

State of Vermont
Agency of Human Services

Global Commitment to Health
11-W-00194/1

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

Quarterly Report for the period
April 1, 2013 – June 30, 2013

Submitted Via Email on August 30, 2013

Background and Introduction

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

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

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

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

Implemented October 1, 2005, the Global Commitment converted the (then Office) Department of Vermont Health Access (DVHA), the state's Medicaid organization, to a public Managed Care Entity (MCE). The Agency of Human Services (AHS) pays the MCE a lump sum premium payment for the provision of all Medicaid services in the state (with the exception of the Long-Term Care Waiver, managed separately).

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

An extension effective January 1, 2011, was granted and included modifications based on the following amendments:

2006: inclusion of Catamount Health to fill gaps in coverage for Vermonters by providing a health services delivery model for uninsured individuals.

2007: a component of the Catamount program was added enabling the State to provide a premium subsidy to Vermonters who had been without health insurance coverage for a year or more, have income at or below 200 percent of the Federal Poverty Level (FPL), and who do not have access to cost effective employer-sponsored insurance, as determined by the State.

2009: CMS processed an amendment allowing the State to extend coverage to Vermonters at or below 300 percent of the FPL.

2011: inclusion of a palliative care program for children who are at or below 300 percent of the FPL, and have been diagnosed with life limiting illnesses that would preclude them from reaching adulthood. This program allows children to receive curative and palliative care services such as expressive therapy, care coordination, family training and respite for caregivers.

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

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 eight, covering the period from April 1, 2013 through June 31, 2013.***

Global Commitment to Health Waiver: Renewal

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

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

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

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

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

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

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

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

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

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

Area	Proposed Change	Impact	Hypothesis
Eligibility Expansions	Eliminate VHAP, Catamount Health and ESI Expansion Populations and VScript, Vscript expanded and VHAP pharmacy programs.	Persons under 133% will move to traditional Medicaid and receive a fuller benefit package; persons over 133% will move into commercial products through the Exchange.	Vermont will retain a high rate of insured Vermonters; transition to Affordable Care Act rules will not diminish coverage rates.
ACA Transition	Adopting a "safe harbor" approach to transitioning current Medicaid beneficiaries: those who are due for eligibility recertification in the first three months of 2014 will be deferred for review and distributed throughout the remainder of the calendar year, and all beneficiaries due for review will be held harmless until March 31, 2014 or their review date, whichever is later.	Current Medicaid beneficiaries would not be required to submit any new information until their anniversary date.	Vermont will minimize coverage gaps, and limited to no new administrative burden will be placed on current beneficiaries.
Modified Adjusted Gross Income	Use new MAGI rules for all eligibility determinations as long as it does not adversely impact optional or expansion populations.	Administrative efficiency in eligibility determinations.	Streamlined and standardized rules will result in easier to understand information requests and timelier processing of health care program applications.
Benefits	Within state budget restrictions, expand the current menu of services offered in the Long Term Care Moderate Needs Group. Enhance Hospice Benefits for persons within 12 months of end of life and allow delivery of both palliative and curative care.	Additional flexibility for current long term care service beneficiaries in available service options.	Long term care beneficiaries will remain in their homes longer and delay the need for nursing facility care.

Area	Proposed Change	Impact	Hypothesis
Affordability	Include a state based, sliding scale premium subsidy for persons purchasing on the Exchange up to 300% FPL. Including Medicare premium subsidies for certain individuals who are low income.	To maintain affordability of Vermont programs at a level of expense substantially similar to former VHAP, Catamount and ESI programs.	Vermont will retain a high rate of insured Vermonters; transition to the Affordable Care Act rules will not diminish coverage rates.
Demonstration Consolidation	Consolidate Choices for Care, Dual Eligible Demonstrations and CHIP into GC under one demonstration.	Administrative simplification in the use of one federal regulatory structure for state and provider network.	Administrative efficiencies will be achieved.
Administrative	Streamline CMS reporting, state plan amendment, auditing and other processes as much as possible under the 42 CFR 438 regulatory structures.	Administrative simplification in the use of one federal regulatory structure for state and provider network.	Administrative efficiencies will be achieved.

Enrollment Information and Counts

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

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

Demonstration Population counts are person counts, not member months.

Demonstration Population	Current Enrollees Last Day of Qtr 6/30/2013	Previously Reported Enrollees Last Day of Qtr 3/31/2013	Variance 03/31/13 to 06/30/13
Demonstration Population 1:	145,178	146,690	-1.03%
Demonstration Population 2:	132,125	136,453	-3.17%
Demonstration Population 3:	29,439	29,377	0.21%
Demonstration Population 4:	N/A	N/A	N/A
Demonstration Population 5:	2,748	2,769	-0.76%
Demonstration Population 6:	9,790	9,871	-0.82%
Demonstration Population 7:	109,242	108,099	1.06%
Demonstration Population 8:	30,450	30,236	0.71%
Demonstration Population 9:	7,833	7,962	-1.62%
Demonstration Population 10:	N/A	N/A	N/A
Demonstration Population 11:	36,909	35,775	3.17%

Outreach/Innovation Activities

Member Relations

The DVHA Provider and Member Relations Unit sent “timely access” surveys to 357 randomly selected primary care providers (PCP) with a return request for May 31, 2013; 148 responses were generated which is roughly a 42% return rate. Letters requesting a corrective action plan (CAP) will be mailed to non-compliant providers by August 1, 2013. Each of the 19 providers required to submit a CAP will receive a copy of their returned survey indicating where they failed to meet timely access standards. These providers will be required to return a CAP, demonstrating future efforts that will ensure timely access standards are met, no later than September 1, 2013. Additionally, enrolled PCPs will be outreached regarding access and waiting time requirements via a Banner. This provider education and reminder notice will make reference to relevant sections of the Provider Manual and Medicaid Rule.

Operational/Policy Developments/Issues

Health Benefit Exchange

The State of Vermont continues to make significant progress in establishing the Vermont Health Connect (VHC), a state-based health benefit exchange for individuals and small businesses in Vermont. Contracts have been executed to cover all major exchange functions, including system integration, web portal, premium processing, and call center. Vermont has successfully procured call center services by negotiating an amendment to a current contract with Maximus to continue their Medicaid services and expand to provide services for individual and small employer private Qualified Health Plans (QHP). Vermont continues to implement an ambitious outreach and education campaign and to collaborate with key stakeholders, including insurance carriers, brokers, small business owners, and community partners. Vermont has developed a comprehensive training plan and continues to work across agencies and departments to ensure that roles and responsibilities are clearly defined, business processes are fully mapped and adequate resources are in place to support exchange operations on October 1. Exchange staff have successfully participated in several CMS/CCIIO reviews and has completed Wave 2 testing in preparation for VHC’s launch. Vermont will complete the process of selecting QHPs for the Exchange and enter into contract negotiations with health insurance issuers in mid-July.

Expenditure Containment Initiatives

Vermont Chronic Care Initiative (VCCI)

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

The VCCI uses a holistic approach of evaluating both the physical and behavioral conditions, as well as the socioeconomic issues, that often are barriers to health improvement. The VCCI emphasizes evidence-based, planned, integrated and collaborative care for beneficiaries who exhibit high-prevalence chronic disease states, high-expense utilization, high medication utilization, and/or high emergency room and inpatient utilization. Ultimately, the VCCI aims to improve health outcomes by supporting better self-care utilizing motivational interviewing and techniques to support behavioral change; and lowering health care expenditures through appropriate utilization of health care services. By targeting predicted high cost beneficiaries, resources can be allocated where there is the greatest cost savings opportunity. The VCCI focuses on helping beneficiaries understand the health risks of their conditions; engage in behavioral changes to improve their overall health, and by facilitating access to and effective communication with their primary care and specialty care providers. The intention ultimately is to empower beneficiaries to take

charge of their own health and health care.

The VCCI supports and aligns with other State health care reform efforts, including the Blueprint for Health advance practice medical homes and their local Community Health Teams (CHTs); and staff function as members of these local resource teams. The VCCI expanded services in FY 2012 to include all age groups and all conditions in the population accounting for the top 5% of expenses; as well as those with ambulatory sensitive conditions which adversely impact utilization trends, such as Emergency Department (ED) and inpatient admissions and readmissions. Collaboration with the Blueprint CHT's is designed to facilitate transition between levels of service and reduce redundancies, with VCCI supporting the highest risk population. The VCCI is further expanding service scope in the last quarter FFY 2013 to include High Risk Pregnancy case management services, and subsequently our network of providers will continue to expand as further outlined below.

Embedding the VCCI staff within high volume Medicaid practices and hospitals has supported our ability to increase our direct referral base and facilitate engagement, as beneficiaries are more likely to engage with the VCCI when services are recommended by their primary care provider or at the point of an acute hospital visit where they are often able to meet VCCI staff directly at the point of referral. In FFY 2013 the VCCI expanded embedded locations to ten (10) sites including seven (7) primary care practice sites and three (3) hospitals. All VCCI staff interface with hospital discharge planners and case managers as appropriate, to facilitate transitions in care including to their medical homes. Additionally, the VCCI receives secure FTP site inpatient data daily from four (4) hospitals including Vermont's tertiary care center; as well as an electronic report from one (1) hospital. There are two (2) hospitals with pending requests and four (4) under consideration for expansion.

The VCCI has not been able to schedule staff within the largest FQHC in Chittenden County (Community Health Center Burlington – CHCB) as space is unavailable. However, leadership met with the Medical and Nursing Directors to outline an action plan to assure service coordination with their internal case managers for the highest risk cohort; as well as potential provider access to the VCCI data management system for updates on case management of patients in common. Additional support and collaboration in the last quarter will include VCCI staff participation at the CHCB case management team meetings. In late July the VCCI leadership will meet with FQHC partners in Springfield to identify opportunities to embed VCCI RN staff in high volume sites on a periodic basis to support direct referral and intervention with patients.

Although Vermont's largest hospital and tertiary care facility also does not have dedicated space available for VCCI staff, assignment of a 'hospital liaison' to the facility with the hire of an additional nurse case manager scheduled to start in the last quarter of FY 2013 is anticipated. Embedding staff continues to foster relationships with providers and hospital partners, and to secure direct referral for high risk populations versus utilizing professional staff to perform outreach to eligible populations via 'cold calling'. Experience has demonstrated that direct referral and engagement with patients vs. a telephone introduction to the VCCI enhances engagement and builds trusting relationships to support behavioral change.

Recruitment of skilled nurses at the pay rate available in state government has continued to pose challenges in hiring. As the VCCI has continued to build credibility however, nurses are beginning to view the work as not only exciting and rewarding, but also vital to the future of health care reform in Vermont. Subsequently in the last quarter, the VCCI hired five (5) nurse case managers including two (2) in Rutland, one (1) in St. Johnsbury and two (2) new High Risk Pregnancy nurses. APS Healthcare has had similar recruitment challenges further challenged by a contract renewal process. They subsequently hired 3 nurses during the third quarter, with one starting in the last quarter of FFY 2013.

Pediatric Palliative Care:

The Pediatric Palliative Care Program (PPCP) has been operational for nearly one year and has enrolled over 30 children in multiple statewide locations since inception. The PPCP offers five (5) core services as authorized by the GC waiver to support children and families living with serious and potentially life threatening illness. These services include care coordination, family training, skilled respite, expressive therapy and bereavement services for eligible Medicaid children not expected to live into adulthood.

To continuously improve efforts in this emerging specialty care area, PPCP has developed and implemented an Advisory Committee with representation from service delivery partners, parents/consumers, providers including pediatric palliative care experts, as well as other AHS departments who serve vulnerable children.

Internal partners include AHS/Integrated Family Services (IFS), Department for Children and Families/Children's Integrated Services (CIS) and the Vermont Department of Health (VDH)/Children with Special Health Needs (CSHN). The PPCP nurse case manager is co-located within the VDH/CSHN once per week to facilitate service coordination. Other partners include pediatric palliative care providers at Fletcher Allen Health Care (FAHC) and Dartmouth Hitchcock's Children's Hospitals, as well as primary care pediatric practitioners and pediatric oncologists are new provider partners. Home Health agencies (hospice and palliative care units), the Vermont Ethics Network and the Vermont Family Network are also collaborating service providers and partners.

Advisory Committee sub-committees were formed based on member interest and/or expertise to support our ongoing need for partner input and service transparency: clinical subcommittee, consumer subcommittee and financial/billing subcommittee all of which provide ongoing input and support. Audit tools, updated clinical forms, and satisfaction surveys are all in development and review, with anticipated updates by the end of FFY 2013. VCCI leadership and PPCP case managers met with partners within the Home Health Agencies (HHAs) and the Licensing and Protection Division within the Department of Disabilities, Aging and Independent Living (DAIL). This was to assure internal alignment between DVHA and DAIL on auditing procedures of HHA partners. As a result of meeting, several modifications were made to support quality and alignment among all stakeholders.

