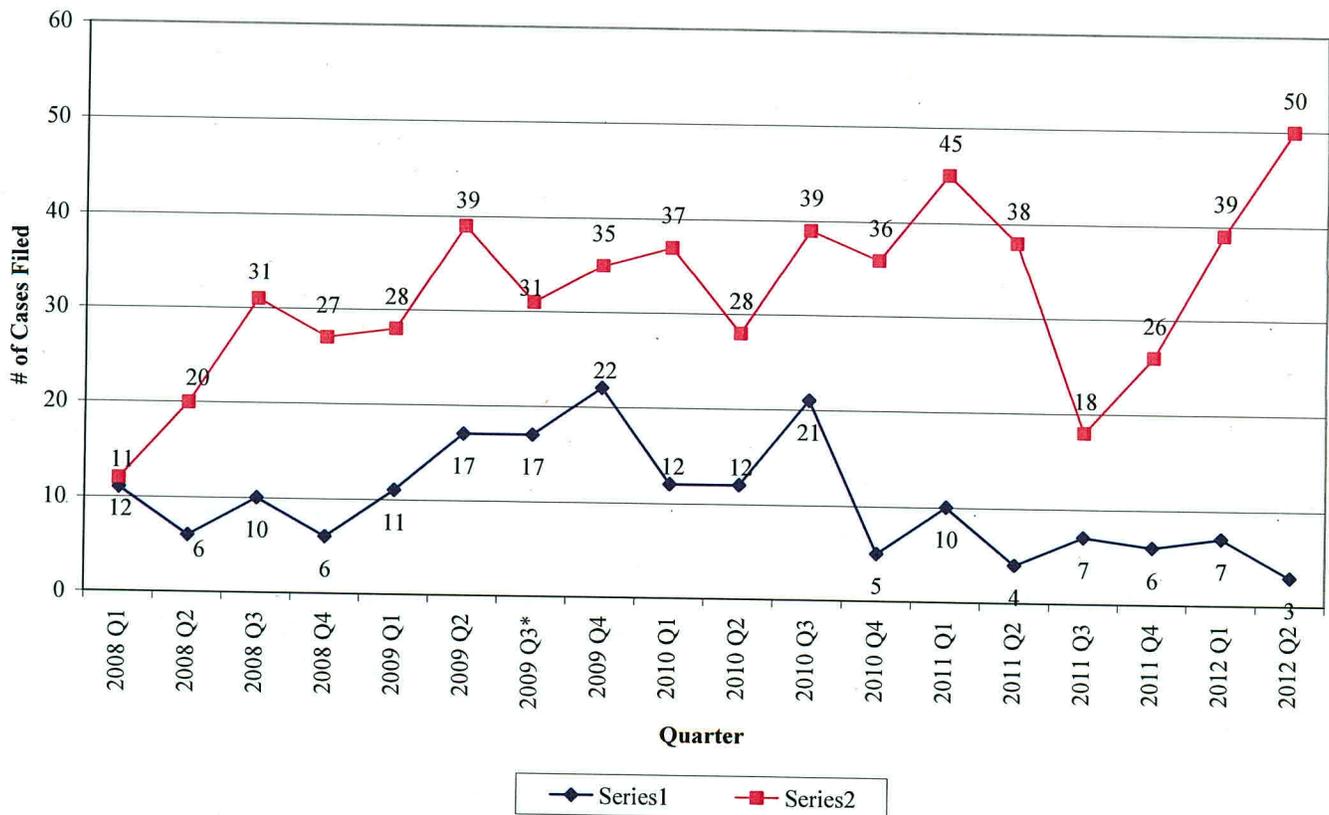
During this quarter, there were 50 appeals filed with the MCE; 16 requested an expedited decision with nine of them meeting criteria. Of these 50 appeals, 27 were resolved (56% of filed appeals), one was withdrawn (2%), and 20 were still pending (42%). In 8 cases (30% of those resolved), the original decision was upheld by the person hearing the appeal, ten cases (37% of those resolved) were reversed, eight were approved by the applicable department/DA/SSA before the appeal meeting (30% of those resolved) and one had a modified decision (3% of those resolved).