The PPCP nurse case manager has had the opportunity to speak about the PPCP to many partners at forums and webinars, including Pediatric Grand Rounds; Vermont Ethics Network annual meeting and Vermont Family Network training.

High Risk Pregnancy

After significant challenge with recruitment and hiring nursing staff with the expertise in high risk pregnancy and women's health, the VCCI successfully hired two (2) highly skilled advance practice nurse practitioners who started their work in planning and developing this new service line in early June. Early efforts include development of a pilot program for the highly engaged community of Franklin County; and assuring coordination and integration with other maternal child health efforts underway in AHS departments including Health (VDH) and Children and Families (DCF). The initiative will also align with the ACA health home effort underway to support individuals with substance abuse disorders (Hub and Spoke) to enhance a healthy pregnancy and delivery. The high risk pregnancy case management program will be centrally administered from DVHA's Williston location and support both the system of care as well as individual case management and care coordination requirements with the obstetric and labor and delivery communities, in alignment with other AHS programs.

APS Contract

The DVHA has contracted with APS Healthcare since 2007 to support the technical and professional case management infrastructure; and data analytical needs required to operationalize the VCCI. DVHA and APS migrated away from the historical model to implement a full risk based contract focused on the top 5% of the population accounting for highest service utilization, without regard for age or diagnosis – as long as the condition and utilization patterns were ‘impactable’. DVHA has found this approach, with its highest cost/highest risk beneficiaries, more effective because VCCI staff are able to communicate directly at the local level with provider, partners, patients and their families.

The change in strategic approach required a different level of support from APS to better align with current needs and healthcare goals. APS now provides enhanced information technology and more sophisticated decision-support tools to assist VCCI (DVHA and APS staff) to outreach the most costly and complex beneficiaries. APS continues to provide supplemental population based reports to support Advance Practice Medical Homes as well as Health Registries outlining gaps in evidence based care for select conditions, consistent with NCQA goals.

The amended contract guaranteed a 2:1 return on investment (ROI) by implementing the enhancements in SFY 2012 and SFY 2013. These results were exceeded by VCCI in 2012 with a demonstrated ROI of \$11.5 million which included the DVHA employed staff expenses. The ROI calculation was consistent with the Blueprint for Health methodology.

In the 3rd quarter of FFY 2013, the APS contract was amended with a one year extension starting July 1, 2013 and ending June 30, 2014. This was necessitated by the DVHA’s desire to assure that VCCI integrates with the newly procured Service Oriented Architecture (SOA) infrastructure which cannot, as a stand-alone solution, meet the operational needs of the VCCI. As part of the overall MMIS procurement, the VCCI will be developing an RFP for care management/case management with a goal of implementation in July of 2014. The requirements gathering process was initiated in the 3rd quarter and will extend into FFY 2014.

In the 3rd quarter, the VCCI via APS data analytics’ team disseminated primary care provider reports on gaps in evidence based care for diabetes, depression and asthma.

In the next contract period, it is anticipated that APS will be developing supplemental analytical reports and tools to support clinical evaluation and policy level decisions, including assessing gaps in clinical treatment for select conditions and impacts of these omitted treatments on utilization patterns.

University of Vermont (UVM) Contract

The DVHA has contracted with the University of Vermont (UVM) for assistance with identifying and implementing quality improvement projects. A clinical performance improvement project (PIP) was developed, focusing on heart failure which is one of the high risk, high cost chronic conditions that VCCI targets. The PIP was designed and implemented according to the CMS PIP requirements for quality outcomes. The PIP addresses the appropriate treatment of heart failure (HF), a progressive chronic condition. HF patients are managed through both APS and VCCI. An important component of outpatient management of HF is appropriate use of evidence-based pharmaceutical treatments. The study design and analysis of the baseline data were completed and submitted for validation to the external quality review organization (EQRO) hired by AHS. DVHA received a validation score of 100%. The PIP was completed and VCCI scored 96%.

Highlights of the Vermont Chronic Care Initiative (Quarter 3 of FFY 2013)

- The VCCI was recognized as one of six states for High Utilizer Program. Anticipate release of the CMS 'Bulletin' with recognition of the VCCI by next quarter.
- VCCI leadership was invited to speak at several public forums to outline program and results, including SIM grantee webinar on successful 'High Utilizer' programs; Center for Health Care Strategies Summit, in partnership with the NGA; and a CMS request to consult with the State of Maryland SIM grantee on the VCCI model.
- Collaborating internally on hub/spoke model using ACA Health Home funding to assure coordinated process for servicing top 5% cohort with SA disorders.
- Contract with APS Healthcare amended with a one year extension to June 30, 2014.
- RFP requirements gathering process initiated with DVHA contractor to support VCCI procurement process for new vendor effective July 1, 2014.
- Hired 5 nurses who started with VCCI between April and June, including in Rutland, and St. Johnsbury field based staff; and two high risk pregnancy case managers in Williston. Also hired a nurse for Burlington who won't begin until mid-August. During the same period the VCCI lost a senior RN case manager to a private insurance company at a significantly higher pay rate, which continues to challenge both recruitment and retention. By the end of the 3rd quarter, the VCCI has 2 remaining vacancies, both in the Barre office.
- A Market Factor analysis for nursing positions remains under consideration; however no time line has been provided for decision making.
- APS vendor hired a key contract position – the Clinical Specialist Liaison – which has been vacant since 12/31/12 due in part to concerns regarding the 6/30/13 contract end date. This individual is scheduled to start in late July. With the new contract in place, APS has also hired 2 additional RNs and is now fully staffed.
- Active VCCI case load for the quarter was 682; with 1324 unique members FFY to-date which is slightly lower than the same reporting period in FFY 2012.
- Completed the Heart Failure (HF) PIP and met goals as established with confirmation of a score of 96% by CMS. The VCCI will continue quality improvement efforts to enhance adherence to evidence based treatment. Data is pending on the cost of gaps in evidence based care to inform potential policy change in pharmacy co-pay.
- Disseminated Diabetes and Depression registries outlining gaps in care for primary care providers statewide. Expanded FTP sites and/or excel tools with partner hospitals for data sharing on emergency department (ED) and inpatient admission to support early notification of patterns of utilization, case assignment and care transitions. Five hospitals are providing data with four using secure FTP sites and 2 additional hospitals exploring this option with internal IT teams to facilitate reduction in ED utilization for ambulatory sensitive conditions; as well as transitions in care post admission.
- The Pediatric Palliative Care Program (PPCP) Advisory Committee launched with 3 active subcommittees formed.
- High Risk Pregnancy staff hired with initial focus on pilot with Franklin VCCI staff and community partners; as well as collaborating with Maternal/Child Health (MCH) partners within VDH to assure operational alignment. Early planning, operational model, clinical and case management tools in development.

Hub and Spoke Initiative: Integrated Treatment for Opioid Dependence:

The Agency of Human Services (AHS) is collaborating with community providers to create a coordinated, systemic response to the complex issues of opioid addictions in Vermont, referred to as the *Hub and Spoke* initiative. This initiative is focused on beneficiaries receiving Medication Assisted Therapy (MAT) for opioid addiction. MAT is the use of medications, in combination with counseling and behavioral therapies, to provide a whole patient approach to the treatment of substance use disorders. Overall health care costs are approximately three times higher among MAT patients than within the general Medicaid population, not only from costs directly associated with MAT, but also due to high rates of co-occurring mental health and other health issues, and high use of emergency rooms, pharmacy benefits, and other health care services.

The *Hub and Spoke* initiative creates a framework for integrating treatment services for opioid addiction into Vermont's state-led *Blueprint for Health (Blueprint)* model, which includes patient-centered medical homes, multi-disciplinary Community Health Teams (CHTs), and payment reforms. Initially focused on primary care, *Blueprint's* goals include improving individual and overall population health and improving control over health care costs by promoting health maintenance, prevention, and care management and coordination.

The two primary medications used to treat opioid dependence are methadone and buprenorphine, with the majority of MAT patients receiving office-based opioid treatment (OBOT) with buprenorphine prescribed by specially licensed physicians in a medical office setting. These physicians generally are not well-integrated with behavioral and social support resources. In contrast, methadone is a highly regulated treatment provided only in specialty opioid treatment programs (OTPs) that provide comprehensive addictions treatment but are not well integrated into the larger health and mental health care systems. To address this service fragmentation, Vermont is developing a state plan amendment to provide Health Home services to the MAT population under section 2703 of the Affordable Care Act. Health Home services include comprehensive care management, care coordination, health promotion, comprehensive transitional care, individual and family support, and referral to community and social support services. State-supported nurses and licensed clinicians will provide the Health Home services and ongoing support to both OTP and OBOT providers.

The comprehensive *Hub and Spoke* initiative builds on the strengths of the specialty OTPs, the physicians who prescribe buprenorphine in office-based (OBOT) settings, and the local *Blueprint* patient-centered medical home and Community Health Team (CHT) infrastructure. Each MAT patient will have an established physician-led medical home, a single MAT prescriber, a pharmacy home, access to existing *Blueprint* CHTs, and access to *Hub* or *Spoke* nurses and clinicians for Health Home services.

Five regional *Hubs* are planned that build upon the existing methadone OTPs and also provide buprenorphine treatment to a subset of clinically complex buprenorphine patients, as well as serve as the regional consultants and subject matter experts on opioid dependence and treatment. *Hubs* will replace episodic care based exclusively on addictions illness with comprehensive health care and continuity of services.

Spokes include a physician prescribing buprenorphine in an OBOT and the collaborating health and addictions professionals who monitor adherence to treatment, coordinate access to recovery supports and community services, and provide counseling, contingency management, care coordination and case management services. Support is provided to *Spoke* providers and their Medicaid MAT patients by nurses and licensed addictions/mental health clinicians, added to the existing *Blueprint* CHTs. Similar to all CHT staff, *Spoke* staff are provided free of cost to MAT patients. Staff are embedded directly in the prescribing

practices to allow more direct access to mental health and addiction services, promote continuity of care, and support the provision of multidisciplinary team care.

Highlights of the Hub and Spoke Initiative (Quarter 3 of FFY 2013)

- The Northwest Hub began taking referrals from regional Spoke providers for patients who needed more intensive services.
- DVHA / Blueprint staff responded to informal questions from CMS on the Health Home State Plan Amendment submitted to CMS the previous quarter.
- Work to engage the Community Health Centers of Burlington and Green Mountain Family Medicine in Rutland in Spoke staffing continues. At present, these are the only two practices not fully participating in the initiative in the first phase of implementation.
- Spoke staffing is now at 18 FTEs.
- Just under 500 Medicaid beneficiaries are receiving MAT services through the Hub serving Chittenden, Franklin, Grand Isle and Addison Counties. This Hub program continued work to occupy a new facility in South Burlington and to manage public concerns about the program site.
- Performance contracts for the Hub programs in Central Vermont, Southeastern Vermont and the Rutland area were executed by ADAP with program start dates of July 1, 2013 and October 2013 respectively for the second and third phases of implementation.
- Spoke staffing plans were developed and approved for Lamoille, Washington, Orange, Windham, and Windham counties with program start dates of July 1, 2013 for the second phase of implementation.

The count of Medicaid beneficiaries, individual Spoke providers, practice sites and staff are:

HSA	Sites	Medicaid Beneficiaries Receiving Buprenorphine MAT	Providers	Spoke FTE Staff	CHT FTE
Bennington	4 Sites: 3 primary care; 1 psychiatry	650	29	3	5.05
Rutland	3 Sites: 1 FQHC, 1 Ob-Gyn, 1 psychiatry	400	9	2	10.65
Addison	0			0	7.5
Chittenden	10 Sites: 6 primary care & 1 FQHC, 1 Ob-Gyn, 1 Pain, 1 DA, 1 Residential			8	32.6
St. Albans	5 Sites: 1 pediatric, 1 Pain/hx, 3			5	6

	primary care/FQHC				
Total	23 Sites	900	35	18	61.8

Manage Substance Abuse Services

DVHA established a Substance Abuse Unit in August 2012 to consolidate its substance abuse services into a single, unified structure and point of contact for prescribers, pharmacists, and beneficiaries. This unit provides seamless and integrated care to beneficiaries receiving Medication Assisted Therapy (MAT) and/or those participating in the *Team Care* program or who have a *Pharmacy Home*. The Substance Abuse Unit coordinates with the *Hub and Spoke* initiative, the Vermont Chronic Care Initiative (VCCI) and the DVHA Pharmacy Unit to provide beneficiary oversight and outreach.