Of the 27 appeals that were resolved this quarter, 100% were resolved within the statutory time frame of 45 days; 89% were resolved within 30 days. The average number of days it took to resolve these cases was 14 days. Acknowledgement letters of the receipt of an appeal must be sent within five days; the average was three days.

Of the 50 appeals filed, 34 were filed by beneficiaries (68%), 7 were filed by a representative of the beneficiary (14%) and 9 were filed by the provider (18%). Of the 50 appeals filed, DVHA had 60%, DAAIL had 36%, and DMH had 4%.

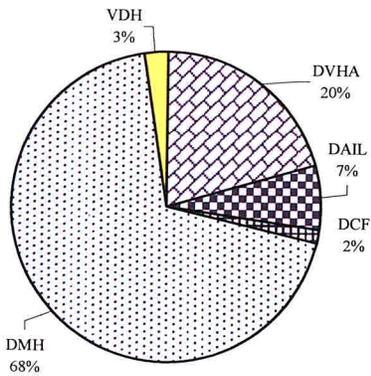
Beneficiaries can file an appeal and a fair hearing at the same time, and they can file a fair hearing if their appeal is not decided in their favor. There were two fair hearing filed this quarter one for DAAIL and one for DVHA.

### Medicaid MCE Grievances & Appeals

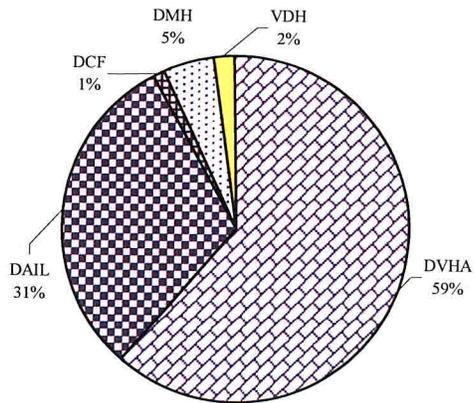


## MCE Grievance & Appeals by Department From January 1, 2008 through June 30, 2012

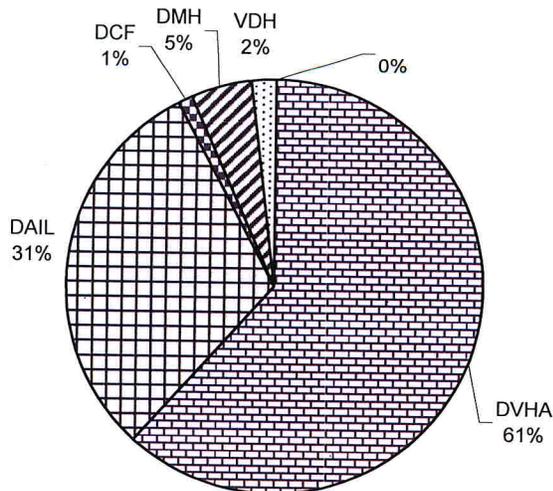
### Grievances



### Appeals



### MCE Appeal Resolutions from January 1, 2008 through June 30, 2012



# OFFICE OF HEALTH CARE OMBUDSMAN

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## QUARTERLY REPORT April 1, 2012 – June 30, 2012

to the  
DEPARTMENT OF FINANCIAL REGULATION  
and the  
DEPARTMENT OF VERMONT HEALTH ACCESS  
submitted by  
Trinka Kerr, Vermont Health Care Ombudsman  
July 13, 2012

### I. Overview

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

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

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

#### **A. Total call volume decreased 7.8% compared to last quarter, but DVHA beneficiary calls increased 12%.**

##### All Calls

The HCO received 717 calls this quarter, compared to 778 in the January to March 2012 quarter, a 7.8% decrease. Call volume was also lower than the same quarter in 2011, when we received 788 calls. Looking back over the last five years, it appears that there has been a drop in calls every second quarter of the calendar year. It is not immediately clear why this might happen.