Team Care (formerly called the lock-in program) designates one prescribing physician and one pharmacy (the *Pharmacy Home*) to improve coordination of care and decrease over-utilization and misuse of services by participants. Beneficiaries who exceed certain thresholds for opiates and other controlled substances or who utilize multiple prescribers and pharmacies to obtain controlled substance prescriptions are identified for *Team Care*. All beneficiaries receiving MAT with buprenorphine/Suboxone[®] have a *Pharmacy Home* that dispenses all their prescriptions. In addition to overseeing these programs, the Substance Abuse Unit coordinates and facilitates prescriber reconsideration requests and appeals when prior authorizations for controlled substances are denied.

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

Buprenorphine Program

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

(Figure 1)

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

The total for the three quarters (October 2012- June, 2013) is \$125,301.72 (Figure 2).

(Figure 2)

Buprenorphine Program Payment Summary FFY 2012	
FIRST QUARTER	
Oct-12	\$23,454.82
Nov-12	\$24,081.24
Dec-12	\$16,365
1st Quarter Total	\$63,901.36
SECOND QUARTER	
Jan – 2013	\$9,818.74
Feb – 2013	\$8,341.92
March- 2013	\$13,541.08
2nd Quarter Total	\$31,541.08
Grand Total	\$95,442.44
THIRD QUARTER	
April - 2013	\$14,120.22
May - 2013	\$15,739.28
June - 2013	*(No data at this time)
3rd Quarter Total	\$29,859.28
Grand Total	\$125,301.72

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

340B Drug Discount Program

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

Organizations that qualify under the 340B drug pricing program are referred to as “covered entities”. Only

federally designated Covered Entities are eligible to purchase at 340B pricing and only patients of record of those Covered Entities may have prescriptions filled by a 340B pharmacy.

Covered entities include:

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

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

A legislative report entitled “Expanding Use of 340B Programs” was published January 1, 2005, and its principal recommendation was that in order to maximize 340B participation, Vermont should expand access to 340B through its FQHCs. Vermont has made substantial progress in expanding 340B availability since 2005, including applying for and receiving federal approval that enables the statewide 340B network infrastructure operated by five of the state’s FQHCs.

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

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

- The Vermont Department of Health, for the AIDS Medication Assistance Program, STD drugs programs, and the TB program, all of which are specifically allowed under federal law.

- Planned Parenthood of Northern New England's Vermont clinics
- All of Vermont's FQHCs, operating 41 health center sites statewide
- Central Vermont Medical Center
- Copley Hospital
- Fletcher Allen Health Care
- Gifford Hospital
- Grace Cottage Hospital
- North Country Hospital
- Northeastern Vermont Regional Hospital
- Porter Hospital
- Rutland Regional Medical Center
- Springfield Hospital

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

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

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

Claims are paid at the regular rates and a monthly true-up process calculates the 340B acquisition cost, dispensing fees, savings, and what is owed back to the state with payments due 30 days after the invoices are mailed. Currently, Community Health Pharmacy and its five FQHCs continue to participate. In addition, Northern Tiers Health Center with the in-house Notch Pharmacy, Central Vermont Medical Center, and Fletcher Allen Health Care have all been enrolled with Medicaid since January 2011. In 2012, all of Fletcher Allen's outpatient pharmacies also enrolled. DVHA continues to encourage Medicaid enrollment with the goal of enrolling all eligible and HRSA-enrolled covered entities in Vermont.

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

Safeguards for Overprescribing

While DVHA is confident that prescribers, covered entities, and pharmacies will continue to operate in an ethical and medically-appropriate fashion, the Department of Vermont Health Access (DVHA) has many

controls and processes in place to monitor and prevent overprescribing. These include both the features of our Program Integrity monitoring, and the Drug Utilization Review programs that are vetted through the state's Drug Utilization Review Board.

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

In addition, DVHA's Program Integrity Unit (PIU) performs data-mining activities, which identify potential overpayments and problem claims in all spending categories, including pharmacy claims. For example, one algorithm looked at claims over a 3-year period where the package size is less than one, such as a 0.5 ml dose, and the drug quantity billed appears excessive for the days supplied. It is an error when a pharmacy bills a quantity of 2 and dispenses only one box. After requesting copies of prescriptions from pharmacies or physicians and comparing the number of injections ordered vs. the number billed, the PI unit recouped a total of \$13,118.18 from seven pharmacies.

DVHA's Drug Utilization Review and Program Integrity Unit's programs continue to develop and run data-mining queries to detect improper prescribing, dispensing, and reimbursement. Findings are 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 potential fraud is detected, the Program Integrity unit may refer cases to the Attorney General's Medicaid Fraud and Residential Abuse unit (MFRAU), the Vermont Medical Practice Board, and/or the Secretary of State's Office of Professional Regulations (OPR). Any Program Integrity investigation may also run parallel or in conjunction with any other investigation initiated by MFRAU, Vermont Medical Practice Board and/or OPR. Standard Program Integrity guidelines and protocols are utilized to ensure appropriate steps are taken.

340B Reimbursement and Calculation of Incentive Payment

Determination of Dispensing Fee and Savings Sharing Amounts

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

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

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

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

Because of federal laws prohibiting "duplicate discounts" on Medicaid drug pricing related to the interaction of 340B and manufacturer rebate programs, Medicaid participation in 340B has been limited both in Vermont and nationally. Vermont has put in place an innovative, first in the nation methodology to maximize Medicaid participation in 340B pricing for Medicaid beneficiaries served by eligible prescribers at 340B enrolled covered entities. This methodology can enable substantial expansion participation in 340B. Using the Global Commitment authority, DVHA provides incentive payments to providers for their 340B participation that recognizes the additional administrative burden of the program. Because of the beneficial 340B pricing, both Vermont and CMS benefit from higher 340B covered entity-employed prescriber and Medicaid beneficiary participation in the program. For the reporting period, Vermont has realized \$124,599.70 for Q2 2013 Net Cost savings through Medicaid participation of a relatively small number of eligible covered entities. DVHA is focused on outreach and education of all Vermont covered entities to encourage enrollment in the 340B discount program.

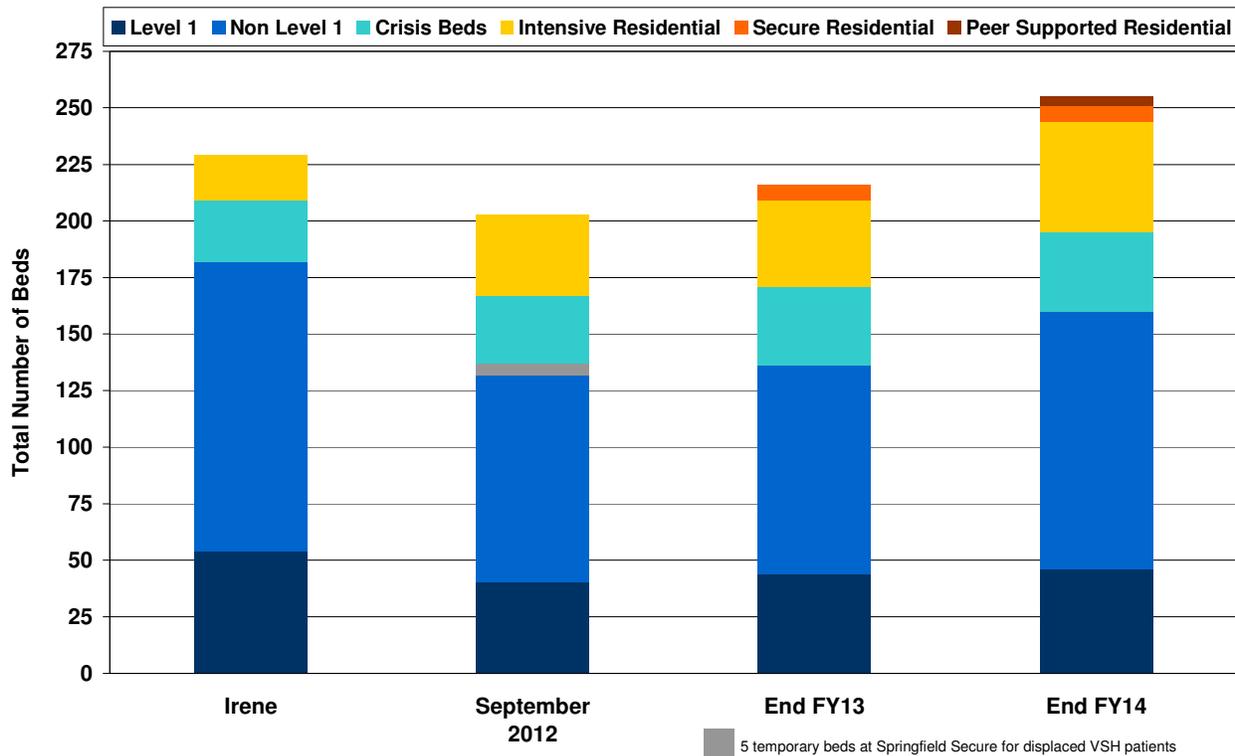
Mental Health System of Care

State Hospital Inpatient Replacement Planning

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

An overview of inpatient psychiatric beds in the system of care Pre-Irene and projected through the end of FY 14 was outlined in the Department's Act 79 report and follows below.

Vermont Department of Mental Health Psychiatric Beds in System of Care



During this period, the Middlesex Therapeutic Community Residence, a secure 7 bed facility opened. The residential program targets individuals who are ready for step down from acute inpatient care, but still require a secure program as a point of transition into the community. Individuals admitted to the facility are placed on orders of non-hospitalization with conditions that include a requirement to reside at this secure program. Residents considered for this residential facility must be reasonably stable in their recovery process as the facility does not routinely employ involuntary emergency procedures in response to behavioral dysregulation. The physical environment maximizes indoor space with quiet areas and ample outside space within secure perimeters.

A care management system, to support patient access and flow into acute care hospitalization or diversion when clinically appropriate and step-down transition from inpatient care, continues in earnest to triage and manage the inpatient needs and system movement. Staffed by department care management personnel, 24/7 admissions personnel of the former state hospital, and monitored by a web-based electronic bed board of inpatient and crisis bed census information that is available to service providers, components of the care management system have been operational with availability of staff and administrators weekdays and 24/7 on weekends throughout this period. Community and inpatient treatment providers have access to these centralized resources to assist with systemic issues or barriers that might arise as an individual moves through the continuum of care. The centralized department function supports timely access to the most acute levels of care and movement to lesser levels of care as quickly as clinically appropriate for individuals, consistent with the statutory directives outlined in Act 79.

Community System Development

Act 79 authorized significant investments in a more robust publicly funded mental health services system for Vermont. Fiscal Year 13 funding supports the implementation of service expansion in several support

and services areas that will offer a stronger continuum of care for the public mental health system. Each new initiative carries reporting requirements to inform the Department of Mental Health (DMH) regarding overall contribution to the system of care and impacts to persons served. A full report of Act 79 funded initiatives and early outcomes were submitted to the Vermont Legislature on January 15, 2013. The report provided an overview of the significant program development areas and preliminary data collection and outcomes findings.

As referenced in last quarter's report, a number of community initiatives were underway:

- As of this reporting period, a statewide peer warm line has been implemented in the evening (8 hours per day) 365 days per year through one of the state's peer operated programs.
- Law enforcement and mobile mental health program trainings focusing on response to individuals with mental illness have continued through a dedicated trainer/facilitator contractor and a cadre of mental health and peer participants.
- An additional 8 bed Intensive Residential Recovery Program will be opening within the next quarter. Site renovations and staff hiring are nearly complete.
- A system "snapshot" of service capacity and utilization was presented to a legislative oversight committee this quarter in order to apprise legislators and key stakeholders of:
 - occupancy rates of both crisis and intensive residential programs;
 - forensic screenings and their outcomes;
 - statewide suicide statistics;
 - stably housing service recipients;
 - intensive residential recovery program occupancy
 - wait times for psychiatric inpatient care from Emergency Departments; and
 - inpatient psychiatric admission and length of stay trends to Designated Hospitals

In areas of future planning, the DMH continues to collaborate with the Department of Corrections, the Divisions of Disability and Aging Services and Vocational Rehabilitation within the Department of Disabilities, Aging, and Independent Living, the Department of Vermont Health Access, and the Division of Alcohol and Drug Abuse Prevention within the Vermont Department of Health in multiple policy and program planning initiatives:

- Service support and access to DOC involved individuals and families either in the community or in correctional facilities
- Mental Health service capacity for older Vermonters
- Service capacity for individuals with both intellectual and mental health disability
- Access to non-categorical case management services
- Technical Assistance to Designated Agencies and Hospitals for complex need individuals
- Health Reform efforts encompassing new State grant opportunities
- Information technology enhancement that will support data collection and reporting capacities

Planning efforts will continue, as well as, the anticipated introduction of additional step-down and treatment/outreach service capacity from new program initiatives and ongoing community services investments.

Integrated Family Services (IFS) Initiative

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

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

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

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

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

- Increased ability to provide the right services to children and their families more immediately.
- Increased ability to provide services in a child's natural setting.
- Increased ability to work with a variety of providers and bring resources together to support families.
- Reduction in separate and conflicting paperwork having a positive impact on the number of hours clinicians can spend on direct services.
- A more immediate response to families who ask for help who, prior to this pilot, were "not sick enough" to meet funding criteria.

- Unified local efforts to offer a single onsite response to families combining multiple state and federal programs that would otherwise be offered at differing times and places.

The financial model supporting this agreement includes a monthly PMPM rate established for the reimbursement of all Medicaid-covered sub-specialty services. Member month rates are based on agreed upon annual allocations for covered services divided by the minimum Medicaid caseload expectation. The same member month rates will be paid for minimal service packages as for intensive service packages. The goal of the funding model is to ensure that beneficiaries get a package of early periodic screening diagnostic and treatment and outreach services commensurate with their functional needs within an overall annual aggregate reimbursement cap. PMPM/Case rates are not based on any one group of services being “loaded” into a claim; they are global aggregate budget/minimum caseload. Annually, providers and the state will reconcile actual financial experience to the grant. This pilot includes two levels of incentives for: 1) caseload, and 2) decreasing utilization and expenditures in intensive more restrictive settings.

This shift continues to be addressed both programmatically and financially. There is a review of the method used to establish the PMPM to see if there is a more effective method. There are currently three other regions interested in undertaking this model with one potentially moving forward FFY 14. It is anticipated that soon after implementing in a few additional regions there will be statewide interest.

Financial/Budget Neutrality Development/Issues

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

AHS selected PMPM rates and sent an IGA for the FFY13 period to CMS on October 4, 2012. AHS worked with CMS throughout QE1212 and into QE0313, toward continued resolution of issues pertaining to approval of the FFY11 and FFY12 IGAs and selected PMPM rates. Vermont would bear a significant retroactive and ongoing financial risk in the event the selected PMPM rates in the IGAs and actuarial certifications for FFY11, FFY12 and FFY13 are not approved as submitted. Resolution of the remaining issues as expeditiously as possible remains a top priority for the State.

Governor Peter Shumlin released his recommended budget for State Fiscal Year 2014 on January 24, 2013. This budget includes the assumption that the Global Commitment waiver will continue beyond 12/31/2013.

AHS worked throughout QE0613 with its actuarial consultant, Milliman, on development of the FFY14 PMPM rate ranges, to include the ACA-related components. AHS anticipates a timely delivery to CMS of the FFY14 IGA and PMPM rate package.

AHS received a deferral notice from CMS for its QE1212 GlobalRx MEG claim on March 28, 2013 and a deferral notice from CMS for its QE0313 GlobalRx MEG claim on June 27, 2013. Vermont has been responsive to CMS and working throughout QE0613 to provide CMS with assurance that the State is claiming appropriate costs for this MEG, so that the Federal Financial Participation for these claims will be released to the State as soon as possible.

Member Month Reporting

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

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

Demonstration Population	Month 1 4/30/2013	Month 2 5/31/2013	Month 3 6/30/2013	Total for Quarter Ending 3rd Qtr FFY '13	Total for Quarter Ending 2nd Qtr FFY '13	Total for Quarter Ending 1st Qtr FFY '13	Total for Quarter Ending 4th Qtr FFY '12	Total for Quarter Ending 3rd Qtr FFY '12	Total for Quarter Ending 2nd Qtr FFY '12
Demonstration Population 1:	48,545	48,375	48,258	145,178	146,690	145,618	145,197	142,952	142,365
Demonstration Population 2:	44,179	44,196	43,750	132,125	136,453	130,969	131,709	132,537	132,285
Demonstration Population 3:	9,890	9,835	9,714	29,439	29,377	29,302	29,326	29,076	28,869
Demonstration Population 4:	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Demonstration Population 5:	914	921	913	2,748	2,769	3,024	2,955	3,012	2,999
Demonstration Population 6:	3,337	3,343	3,110	9,790	9,871	10,063	9,795	9,536	9,646
Demonstration Population 7:	36,420	36,536	36,286	109,242	108,099	106,273	107,004	107,528	106,610
Demonstration Population 8:	10,124	10,118	10,208	30,450	30,236	29,808	29,086	30,939	30,730
Demonstration Population 9:	2,615	2,622	2,596	7,833	7,962	8,101	7,970	7,874	7,889
Demonstration Population 10:	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Demonstration Population 11:	12,141	12,134	12,634	36,909	35,775	36,702	35,797	35,175	33,674

Consumer Issues

The AHS and DVHA have several mechanisms whereby consumer issues are tracked and summarized. The first is through Health Access Member Services. This is a contracted function for providing information on health care programs, assisting with the eligibility process, and helping beneficiaries to understand the benefits and responsibilities of their particular program. The complaints received by Member Services are based on anecdotal weekly reports provided to DVHA (see Attachment 2). Member Services works to resolve the issues raised by beneficiaries, and their data helps DVHA look for any significant trends. The weekly reports are seen by several management staff at DVHA and staff ask for additional information on complaints that may appear to need follow-up to ensure that the issue is addressed.

When a caller is dissatisfied with the resolution that Member Services offers, the Member Services representative explains the option of filing a grievance and assists the caller with that process. It is noteworthy that Member Services receives an average of approximately 25,000 calls a month. Based on the low volume of complaints and grievances received in relation to the quantity of calls, it is an indicator that the system is working well.

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

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

Quality Assurance/Monitoring Activity

Review documents were sent by the EQRO to DVHA for all three EQRO required activities: Performance Improvement Project (PIP) Validation; Review of Compliance with Standards; and Validation of Performance Measures. The AHS Quality Improvement Manager (QIM) participated in a technical assistance call with the EQRO and DVHA to clarify elements contained in the PIP data collection tool. In addition to this call, the AHS QIM attended an educational session conducted by the EQRO for DVHA and IGA partner staff; the purpose of the session was to broadly review the CMS PIP validation protocol and provide guidance on how this protocol might impact the current PIP; the PIP validation tool was completed by DVHA and submitted to the EQRO at the end of the quarter. Feedback and scoring is expected to take place during next quarter.

The AHS QIM has also been engaging DVHA and its IGA partners in broader discussions of Performance/Quality Improvement. In addition to the formal PIP work conducted by DVHA, this discussion also included improvement work that staff are doing using the Agency Improvement Model (AIM). Also, the AHS QIM participated in technical assistance calls with the EQRO and DVHA to prepare for the Performance Measure Validation on-site review. During these calls, it was decided that administrative only measures would be validated by the EQRO this year. Originally, DVHA was to initiate the use of the hybrid methodology for calculating HEDIS rates this calendar year. Due to a lack of vendor capacity, the work was delayed until next year. In addition, the scope of the review was finalized and initial rates were sent to the EQRO along with requested documentation.

In an attempt to leverage this work, the AHS QIM participated in a number of discussions re: the use of performance measures to support separate, yet related, AHS initiatives. Finally, the AHS QIM participated in a number of calls/meetings to clarify the requirements for this year's compliance on-site review. All review documents were posted by the EQRO and completed/reposted by DVHA. The on-site review is scheduled for early next quarter. The AHS QIM also engaged the DVHA Compliance Director in discussions re: the DVHA/Department IGAs. During upcoming quarters, it is expected that the DVHA Compliance Director will begin the work of updating the IGAs.

DVHA Quality Improvement and Compliance

The DVHA Quality Committee went through a restructuring and held two meetings with the new membership. The committee updated the charter which included an increased focus on quality improvement in addition to compliance. The DVHA Quality Committee reports to the AHS Performance Accountability Committee (PAC) on a timeline established by the PAC. The committee worked on the new DVHA Quality Plan and the development of a quality work plan. The new DVHA Quality Plan has been broadened to include quality planning and improvement, and compliance, and is part of the larger DVHA Performance Accountability Plan. The DVHA Quality Committee will include representation from each of the IGA partners and will be the oversight body of quality improvement initiative focusing on

Global Commitment beneficiaries.

The DVHA Compliance Director, the DVHA Quality Improvement Director and the AHS Quality Analyst met several times to develop the DVHA Compliance Plan. The DVHA Compliance Director is responsible for this plan and will report to the DVHA Quality Committee the outcomes of the oversight activities of DVHA and the IGA partners on a regular schedule. The committee will identify areas for improvement and track quality improvement projects.

The DVHA Quality Improvement Director attended the AHS Performance Accountability Committee meetings during this quarter. A performance accountability plan template was developed and distributed to each of the IGA partners. The IGA partners have begun developing the new plans which will include Global Commitment beneficiary specific quality improvement indicators and performance improvement projects. In collaboration with the IGA partners, DVHA will identify the quality indicators that each of the IGA partners will be report to the DVHA Quality Committee.

The Managed Care Medical Committee performed the final review of the Buprenorphine Practice Guidelines and the guidelines were approved. A new provider mapping tool was presented to the committee which will improve the committee's ability to assess access to services. The new tool will provide the committee with data on travel times to PCPs and specialty care providers.

The DVHA performance improvement project "Increasing Adherence to Evidence-based Pharmacy Guidelines for Members Diagnosed with Congestive Heart Failure" was completed during and sent to the EQRO. Two additional performance improvement projects were implemented as part of the CMS Adult Quality Measures grant that was awarded to DVHA. These two projects focus on increasing breast cancer screenings and improving initiation and engagement in alcohol and other substance abuse treatment.

Quality Strategy

The Quality Strategy was posted to the AHS Performance Accountability Committee (PAC) SharePoint site. While no issues with the current Quality Strategy were identified by the members of the PAC, it will be important to review the current plan with the recent CMS documents in mind. It is expected that the PAC will modify the current plan as needed to conform to the new guidance provided by CMS as well compare/contrast the content of the plan with the broader National Quality Strategy as well as the AHS Strategic Plan.

Demonstration Evaluation

The draft evaluation report accompanied Vermont's waiver renewal application. The AHS QIM will continue to work with evaluation staff at the Pacific Health Policy Group (PHPG) through the end of the current waiver period to finalize the evaluation.