Access to care calls decreased the most; eligibility calls decreased slightly. Notably, the number of calls from Medicare beneficiaries has been increasing.

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

#### DVHA Beneficiary Calls

We received 345 calls (48.12% of all calls) from individuals on state programs this quarter, compared to 308 calls (39.63% of all calls) last quarter. This is somewhat higher than the usual number and percentage of calls from DVHA beneficiaries. Typically callers on state programs have constituted 35-40% of all calls.

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

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

#### All Calls

1. Affordability 91 (118 last quarter)
2. Complaints about Providers 83 (83)
3. Information about applying for DVHA programs 77 (69)
4. Eligibility for VHAP 66 (74)
5. Eligibility for Medicaid 60 (71)
6. Access to Prescription Drugs 58 (72)
7. Communication Problems with DCF 45 (47)
8. Claim Denials 37 (44)
9. Access to Dental Care, Dentists, Dentures, Orthodontics 37
10. Eligibility for VPharm 32

#### DVHA Beneficiary Calls

1. Complaints about Providers 48 (39 last quarter)
2. Access to Prescription Drugs 29 (21)
3. Eligibility for VHAP 28 (24)
4. Affordability 35 (28)
5. Information about applying for DVHA programs 32
6. Communication Problems with DCF 28 (27)
7. Eligibility for Medicaid 26 (30)
8. Access to Dental Care, Dentists, Dentures, Orthodontics 23 (17)
9. Transportation 24 (29)
10. Fair Hearings 22 (23)

#### **C. The affordability of health care remains an issue.**

We started tracking Affordability as an access issue at the end of 2009, and since then it has been an increasingly common complaint. This quarter we had 91 calls from consumers saying they had problems affording health care (looking at primary and secondary issues), compared to 118 last quarter.

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

- DVHA programs: 35 calls; 3 calls as a primary issue, 32 as a secondary;
- Commercially insured: 21 calls; 4 calls as a primary issue, 17 as a secondary;
- Uninsured: 16 calls; 1 call as a primary issue, 15 as a secondary; and
- In the remaining calls we did not get the caller's insurance status.

**D. The number of complaints about providers remained the same overall, but rose for DVHA beneficiaries.**

The HCO received 83 calls this quarter from consumers having problems with their providers, the same as last quarter. However, the number of complaints from DVHA program beneficiaries increased to 48 from 39. The reasons for these complaints were extremely varied, but included: the provider's decision to no longer treat the individual, rude or inappropriate treatment by medical or administrative staff, failure to provide information or medical records, refusal to provide requested treatment, refusals to help with prior authorizations or appeals, refusals to accept the individual's insurance, breaches of confidentiality, provider mistakes, etc.

**E. Access to dental care grows as a problem, but mainly for DVHA beneficiaries.**

The HCO received 37 calls this quarter, including both primary and secondary issue codes, regarding access to dental care, dentists, dentures, and orthodontists. Last quarter we received 34 such calls.

Of the 24 dental calls coded as primary issues (so no overlap in the data), 17 (71%) were from DVHA beneficiaries. Only two such callers had commercial insurance.

**F. The HCO is poised to get more federal money through the Affordable Care Act.**

On June 25, 2012, DFR and the HCO learned that Vermont was awarded a new grant from the Department of Health and Human Services as a Consumer Assistance Program. This grant money was suddenly available from HHS because two states gave back their CAP funds. HHS issued a Funding Opportunity Announcement at the end of April with a one month turnaround time for this competitive grant which was available only to those states that received the first CAP grant in 2010. The HCO received that 2010 grant, which expired in January. The HCO wrote an application for this limited competition grant with DFR's assistance to expand its online capabilities and develop better outreach and education materials. We were very pleased to win this \$128,000 award, which is for one year. It will enable the HCO to improve its website, create a method for Vermonters to apply for its services online, and easily post more consumer education materials.