Reported Purposes for Capitated Revenue Expenditures

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

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

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

Enclosures/Attachments

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

Attachment 1: Catamount Health Enrollment and Expenditure Report

Attachment 2: Budget Neutrality Workbook

Attachment 3: Complaints Received by Health Access Member Services

Attachment 4: Medicaid Managed Care Entity Grievance and Appeal Reports

Attachment 5: Office of Health Care Ombudsman Report

Attachment 6: DVHA Managed Care Entity Investment Summary

State Contact(s)

Fiscal:	Jim Giffin, CFO VT Agency of Human Services 208 Hurricane Lane Williston, VT 05495	802-871-3005 (P) 802-871-3001 (F) jim.giffin@state.vt.us
Policy/Program:	Stephanie Beck, Director AHS Health Care Operations, Compliance, and Improvement VT Agency of Human Services 208 Hurricane Lane Williston, VT 05495	802-871-3265 (P) 802-871-3001 (F) stephanie.beck@state.vt.us
Managed Care Entity:	Mark Larson, Commissioner Department of VT Health Access 312 Hurricane Lane, Suite 201 Williston, VT 05495	802-879-5901 (P) 802-879-5952 (F) mark.larson@state.vt.us

Date Submitted to CMS: August 30, 2013

ATTACHMENTS

The Department of Vermont Health Access
Caseload and Expenditure Report ~ All AHS Medicaid Spend

All AHS YTD '13
 Friday, August 09, 2013

	SFY '13 Appropriated			SFY '13 Budget Adjustment			SFY '13 Actuals thru June 30, 2013			% of Approp.	% of BAA
	Caseload	Expenses	PMPM	Caseload	Expenses	PMPM	Caseload	Expenses *	PMPM	Spent to Date	Spent to date
ABD Adult	14,445	\$ 171,838,251	\$ 991.36	14,189	\$ 168,678,573	\$ 990.65	14,377	\$ 168,884,494	\$ 978.90	98.28%	100.12%
ABD Dual	17,155	\$ 194,934,351	\$ 946.93	17,215	\$ 192,935,162	\$ 933.93	17,171	\$ 191,152,840	\$ 927.71	98.06%	99.08%
General Adult	11,686	\$ 79,100,241	\$ 564.08	11,614	\$ 73,162,753	\$ 524.96	11,454	\$ 70,921,115	\$ 515.99	89.66%	96.94%
VHAP	38,799	\$ 173,502,508	\$ 372.65	37,340	\$ 159,569,907	\$ 356.12	37,669	\$ 159,312,823	\$ 352.44	91.82%	99.84%
VHAP ESI	810	\$ 2,006,576	\$ 206.35	807	\$ 1,429,801	\$ 147.62	788	\$ 931,973	\$ 98.56	46.45%	65.18%
Catamount	11,440	\$ 62,002,768	\$ 451.65	11,582	\$ 59,153,214	\$ 425.61	11,296	\$ 53,960,735	\$ 398.09	87.03%	91.22%
ESIA	874	\$ 2,270,715	\$ 216.52	766	\$ 1,000,629	\$ 108.80	748	\$ 698,879	\$ 77.83	30.78%	69.84%
ABD Child	3,614	\$ 93,601,570	\$ 2,158.44	3,727	\$ 87,208,278	\$ 1,950.14	3,703	\$ 81,850,572	\$ 1,842.15	87.45%	93.86%
General Child	55,564	\$ 228,797,327	\$ 343.14	55,519	\$ 226,071,854	\$ 339.33	55,447	\$ 209,219,218	\$ 314.44	91.44%	92.55%
Underinsured Child	943	\$ 2,088,216	\$ 184.56	1,029	\$ 2,101,240	\$ 170.14	955	\$ 1,939,902	\$ 169.22	92.90%	92.32%
SCHIP	4,017	\$ 10,358,905	\$ 214.90	4,017	\$ 9,289,125	\$ 192.69	3,952	\$ 10,023,964	\$ 211.39	96.77%	107.91%
	-										
Pharmacy Only	12,698	\$ 4,777,918	\$ 31.36	12,565	\$ (440,929)	\$ (2.92)	12,659	\$ 1,598,693	\$ 10.52	33.46%	-362.57%
Choices for Care	3,758	\$ 198,654,108	\$ 4,405.70	3,859	\$ 203,142,801	\$ 4,387.16	3,884	\$ 196,459,829	\$ 4,214.79	98.90%	96.71%
										93.71%	96.93%
GME							\$ 59,628,783				
Total Medicaid	175,802	\$ 1,223,933,456	\$ 580.17	174,230	\$ 1,183,302,408	\$ 565.97	174,103	\$ 1,206,583,819	\$ 577.53	98.58%	101.97%

* \$59 mil in GME expense was not included in SFY '13 BAA Expenses. The GME expense is excluded from the SFY '13 Actual expense per MEG above, but was reported to CMS in SFY'13

The Department of Vermont Health Access
Caseload and Expenditure Report ~ All AHS Medicaid Spend

All AHS YTD '13

Friday, August 09, 2013

	SFY '13 Appropriated			SFY '13 Budget Adjustment			SFY '13 Actuals thru June 30, 2013			% of Approp.	% of BAA
	Caseload	Expenses	PMPM	Caseload	Expenses	PMPM	Caseload	Expenses *	PMPM	Spent to Date	Spent to date
ABD Adult	14,445	\$ 171,838,251	\$ 991.36	14,189	\$ 168,678,573	\$ 990.65	14,377	\$ 178,956,858	\$ 1,037.29	104.14%	106.09%
ABD Dual	17,155	\$ 194,934,351	\$ 946.93	17,215	\$ 192,935,162	\$ 933.93	17,171	\$ 194,354,293	\$ 943.25	99.70%	100.74%
General Adult	11,686	\$ 79,100,241	\$ 564.08	11,614	\$ 73,162,753	\$ 524.96	11,454	\$ 79,771,934	\$ 580.38	100.85%	109.03%
VHAP	38,799	\$ 173,502,508	\$ 372.65	37,340	\$ 159,569,907	\$ 356.12	37,669	\$ 177,748,055	\$ 393.23	102.45%	111.39%
VHAP ESI	810	\$ 2,006,576	\$ 206.35	807	\$ 1,429,801	\$ 147.62	788	\$ 940,758	\$ 99.49	46.88%	65.80%
Catamount	11,440	\$ 62,002,768	\$ 451.65	11,582	\$ 59,153,214	\$ 425.61	11,296	\$ 53,960,735	\$ 398.09	87.03%	91.22%
ESIA	874	\$ 2,270,715	\$ 216.52	766	\$ 1,000,629	\$ 108.80	748	\$ 699,507	\$ 77.90	30.81%	69.91%
ABD Child	3,614	\$ 93,601,570	\$ 2,158.44	3,727	\$ 87,208,278	\$ 1,950.14	3,703	\$ 83,880,303	\$ 1,887.84	89.61%	96.18%
General Child	55,564	\$ 228,797,327	\$ 343.14	55,519	\$ 226,071,854	\$ 339.33	55,447	\$ 225,987,291	\$ 339.64	98.77%	99.96%
Underinsured Child	943	\$ 2,088,216	\$ 184.56	1,029	\$ 2,101,240	\$ 170.14	955	\$ 1,986,567	\$ 173.29	95.13%	94.54%
SCHIP	4,017	\$ 10,358,905	\$ 214.90	4,017	\$ 9,289,125	\$ 192.69	3,952	\$ 10,023,964	\$ 211.39	96.77%	107.91%
Pharmacy Only	12,698	\$ 4,777,918	\$ 31.36	12,565	\$ (440,929)	\$ (2.92)	12,659	\$ 1,813,724	\$ 11.94	37.96%	-411.34%
Choices for Care	3,758	\$ 198,654,108	\$ 4,405.70	3,859	\$ 203,142,801	\$ 4,387.16	3,884	\$ 196,459,829	\$ 4,214.79	98.90%	96.71%
Total Medicaid	175,802	\$ 1,223,933,456	\$ 580.17	174,230	\$ 1,183,302,408	\$ 565.97	174,103	\$ 1,206,583,819	\$ 577.53	98.58%	101.97%

* \$59 mil in GME expense was not included in SFY '13 BAA Expenses. The GME expense is included in the SFY '13 Actual expense per MEG above, skewing %'s Spent to Date

The Department of Vermont Health Access
Caseload and Expenditure Report ~ DVHA Only Medicaid Spend
DVHA YTD '13

Friday, August 09, 2013

	SFY '13 Appropriated			SFY '13 Budget Adjustment			SFY '13 Actuals thru June 30, 2013			% of Approp.	% of BAA
	Caseload	Expenses	PMPM	Caseload	Expenses	PMPM	Caseload	Expenses *	PMPM	Spent to Date	Spent to Date
ABD Adult	14,445	\$ 100,440,442	\$ 579.46	14,189	\$ 97,260,433	\$ 571.21	14,377	\$ 94,163,879	\$ 545.80	93.75%	96.82%
ABD Dual	17,155	\$ 48,138,865	\$ 233.84	17,215	\$ 46,097,874	\$ 223.14	17,171	\$ 45,022,699	\$ 218.51	93.53%	97.67%
General Adult	11,686	\$ 71,664,326	\$ 511.06	11,614	\$ 65,724,721	\$ 471.59	11,454	\$ 64,228,882	\$ 467.30	89.62%	97.72%
VHAP	38,799	\$ 161,957,523	\$ 347.86	37,340	\$ 148,021,635	\$ 330.34	37,669	\$ 147,517,392	\$ 326.35	91.08%	99.66%
VHAP ESI	810	\$ 2,006,576	\$ 206.35	807	\$ 1,429,801	\$ 147.62	788	\$ 927,939	\$ 98.13	46.24%	64.90%
Catamount	11,440	\$ 62,002,768	\$ 451.65	11,582	\$ 59,153,214	\$ 425.61	11,296	\$ 53,960,735	\$ 398.09	87.03%	91.22%
ESIA	874	\$ 2,270,715	\$ 216.52	766	\$ 1,000,629	\$ 108.80	748	\$ 698,879	\$ 77.83	30.78%	69.84%
ABD Child	3,614	\$ 35,654,068	\$ 822.18	3,727	\$ 29,244,275	\$ 653.96	3,703	\$ 30,764,843	\$ 692.40	86.29%	105.20%
General Child	55,564	\$ 123,109,797	\$ 184.64	55,519	\$ 120,354,228	\$ 180.65	55,447	\$ 114,521,390	\$ 172.12	93.02%	95.15%
Underinsured Child	943	\$ 677,890	\$ 59.91	1,029	\$ 690,513	\$ 55.91	955	\$ 744,344	\$ 64.93	109.80%	107.80%
SCHIP	4,017	\$ 7,598,806	\$ 157.64	4,017	\$ 6,528,240	\$ 135.42	3,952	\$ 7,279,703	\$ 153.52	95.80%	111.51%
Pharmacy Only	12,698	\$ 4,777,918	\$ 31.36	12,565	\$ (440,929)	\$ (2.92)	12,659	\$ 1,598,693	\$ 10.52	33.46%	-362.57%
Choices for Care	3,758	\$ 198,654,108	\$ 4,405.70	3,859	\$ 203,142,801	\$ 4,387.16	3,884	\$ 196,459,829	\$ 4,214.79	98.90%	96.71%
GME							\$ 59,628,783			92.54%	97.39%
Total Medicaid	175,802	\$ 818,953,805	\$ 388.20	174,230	\$ 778,207,433	\$ 372.21	174,103	\$ 817,517,989	\$ 391.30	99.82%	105.05%

* \$59 mil in GME expense was not included in SFY '13 BAA Expenses. The GME expense is excluded from the SFY '13 Actual expense per MEG above, but was reported to CMS in SFY'13

The Department of Vermont Health Access
Caseload and Expenditure Report ~ DVHA Only Medicaid Spend
DVHA YTD '13

Friday, August 09, 2013

	SFY '13 Appropriated			SFY '13 Budget Adjustment			SFY '13 Actuals thru June 30, 2013			% of Approp.	% of BAA
	Caseload	Expenses	PMPM	Caseload	Expenses	PMPM	Caseload	Expenses *	PMPM	Spent to Date	Spent to Date
ABD Adult	14,445	\$ 100,440,442	\$ 579.46	14,189	\$ 97,260,433	\$ 571.21	14,377	\$ 104,236,243	\$ 604.18	103.78%	107.17%
ABD Dual	17,155	\$ 48,138,865	\$ 233.84	17,215	\$ 46,097,874	\$ 223.14	17,171	\$ 48,224,153	\$ 234.04	100.18%	104.61%
General Adult	11,686	\$ 71,664,326	\$ 511.06	11,614	\$ 65,724,721	\$ 471.59	11,454	\$ 73,079,701	\$ 531.69	101.98%	111.19%
VHAP	38,799	\$ 161,957,523	\$ 347.86	37,340	\$ 148,021,635	\$ 330.34	37,669	\$ 165,952,625	\$ 367.13	102.47%	112.11%
VHAP ESI	810	\$ 2,006,576	\$ 206.35	807	\$ 1,429,801	\$ 147.62	788	\$ 936,724	\$ 99.06	46.68%	65.51%
Catamount	11,440	\$ 62,002,768	\$ 451.65	11,582	\$ 59,153,214	\$ 425.61	11,296	\$ 53,960,735	\$ 398.09	87.03%	91.22%
ESIA	874	\$ 2,270,715	\$ 216.52	766	\$ 1,000,629	\$ 108.80	748	\$ 699,507	\$ 77.90	30.81%	69.91%
ABD Child	3,614	\$ 35,654,068	\$ 822.18	3,727	\$ 29,244,275	\$ 653.96	3,703	\$ 32,794,574	\$ 738.08	91.98%	112.14%
General Child	55,564	\$ 123,109,797	\$ 184.64	55,519	\$ 120,354,228	\$ 180.65	55,447	\$ 131,289,464	\$ 197.32	106.64%	109.09%
Underinsured Child	943	\$ 677,890	\$ 59.91	1,029	\$ 690,513	\$ 55.91	955	\$ 791,009	\$ 69.00	116.69%	114.55%
SCHIP	4,017	\$ 7,598,806	\$ 157.64	4,017	\$ 6,528,240	\$ 135.42	3,952	\$ 7,279,703	\$ 153.52	95.80%	111.51%
Pharmacy Only	12,698	\$ 4,777,918	\$ 31.36	12,565	\$ (440,929)	\$ (2.92)	12,659	\$ 1,813,724	\$ 11.94	37.96%	-411.34%
Choices for Care	3,758	\$ 198,654,108	\$ 4,405.70	3,859	\$ 203,142,801	\$ 4,387.16	3,884	\$ 196,459,829	\$ 4,214.79	98.90%	96.71%
Total Medicaid	175,802	\$ 818,953,805	\$ 388.20	174,230	\$ 778,207,433	\$ 372.21	174,103	\$ 817,517,989	\$ 391.30	99.82%	105.05%

* \$59 mil in GME expense was not included in SFY '13 BAA Expenses. The GME expense is included in the SFY '13 Actual expense per MEG above, skewing %'s Spent to Date

Glossary of Terms

PMPM – Per Member Per Month

MEG – Medicaid Eligibility Group

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

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

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

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

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

VHAP – Beneficiaries over age 18 without children who have a household income below 150% FPL or beneficiaries 18 and older with children who have a household income below 185% FPL

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

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

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

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

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

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

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

Global Commitment Expenditure Tracking

QE	Quarterly Expenditures										Net Program PQA	Net Program Expenditures as reported on 64	non-MCO Admin Expenses	Total columns J-K for Budget Neutrality calculation	Cumulative Waiver Cap per 1/1/11 STCs	Variance to Cap under/(over)	
	PQA: WY1	PQA: WY2	PQA: WY3	PQA: WY4	PQA: WY5	PQA: WY6	PQA: WY7	PQA: WY8	PQA: WY9								
1205	\$ 178,493,793										\$ 178,493,793	\$ 178,493,793					
0306	\$ 189,414,365	\$ 14,472,838									\$ 14,472,838	\$ 203,887,203					
0606	\$ 209,647,618	\$ (14,172,165)									\$ (14,172,165)	\$ 195,475,453					
0906	\$ 194,437,742	\$ 133,350									\$ 133,350	\$ 194,571,092					
WY1 SUM	\$ 771,993,518	\$ 434,023									\$ 434,023	\$ 782,159,845	\$ 4,620,302	\$ 786,780,147	\$ 841,266,663	\$ 54,486,516	
1206	\$ 203,444,640	\$ 8,903									\$ 8,903	\$ 203,453,543					
0307	\$ 203,804,330	\$ 8,894,097									\$ 8,894,097	\$ 212,698,427					
0607	\$ 186,458,403	\$ 814,587	\$ (68,408)								\$ 746,179	\$ 187,204,582					
0907	\$ 225,219,267	\$ -	\$ -								\$ -	\$ 225,219,267					
WY2 SUM	\$ 818,926,640	\$ 9,717,587	\$ (68,408)								\$ 9,649,179	\$ 802,884,359	\$ 6,464,439	\$ 809,348,797	\$ 1,684,861,317	\$ 88,732,372	
Cumulative																	
1207	\$ 213,871,059	\$ -	\$ 1,010,348								\$ 1,010,348	\$ 214,881,406					
0308	\$ 162,921,830	\$ -	\$ -								\$ -	\$ 162,921,830					
0608	\$ 196,466,768	\$ 14,717	\$ -	\$ 40,276,433							\$ 40,291,150	\$ 236,757,918					
0908	\$ 228,593,470	\$ -	\$ -	\$ -							\$ -	\$ 228,593,470					
WY3 SUM	\$ 801,853,126	\$ 14,717	\$ 1,010,348	\$ 40,276,433							\$ 41,301,498	\$ 881,729,256	\$ 6,457,896	\$ 888,187,152	\$ 2,484,316,097	\$ 2,604,109,308	\$ 119,793,211
Cumulative																	
1208	\$ 228,768,784	\$ -	\$ -								\$ -	\$ 228,768,784					
0309	\$ 225,691,930	\$ (16,984,221)	\$ 38,998,635	\$ (4,144,041)							\$ 17,870,373	\$ 243,562,303					
0609	\$ 204,169,638	\$ -	\$ 686,851	\$ 5,522,763							\$ 6,209,614	\$ 210,379,252					
0909	\$ 235,585,153	\$ -	\$ 30,199	\$ 34,064,109							\$ 34,094,308	\$ 269,679,461					
WY4 SUM	\$ 894,215,505	\$ -	\$ (16,984,221)	\$ 39,715,685	\$ 35,442,831						\$ 58,174,295	\$ 935,368,819	\$ 5,495,618	\$ 940,864,437	\$ 3,425,180,534	\$ 3,606,430,571	\$ 181,250,037
Cumulative																	
1209	\$ 241,939,196			\$ 5,192,468							\$ 5,192,468	\$ 247,131,664					
0310	\$ 246,257,198			\$ 531,141	\$ 4,400,166						\$ 4,931,306	\$ 251,188,504					
0610	\$ 253,045,787			\$ 248,301	\$ 5,260,537						\$ 5,508,838	\$ 258,554,625					
0910	\$ 252,294,668			\$ (115,989)	\$ (261,426)	\$ 3,348,303					\$ 2,970,888	\$ 255,265,556					
WY5 SUM	\$ 993,536,849	\$ -	\$ -	\$ (115,989)	\$ 5,710,484	\$ 13,009,006					\$ 18,603,501	\$ 1,012,990,839	\$ 5,939,459	\$ 1,018,930,298	\$ 4,444,110,832	\$ 4,700,022,174	\$ 255,911,342
Cumulative																	
1210	\$ 262,106,988			\$ -	\$ 6,444,984						\$ 6,444,984	\$ 268,551,972					
0311	\$ 257,140,611										\$ -	\$ 257,140,611					
0611	\$ 277,708,043					\$ (121,416)					\$ (121,416)	\$ 277,586,627					
0911	\$ 243,508,248					\$ 5,528,143					\$ 5,528,143	\$ 249,036,391					
WY6 SUM	\$ 1,040,463,890	\$ -	\$ -	\$ -	\$ 6,444,984	\$ 5,406,727					\$ 11,851,711	\$ 1,045,342,616	\$ 6,071,553	\$ 1,051,414,168	\$ 5,495,525,000	\$ 5,865,213,737	\$ 369,688,737
Cumulative																	
1211	\$ 253,147,037					\$ (531,744)					\$ (531,744)	\$ 252,615,293					
0312	\$ 267,978,672					\$ 3,742	\$ 49,079				\$ 52,821	\$ 268,031,493					
0612	\$ 302,958,610						\$ 6,393,928				\$ 6,393,928	\$ 309,352,538					
0912	\$ 262,406,131						\$ 7,750,994				\$ 7,750,994	\$ 270,157,125					
WY7 SUM	\$ 1,086,490,450	\$ -	\$ -	\$ -	\$ -	\$ -	\$ (528,002)	\$ 14,194,000			\$ 13,665,998	\$ 1,134,526,550	\$ 5,751,066	\$ 1,140,277,616	\$ 6,635,802,617	\$ 7,113,290,903	\$ 477,488,286
Cumulative																	
1212	\$ 282,701,072					\$ 3,036,447					\$ 3,036,447	\$ 285,737,519					
0313	\$ 285,985,057					\$ 991,340					\$ 991,340	\$ 286,976,397					
0613	\$ 336,946,361						29,814,314	\$ (125,679)			\$ 29,688,635	\$ 366,634,996					
0913											\$ -	\$ -					
WY8 SUM	\$ 905,632,490	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 33,842,100	\$ (125,679)		\$ 33,716,421	\$ 905,506,811	\$ 4,901,889	\$ 910,408,700	\$ 7,546,211,317	\$ 8,450,684,486	\$ 904,473,169
Cumulative																	
1213											\$ -	\$ -					
WY9 SUM	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Cumulative																	
	\$ 7,313,112,468	\$ 10,166,327	\$ (16,042,281)	\$ 79,876,130	\$ 41,153,315	\$ 19,453,990	\$ 4,878,725	\$ 48,036,100	\$ (125,679)	\$ -	\$ -	\$ 7,500,509,095	\$ 45,702,222	\$ -	\$ 7,546,211,317	\$ 8,955,886,798	\$ 1,409,675,481

Complaints Received by Health Access Member Services
April 1, 2013 – June 30, 2013

Eligibility forms, notices, or process	36
ESD Call-center complaints (IVR, rudeness, hold times)	1
Use of social security number as identifiers	0
General premium complaints	5
Catamount Health Assistance Program premiums, process, ads, plans	8
Coverage rules	3
Member services	0
Eligibility rules	0
Eligibility local office	0
Prescription drug plan complaint	0
Copays/service limit	0
Pharmacy coverage	2
Provider issues (perceived rudeness, refusal to provide service, prices) (variety of provider types)	0
Provider enrollment issues	0
Chiropractic coverage change	0
Shortage of enrolled dentists	0
Green Mountain Care Website	1
DVHA	0
<hr/> Total	<hr/> 56



**Grievance and Appeal Quarterly Report
Medicaid MCE All Departments Combined Data
April 1, 2013 – June 30, 2013**

The MCE is composed of various administrative areas within the Agency of Human Services (AHS). These include: the Department of Vermont Health Access (DVHA), the Department for Children and Families (DCF), the Department of Mental Health (DMH), the Department of Disabilities, Aging and Independent Living (DAIL), and the Department of Health (VDH). Also included in the MCE are the Designated Agencies (DA) and Specialized Service Agencies (SSA) that provide service authorizations for DMH and DAIL. Each entity should have at least one assigned grievance and appeal coordinator who enters data into the MCE database. This report is based on data compiled on July 2, 2013, from the centralized database for grievances and appeals that were filed from April 1, 2013 through June 30, 2013.

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

During this quarter, there were 9 grievances filed with the MCE; two were addressed during the quarter and none were withdrawn. Grievances must be addressed within 90 days of filing, so having pending cases at the end of the quarter is to be expected. Acknowledgement letters of the receipt of a grievance must be sent within five days; the average was two days. Of the grievances filed, 88% were filed by beneficiaries, and 11% were filed by other. Of the 9 grievances filed, DMH had 78% and DAIL had 2%. There were no grievances filed for the DVHA, DCF, or VDH during this quarter.

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

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

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

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

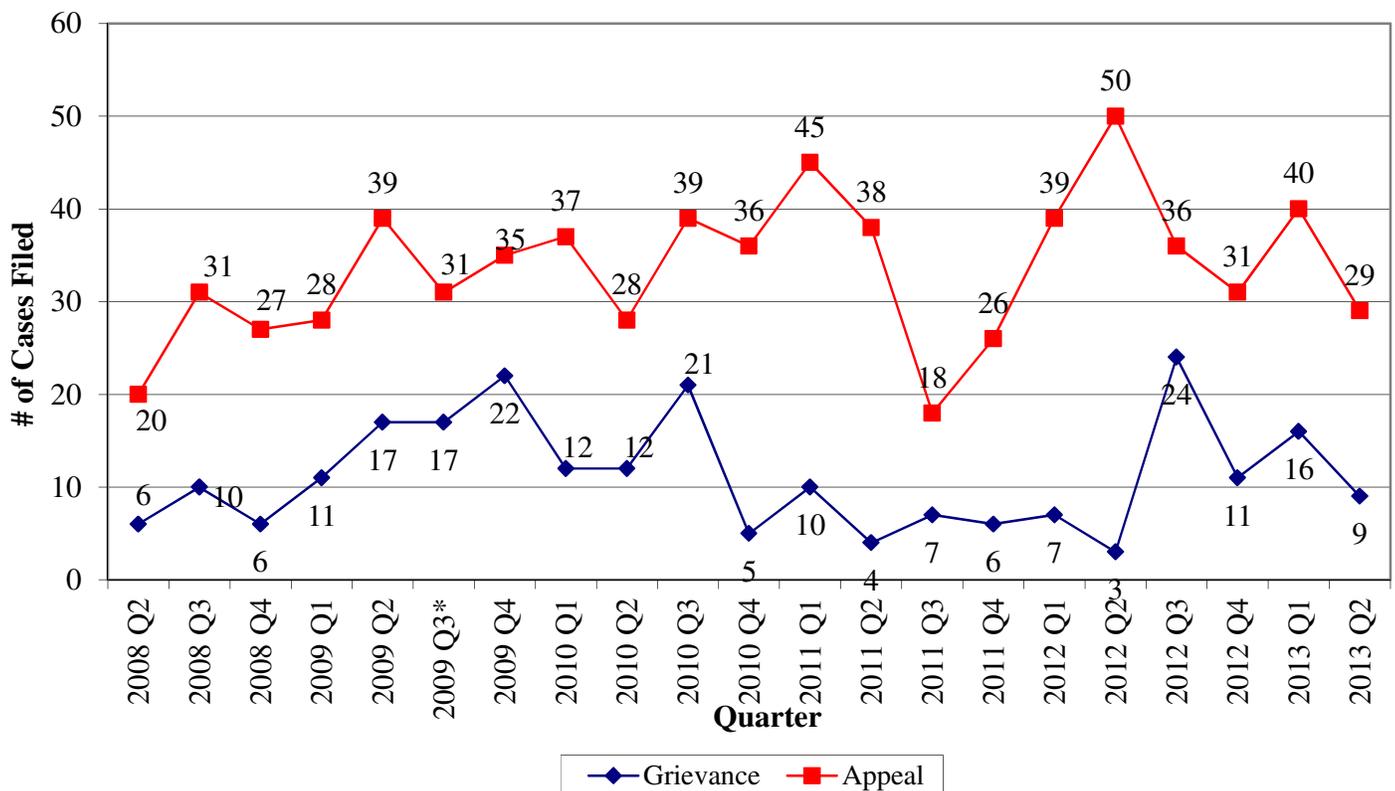
During this quarter, there were 29 appeals filed with the MCE; 7 requested an expedited decision with two of them meeting criteria. Of these 29 appeals, 18 were resolved (62% of filed appeals), 9 were still pending (31%), and two were withdrawn (7%). In three cases (17% of those resolved), the original decision was upheld by the person hearing the appeal, eleven cases (61% of those resolved) were reversed, and four were approved by the applicable department/DA/SSA before the appeal meeting (22% of those resolved).