In addition, HHS issued another FOA on June 7, 2012, for additional Consumer Assistance Program activities. DFR submitted our application for this grant, which is a request for \$200,000, the small state minimum available. This is also a one year grant, available to all states. If awarded, this grant would allow the HCO to expand its direct consumer assistance with additional staff and to do significantly more outreach and education around the state. The anticipated award date is August 23, 2012.

**G. 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:** 717 calls;
  - **DVHA beneficiaries:** 345 calls or **48%** of total calls;
  - **Commercial plan beneficiaries:** 122 calls or **17%**; and
  - **Uninsured Vermonters:** 58 callers or **8%**.

**II. Green Mountain Care Board and Rate Review Activities**

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

- GMCB meetings
  - Attended thirteen GMCB meetings and listened to one meeting on CD;
  - Attended three monthly meetings with the GMCB executive director, general counsel and health policy director;
  - Made a presentation to the GMCB about the HCO;
  - Attended one GMCB advisory board meeting;
  - Attended one payment reform advisory group meeting;
- Rate review regulations:
  - Attended LCAR meeting on expedited rule on the rate review process
  - Exchanged information with other consumer groups about the section on opportunities for public participation in the draft regulations on the rate review process
  - Participated in stakeholder meeting about proposed permanent rate review regulations
  - Submitted one sets of written comments on proposed permanent GMCB rate review regulations.
- Rate reviews
  - Monitored and reviewed rate review filings on the DFR and GMCB websites;
  - Submitted public comments to DFR on one rate filing (MVP Catamount)
  - Entered appearances and filed memoranda in twelve rate review cases before the GMCB
- National conference calls/state training
  - Community Catalyst call regarding hospitals as community resources and hospital accountability under the ACA
  - Families USA call on rate review and consumer cost education tools
  - Webinar of National Rate Review Meeting Workshop on enhancing consumer transparency and outreach
  - ACA and state health care reform training by Robin Lunge, Vermont Director of Health Care Reform
- Green Mountain Care (GMC) benefits package

- Discussed basic elements of a GMC benefits package, including principles of cost sharing with the Vermont Workers Center, the Vermont chapter of the American Cancer Society, Voices for Vermont's Children and the Vermont Campaign for Health Care Security Education Fund
- Assisted consumers interested in commenting on the GMC benefits package
- Testified at GMCB public hearing on GMC benefits package, and submitted written comments
- Reviewed the DFR and GMCB websites with the Vermont Public Interest Group to prepare comments that would make the consumer information on these sites more complete and user-friendly for consumers.
- Monitored and testified on health care reform legislation, including H. 559 and S. 222.
- Tracked consumer complaints to the HCO hotline about premium rates:
  - 2 complaints about rate increases
  - 7 complaints about premium rates being too high

### III. Hotline call volume by type of insurance:

The HCO received 717 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 **48%** (345 calls), compared to 40% (308) 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 **29%** (206), compared to 25% (198) last quarter;
  - **8% of all callers (58) had Medicare only;**
  - **15% (108) had both Medicare coverage and coverage through a state program** such as Medicaid, a Medicare Savings Program aka a Buy-In program, or VPharm;
  - **3% (18) had a Medicare Supplemental plan;** and
  - The remaining could have had Medicare along with a retiree plan, but our data is not clear on this.
- **Commercial carriers** (employer sponsored insurance, individual or small group plans, and Catamount Health plans) insured **17%** (122), compared to 17% (135) last quarter; and
- **8% (58) identified themselves as Uninsured,** compared to 9% (73) last quarter.
- In the remainder of calls the insurance status was either unknown or not relevant.

### IV. Disposition of cases

#### All Calls

We closed 708 cases this quarter, compared to 786 last quarter.

- 42% (299 cases) were resolved by brief analysis and advice;
- 21% (150) were resolved by brief analysis and referral;

- 18% (130) were resolved by direct intervention, including calling an insurance company, calling providers, writing letters, gathering supporting medical documentation, etc. (these numbers include complex interventions);
- 14% (97) of the cases were complex interventions, which involves complex analysis and more than two hours of an advocate's time;
- 6% (39) of the cases involved appeals; and
- 3% (21) of the cases were resolved in the initial call.
- In the remaining calls clients either withdrew or resolved the issue on their own.

#### DVHA Beneficiary Calls

We closed 337 DVHA cases this quarter, compared to 305 last quarter:

- 39% (132 calls) were resolved by brief analysis and advice ;
- 24% (80 calls) were resolved by brief analysis and referral;
- 32% (107 calls) were resolved by direct intervention on the caller's behalf, including advocacy with DVHA and providers, writing letters, and gathering medical information (these numbers include complex interventions);
- About 15% (52 calls) were considered complex intervention, which involves complex analysis and more than two hours of an advocate's time;
- 7% (24) involved appeals (Fair Hearings); and
- 3% of calls (11) from DVHA beneficiaries were resolved in the initial call.
- In the remaining calls clients either withdrew or resolved the issue on their own.

#### V. Case outcomes

##### All Calls

The HCO prevented 10 insurance terminations or reductions and got 29 individuals onto insurance. We assisted 6 people with applications and estimated the eligibility for state programs for 9 individuals. We got 23 claims paid or written off on behalf of consumers, and obtained coverage for services for 12, totaling a **savings to consumers of \$9,105**. We provided 479 individuals with advice and education.

A recent example of a very successful outcome started with a referral from an Area Agency on Aging. The AAA's client was disabled and living on Social Security Disability Income. He had received multiple claim denials from a Catamount Health plan, a private individual plan for which he received state premium assistance. The denial was due to a pre-existing condition that had disabled the individual the previous year. On his limited income, he was unable to pay the medical bills. The HCO advocate determined that, through two earlier employer-sponsored plans, the individual had in fact had sufficient continuous creditable coverage to avoid the pre-existing condition exclusion. The advocate filed a first level appeal with the requisite certificates of coverage. Within days the plan overturned the denials and paid more than \$2,200 in claims.

Another example of a great outcome as a result of an HCO advocate's work involved an individual whose chronic care manager had recommended a peak flow meter to help monitor the individual's asthma. Our client's commercial plan was requiring her to pay co-insurance for the device, even though preventive services recommended by the plan's chronic care management program were not supposed to have cost-sharing. At first the plan insisted that devices like this

were not part of preventive care. The HCO advocate pressed the carrier, going up the chain of command. Eventually the carrier agreed it should be completely covered for this individual without cost-sharing. More importantly, the carrier agreed to eliminate the cost-sharing for all other plan members in the chronic care management program as well.

### DVHA Beneficiary Calls

We prevented 9 terminations or reductions in coverage for DVHA beneficiaries, and got 3 more onto different DVHA programs. We assisted 2 individuals with applications or reviews. We estimated the eligibility for other programs for 1 DVHA beneficiary. We got 10 claims paid or written off, and obtained coverage for services for 8 individuals. We provided 234 DVHA beneficiaries with advice or education.

## **VI. Issues**

The HCO database allows us to track more than one issue per case, so we can see the total number of calls that involved a particular problem. For example, although only 74 cases had Consumer Education as the primary issue, there were actually a total of 216 calls in which we spent a significant amount of time educating consumers about insurance. See the breakouts of the issue numbers in the individual data reports for a more detailed look at how many callers had questions about issues other than the primary reason for their call.