Of the 18 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 29 appeals filed, 19 were filed by beneficiaries (66%), 7 were filed by a representative of the beneficiary (24%) and 3 were filed by the provider (10%). Of the 29 appeals filed, DVHA had 83%, DAAIL had 7%, VDH had 7% and DMH had 3%.

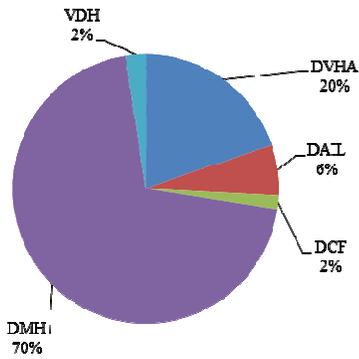
Beneficiaries can file an appeal and a fair hearing at the same time, and they can file a fair hearing if their appeal is not decided in their favor. There were no fair hearings filed this quarter.

Medicaid MCE Grievances & Appeals

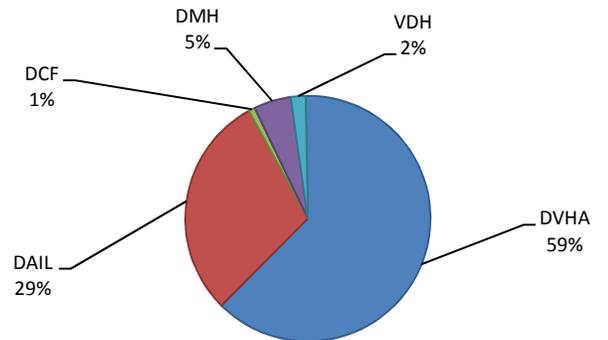


MCE Grievance & Appeals by Department From April 1, 2008 through June 30, 2013

Grievances



Appeals



VERMONT LEGAL AID, INC.

OFFICE OF HEALTH CARE OMBUDSMAN

264 NORTH WINOOSKI AVE.

P.O. BOX 1367

BURLINGTON, VERMONT 05402

(800) 917-7787 (VOICE AND TTY)

FAX (802) 863-7152

(802) 863-2316

OFFICES:

BURLINGTON
RUTLAND
ST. JOHNSBURY

OFFICES:

MONTPELIER
SPRINGFIELD

QUARTERLY REPORT

April 1, 2013 – June 30, 2013

to the

DEPARTMENT OF FINANCIAL REGULATION

and the

DEPARTMENT OF VERMONT HEALTH ACCESS

submitted by

Trinka Kerr, Vermont Health Care Ombudsman

July 17, 2013

I. Overview

This is the Office of Health Care Ombudsman's (HCO) report to the Department of Financial Regulation (DFR) and the Department of Vermont Health Access (DVHA) for the quarter April 1, 2013, through June 30, 2013. In addition to operating a hotline to provide individual consumer assistance, the HCO also does policy work and represents the public in Green Mountain Care Board activities and rate review proceedings.

There are six parts to this report: this narrative section which includes a table of all calls the HCO hotline received, broken out by month and year; a website update; and four data reports. One data report has the HCO statistics for all of the calls. The other three data reports are based on the insurance status of the client at the time the case was initiated, i.e. the client was a commercial plan beneficiary, a DVHA program beneficiary or uninsured. We don't get a caller's insurance status in every case. In the interests of efficiency, sometimes we don't ask if it is not relevant to the caller's issue.

Note that the most accurate information about eligibility for state programs is in the All Calls data report because callers who had questions about the DVHA programs fell into all three insurance status categories.

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

A. Total call volume decreased by 14% from last quarter, but was about the same as the second quarter in 2012.

All Calls

The HCO received 721 calls this quarter, compared to 835 in the first quarter of this year. In 2012 we received 717 calls in the second quarter. In 2011 we received 788, and in 2010, we received 677. April's call volume of 253 was similar to the 252 in April 2012. May's was lower, 228 as compared to 242 last year, and June's was higher, 240 as compared to 223. There was no identifiable reason for the decrease in May.

B. The top issues generating calls

This section includes both primary and secondary issues. The affordability of health care, information about applying for state programs, complaints about providers and access to prescription drugs continue to be the most common reasons for calls

All Calls (721, compared to 835 last quarter)

1. Affordability 116 (compared to 135 last quarter)
2. Information about applying for DVHA programs 113 (112 last quarter)
3. Complaints about Providers 104 (89 last quarter)
4. Access to Prescription Drugs 73 (94 last quarter)
5. Eligibility for VHAP 69 (82 last quarter)
Communication Problems with DCF 69 (69 last quarter)
6. Eligibility for Medicaid 57 (68 last quarter)
7. Access to Mental Health treatment 38 (28 last quarter)
8. Consumer Education about Fair Hearings 31 (35 last quarter)
9. Eligibility for Premium Assistance 30 (50 last quarter)
Transportation to medical care 30 (26 last quarter)
10. Access to Specialty Care 29 (26 last quarter)
11. Consumer Education about Medicare 28 (42 last quarter)
12. Access to Substance Abuse treatment 22 (24 last quarter)
13. Access to Durable Medical Equipment & Supplies 19 (13 last quarter)
14. Access to Dental Care 18 (23 last quarter)
15. DCF Eligibility Mistake 17 (35 last quarter)

DVHA Beneficiary Calls (363, compared to 441 last quarter)

1. Complaints about Providers 56 (55 last quarter)
2. Affordability 49 (57 last quarter)
3. Information about applying for DVHA programs 43 (52 last quarter)
Access to Prescription Drugs 43 (40 last quarter)
4. Communication Problems with DCF 37 (33 last quarter)
5. Eligibility for VHAP 34 (40 last quarter)
6. Fair Hearings 28 (26 last quarter)

7. Transportation to medical care 27 (24 last quarter)
8. Eligibility for Medicaid 25 (38 last quarter)
9. Access to Mental Health treatment 20 (17 last quarter)
10. Access to Specialty Care 16 (18 last quarter)
11. Access to Substance Abuse treatment 15 (17 last quarter)
12. Eligibility for Medicaid Spend Down 13 (13 last quarter)
Medicaid Billing 13 (8 last quarter)

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

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

The high cost of health care continued to be the most-identified barrier to access to health care. The HCO had 116 calls, about 16% of all calls, in which the consumer said that cost was making it difficult for them to get care. This is the same percentage of callers with this problem as last quarter. Of these 116 calls, 49 or 42 % were from DVHA beneficiaries. The inability to access care due to the cost of a service, or the cost of insurance, is an issue for consumers across all groups, those insured by state programs, federal programs, private companies, and the uninsured.

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

The HCO continues to provide consumer education about DVHA programs to a high percentage of callers, which is related to the affordability problem. It was once again the second most common issue overall, with 113 calls. Interest in DVHA's programs is due to a number of factors: the cost of commercial plans and health care generally, the high degree of complexity of the programs which results in questions about the rules and navigating the requirements for eligibility, confusing notices from DCF, and insufficient education provided by DCF eligibility staff or Member Services.

E. Complaints about providers continue, especially from DVHA beneficiaries.

Calls about problems with providers increased to 104 from 89 last quarter, or about 15% of all calls. Of those, 56 calls or 53% were from DVHA beneficiaries, compared to 55 last quarter. The reasons for these calls are varied. They range from claims of rude treatment to medical malpractice.

F. Problems with mental health treatment increased by 36%.

More callers had problems related to mental health care this quarter, 38 calls compared to 28 last quarter. More than half of the callers (22) were on DVHA programs. Although 38 calls is only 5% of All Calls, we decided to look more deeply at the reasons for the calls. This closer examination revealed the following issues:

- 7 callers couldn't get mental health treatment because they were uninsured
- 5 callers couldn't find a psychiatrist
- 4 involved commercial plan denials of residential treatment or inpatient hospitalization
- 4 callers couldn't find a therapist
- 3 couldn't get to MH appointments due to transportation problems
- 2 who had Medicaid and Medicare were having trouble getting care because their therapists did not have the right credentials for Medicare payment
- 2 were going to be discharged from a psych ward in a hospital and needed help finding outpatient care and a place to live
- 2 involved commercial plan denials of psych meds
- 1 wanted help finding care after leaving the Emergency Department of a hospital, which he had visited because he was suicidal
- 1 was having a problem getting psych meds that were court ordered
- 1 wanted help finding aftercare because he was about to leave residential treatment
- 1 wanted to know how to find residential treatment
- 1 wanted help getting Medicaid to pay for an emotional support dog
- 1 wanted help getting an airline to allow her emotional support dog to fly with her
- 1 said her psychiatrist was not managing her medications properly
- 1 had a complaint about the food on the psych ward at a hospital
- 1 complained of treatment at a psych ward at a hospital (he said he was being tortured)

G. More consumers are asking questions about the marketplace.

The HCO is starting to get more callers asking for information about health care reform and what the new marketplace for health benefits in Vermont will mean for them. We are currently coding these cases as "Info re the ACA". This quarter we received 24 such inquiries. Last quarter we received 10. We expect the call volume about the marketplace to increase next quarter and will be adding codes to track new issues as they come up. In addition to receiving more inquiries through our hotline, the HCO's new health care reform section on our website received 47 pageviews, with an average viewing time of 7:56 minutes (which, I am told, is an amazingly long time). See section III below for more information about our website changes.

H. Recommendations to DVHA

- *Ask DCF eligibility workers to return HCO advocate calls promptly.* We have noticed that it seems to be taking longer and longer for eligibility workers and supervisors to get back to us. We try to resolve as many problems as we can without going to Health Care Operations (AOPS), but that is becoming harder to do.

- *Assign designated workers to assist individuals with Medicaid Spenddowns.* This is a repeated request from last quarter, as the processing of spenddowns actually seems to be getting slower. The same number of people called this quarter regarding spenddowns as last quarter, 13. Individuals on spenddowns frequently have problems understanding and navigating the program.
- *Encourage DCF staff and Member Services to make sure their clients understand how the DVHA programs work. Provide applicants and beneficiaries with written materials that explain the programs and checklists.* This is a repeat recommendation from last quarter because we continue to get calls from individuals who are confused about the requirements of the programs.
- *Improve notices to make them readable and clear.* This is also a repeat recommendation from last quarter as the current notices remain a big problem. We recently agreed to comment on the proposed Vermont Health Connect notices, which we are hoping will be more understandable.

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

- A table showing monthly totals for All Calls at the end of this narrative
- Four data reports based on type of insurance coverage:
 - **All calls/all coverages:** 721 calls;
 - **DVHA beneficiaries:** 363 calls or **50%** of total calls;
 - **Commercial plan beneficiaries:** 111 calls or **15%**;
 - **Uninsured Vermonters:** 67 calls or **9%** and
- Health Website Usage Report

II. Green Mountain Care Board activities

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

- Attending nine regular Board meetings and one Board Advisory Committee meeting
- Participating in five meetings of the Accountable Care Organization (ACO) Measures Work Group convened by the Board's Director of Payment Reform and one meeting of the Patient Experience Survey Subgroup. This ACO work group is one of three groups working to support the Board's initiative to establish population-based payment pilots with ACO's. The group has been working to identify standardized measures that will be used for commercial plans and Medicaid to: evaluate the performance of Vermont's Accountable Care Organizations (ACOs), qualify and modify shared savings payments and guide improvements in health care delivery.
- Working with the Board and insurers on legislative revisions of the rate review process.