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

- **25.94%** (186) of our total calls were regarding **Access to Care**;
- **14.92%** (107) were regarding **Billing/Coverage**;
- **.14%** (1) was questions regarding **Buying Insurance**;
- **10.32%** (74) were **Consumer Education**;
- **26.92%** (193) were regarding **Eligibility** for state programs, Medicare and Catamount Health plans; and
- **21.76%** (156) were categorized as **Other**, which includes Medicare Part D, communication problems with providers or plans, accessing medical records, changing providers or plans, enrollment problems, confidentiality issues, and now complaints about rates.

### **A. Access to Care (25.94% of all calls)**

We received 186 calls from individuals for whom the primary issue was difficulty getting specific health care, down from 223 last quarter. The top ten Access to Care issues, out of over 35 codes were, in descending order:

- 31 calls were for problems obtaining Prescription Drugs, not including Medicare Part D, compared to 46 last quarter;
- 24 Dental, Dentists, Dentures or Orthodontic care, compared to 24;
- 22 Transportation to medical appointments, compared to 28;
- 18 Durable Medical Equipment (DME), Supplies and Wheelchairs, compared to 16;
- 12 Affordability of health care, compared to 18;
- 11 Pain Management, compared to 12;

- 10 Specialty Care, compared to 17;
- 9 Mental Health, compared to 11 (not including Substance Abuse);
- 9 Nursing Home, compared to 2 (These calls get referred immediately to the Long Term Care Ombudsman. This increase could be due to a change in VLA's outgoing phone message, although people are sometimes confused about which ombudsman they are trying to call.); and
- 7 Substance Abuse, compared to 7.

#### **B. Billing/Coverage (14.92%)**

We received 107 calls related to primary issues with billing, compared to 105 last quarter. The top six billing related issues were:

- 13 Hospital billing;
- 19 Claim denials by insurers;
- 17 Provider problems;
- 10 Out of state billing for state programs;
- 10 Medicaid and VHAP billing; and
- 8 Medicare billing

#### **C. . Consumer Education (10.32%)**

We received 74 calls in which consumer education was the primary issue, compared to 60 last quarter. The top five consumer education issues were:

- 35 Information about applying for DVHA programs;
- 9 General questions about insurance;
- 8 Catamount programs;
- 4 Fair Hearings; and
- 4 Medicare.

#### **D. Eligibility (26.92%)**

We received 193 calls from individuals for whom eligibility for state programs was the primary issue, as compared to 214 last quarter. The top five issues in this category were:

- 38 Medicaid;
- 34 VHAP;
- 26 Catamount, Premium Assistance, and VHAP-ESIA; and
- 17 Medicaid Spend Down; and
- 12 Buy In Programs (aka Medicare Savings Programs).

#### **E. Other (21.76%)**

We received 156 calls in this category for which the primary issue was categorized as Other, compared to 167 last quarter. The top five issues in this category were:

- 41 Communication/Complaints: Providers;
- 10 Provider error/medical malpractice;

- 9 Access to medical records;
- 6 Info about HCO; and
- 5 DCF ID card problems.

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

<b>All Cases (as of 7/12/12)</b>										
	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
<b>January</b>	241	252	178	313	280	309	240	218	329	282
<b>February</b>	187	188	160	209	172	232	255	228	246	233
<b>March</b>	177	257	188	192	219	229	256	250	281	262
<b>April</b>	161	203	173	192	190	235	213	222	249	252
<b>May</b>	234	210	200	235	195	207	213	205	253	242
<b>June</b>	252	176	191	236	254	245	276	250	286	223
<b>July</b>	221	208	190	183	211	205	225	271	239	95
<b>August</b>	189	236	214	216	250	152	173	234	276	
<b>September</b>	222	191	172	181	167	147	218	310	323	
<b>October</b>	241	172	191	225	229	237	216	300	254	
<b>November</b>	227	146	168	216	195	192	170	300	251	
<b>December</b>	226	170	175	185	198	214	161	289	222	
<b>Total</b>	2578	2409	2200	2583	2560	2604	2616	3077	3209	1589

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

## 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