The Health Care Ombudsman is also a member of the State Innovation Model (SIM) grant steering committee, which held its first meeting this quarter.

Rate Reviews

While there were relatively few rate filings which were ready for review by the Green Mountain Care Board in this calendar quarter, the quarter included the two Vermont 2014 exchange product filings on which the HCO invested substantial time and resources. The HCO filed notices of appearance in ten new rate filing cases, appeared at the two contested hearings for the exchange filings and filed ten memoranda. At the end of June there were ten rate filings pending at either the DFR initial review stage or the DFR recommendation stage of the review process.

The HCO spent most of its time during the quarter reviewing the two filings for products to be offered on the state's health benefit exchange, Vermont Health Connect, by BCBSVT and MVP. These exchange product filings were filed on March 27th.

Due to the complex nature of the exchange filings, the carriers, the HCO and the Board spent much more time than is usual preparing for the hearings prior to DFRs recommendations to the Board. The Board held three pre-hearing conferences for each filing. At the HCO's suggestion, and in advance of the hearings, BCBSVT and MVP provided the HCO and the Board with interrogatories posed by the DFR's contracted actuary to the carriers and with the carriers' responses to these interrogatories.

The MVP exchange filing was complicated by MVP amending its filing to include a pediatric dental benefit as part of the MVP plans. MVP had originally planned to rely on a supplemental dental product but this was not offered.

The HCO worked with its contracted actuary, Allan I. Schwartz of AIS Risk Consultants in Freehold, New Jersey in reviewing the two filings. Mr. Schwartz prepared reports identifying issues with the filings and testified by phone at the June 18, 2013 and June 21, 2013 hearings. He recommended modifications to the rates based on an anticipated decrease in morbidity (health status) for the BCBSVT filing, and reduced medical and pharmacy trend assumptions in the MVP filing.

The Green Mountain Care Board issued its decisions for the exchange filings on July 8th. It modified the rate requests from both carriers. Major factors in the modifications included reduction of the proposed medical trend for MVP, and rate adjustments based on assumed changes in morbidity, reductions in pharmacy trend, and proposed levels of contributions to surplus for both carriers.

The Board's decision in the BCBSVT filing reduced the cost of the non-standard silver copayment plan by 4.3%. The reduction in the BCBS rate due to changes in morbidity was consistent with testimony and arguments supplied by the HCO.

The Board's decision in the MVP filing reduced the proposed rate by 4.7%. DFR had recommended that MVP's medical trend be lowered from 5.2% to 4.8% and the pharmacy trend be unaltered from the requested 5.7%. The HCO had argued that MVP's medical trend should be lowered to 4.7%, and the pharmacy trend lowered to 3.4%. The Board's decision lowered MVP's medical trend to 4.7% and lowered MVP's pharmacy trend to 4.5%.

In other cases, the HCO requested that the Board lower rates in order to make the products more affordable to consumers and to promote access to health care by accepting modifications recommended by DFR and/or by reducing rates beyond DFR's suggested modifications.

- In the TVHP 2013 small group filing, the Board lowered the rates beyond DFR's recommendations as requested by the HCO.
- For MVP's 2013 third and fourth quarter PPO filing, DFR recommended a 2% reduction in the carrier's contribution to surplus. The HCO asked the Board to remove the entire contribution to surplus. The Board removed the entire contribution to surplus, thus lowering the rate.
- In another TVHP filing, the Board agreed with the HCO's request to go beyond the DFR recommendation and lower the requested medical and pharmacy trends to the lowest point in the ranges calculated by DFR's actuary, thus lowering the rate.

The HCO worked with the Vermont Public Interest Research Group (VPIRG), the Vermont Campaign for Health Care Security and AARP to explain the public comment process for the two exchange rate filings and the proposed rate increase for Catamount Health. The HCO also persuaded the Board to extend the exchange filings public comment period for an additional week.

The HCO added additional staff to work on rate reviews this quarter. A law school intern, Kroopa Desai, began working with staff attorneys Lila Richardson and Kaili Kuiper in late May. She has assisted with research, writing memoranda and hearing preparation for rate review cases, particularly the two filings for the exchange.

III. Website update

This is a new section of our quarterly report. The HCO currently has funding from the federal government through the Affordable Care Act to update its website. The new website is under development, and we expect to launch it within the next few weeks. All of the health contents from the current site have been reviewed, revised or deleted and new contents have been created. Great efforts have been made to enhance consumer experience with the site, including improved search and navigation functions. A new platform and underlying structure will help us to obtain more accurate and specific information about website usage via Google Analytics. The new site is device-responsive, which means that the 12% of visitors who access

our site from mobile devices will find a site that is both readable and navigable on those devices.

We received 1,766 health-related views to the Vermont Law Help website this quarter, compared to 490 for the same period last year, an increase of more than 260%. Vermont Law Help is Vermont Legal Aid and Law Line's current joint website, which includes a Health section. The average time viewers spent on a health page increased by more than 12% over last year. The number of health pageviews resulting from Google searches increased from 16 to 80, a 400% gain. We also are developing a new section on health care reform. That page received 47 pageviews, with 7:56 minutes average time on a page. We expect even greater viewing increases after we launch the new site and further improve the health care content.

[See the attached report called Health Website Usage Report for more detail.]

IV. Hotline call volume by type of insurance:

The HCO received 721 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 **50%** (363 calls), compared to 53% (440) 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%** (209), compared to 30% (249) last quarter;
 - **Commercial carriers** (employer sponsored insurance, individual or small group plans, and Catamount Health plans) insured **15%** (111), compared to 16% (133) last quarter; and
 - **Uninsured** callers made up **9%** (67) of the calls, compared to 10% (84) last quarter.
 - In the remainder of calls the insurance status was either unknown or not relevant.

V. Disposition of closed cases

All Calls

We closed 745 cases this quarter, compared to 813 last quarter.

- 33% (245 cases) were resolved by brief analysis and advice;
- 24% (179) were resolved by brief analysis and referral;
- 20% (146) of the cases were complex interventions, which involves complex analysis, usually direct intervention, and more than two hours of an advocate's time;
- 15% (109) were resolved by direct intervention, including calling an insurance company, calling providers, writing letters, gathering supporting medical documentation, etc.;
- 5% (34) of the cases were resolved in the initial call.

- In the remaining cases, clients withdrew, resolved the issue on their own, or had some other outcome
- Appeals: 49 cases involved help with appeals.

DVHA Beneficiary Calls

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

- 28% (109 cases) were resolved by brief analysis and advice;
- 26% (100) were resolved by brief analysis and referral;
- 20% (80) were considered complex intervention, which involves complex analysis, usually direct intervention, and more than two hours of an advocate's time;
- 20% (79) were resolved by direct intervention on the caller's behalf, including advocacy with DVHA and providers, writing letters, and gathering medical information;
- 3% of calls (11) from DVHA beneficiaries were resolved in the initial call.
- In the remaining cases, clients withdrew, resolved the issue on their own, or had some other outcome.
- Appeals: 31 cases involved help with DVHA program appeals, of which 6 were internal MCO appeals and 25 were Fair Hearings. In addition, two DVHA beneficiaries, who had Medicaid as secondary coverage, had external reviews through DFR because their primary insurance denied coverage for a service.

VI. Case outcomes

All Calls

The HCO helped 43 people get insurance and prevented 24 insurance terminations or reductions. We obtained coverage for services for 29 people. We got 21 claims paid, written off or reimbursed. We assisted 4 people complete applications for DVHA programs and estimated program eligibility for 24 more. We provided billing assistance to 18 individuals. We obtained patient assistance for 2 people. We provided 381 individuals with advice and education. We obtained other access or eligibility outcomes for 59 more people, many who will be approved for medical services and state insurance. We encourage clients to call us back if they are subsequently denied insurance or a medical service. In total, this quarter the **HCO saved individual consumers \$23,299.31.**

DVHA Beneficiary Calls

The HCO prevented 22 terminations or reductions in coverage for DVHA beneficiaries, and got 7 more people onto different DVHA programs. We estimated the eligibility for other programs for 7 DVHA beneficiaries. We got 11 claims paid, written off or reimbursed. We got other billing assistance for 10 people, and hospital patient assistance for 1 individual. We obtained coverage for services for 23 individuals. We provided 192 DVHA beneficiaries with advice or education, and obtained other access or eligibility outcomes for 41 more people.

Case examples

Helped a working individual stay insured and maximized his coverage, allowing him to continue his substance abuse treatment and his employment. When Mr. A learned he was losing his VHAP because his employer had failed to return a form, he contacted the HCO for assistance. His HCO advocate learned that DCF had in fact already received the form. However, DCF then determined that Mr. A was actually over income for VHAP due to a pay increase. This meant he would go onto premium assistance for Catamount (CHAP). The HCO advocate assured that Mr. A would receive continuing coverage during the transition to the new plan. In addition, the advocate recommended that Mr. A enroll in the Catamount Blue Chronic Care Management Program so he could continue to get his daily substance abuse treatment. Without CCMP he would have had a copayment of \$15 a day for his treatments. The advocate helped him enroll in the CCMP. Mr. A called the advocate back later because the CCMP enrollment had not been completed as expected. The advocate was able to get him enrolled in the CCMP and have it backdated so that the treatment clinic could be paid, as it had been treating Mr. A without payment for six weeks. This saved Mr. A \$660.

Helped a consumer resolve a dispute over two deductibles so she could afford her medication. Mrs. B had employer sponsored insurance (ESI). She needed an extremely expensive prescription medication. Her ESI group plan was renewed on January 1st and included a \$3,000 deductible. Because of the high deductible, Mrs. B could not afford her medication. She was able to get assistance from a foundation to help pay for the medication in January. However, in February the carrier renewed the plan again, saying it had to do so because of the new state-mandated out of pocket prescription maximum. The new plan included a new deductible set at \$2,500. This meant that the insurer expected Mr. and Mrs. B to meet another annual deductible, or two deductibles in the space of two months. The foundation which had assisted them earlier would not help with two deductibles in the same year. The carrier refused to apply the previous deductible payment to the new deductible. After trying to solve the problem on her own for two months, Mrs. B called the HCO for help. The HCO advocate advised her to file a complaint against the carrier through DFR, and helped her file it. Within a month the carrier agreed to apply the first deductible to the second contract, saving Mr. and Mrs. B \$2,125.

Identified and resolved a coordination of benefits problem so a child could get his medication. The mother of C called the HCO because she was having trouble getting a specialty medication for him. The medication had to be special ordered for overnight mail delivery. C had both ESI through his mother and Dr. Dynasaur. His mother's employer switched carriers and plans on January 1st. The new primary insurer's mail order pharmacy did not work properly with the Dr. Dynasaur, and C's mother was charged a copayment of about \$1,000. For two weeks she tried to figure out what the problem was. Everywhere she turned she got different and conflicting answers. Eventually she called the HCO. The HCO advocate investigated and learned that the issue was that the ESI plan's specialty pharmacy was not contracted with Vermont Medicaid. Working with DVHA, the HCO was able to resolve the problem so that the family could get the medication. The ESI paid first and Dr. Dynasaur paid the coinsurance. This saved C's mother \$1,000.

Got an uninsured individual in severe pain onto insurance quickly. D called the HCO following an emergency room visit the previous week. At the time of the ER visit, D was in extreme pain, which he later learned was due to a kidney stone. The ER physician referred him to a urologist for specialized care to resolve the underlying problem. Though in considerable pain, D was delaying the urology appointment because he was uninsured and could not afford it. D told the HCO he had been uninsured for seven years and had never heard of Green Mountain Care. The HCO advocate explained that he should be eligible for VHAP and helped him file an online application. Within three days Mr. D was enrolled in VHAP-Limited and able to get an appointment.

VII. Issues

The HCO divides calls into five issue categories. The breakout by issue category in this quarter based on the caller's primary issue was as follows. [See the DVHA data report for a similar breakdown for the DVHA beneficiaries who called us.]

- **29.40%** (212) of our total calls were regarding **Access to Care**;
- **13.18%** (95) were regarding **Billing/Coverage**;
- **.55%** (4) were questions regarding **Buying Insurance**;
- **9.15%** (66) were **Consumer Education**;
- **24.27%** (175) were regarding **Eligibility** for state programs, Medicare and Catamount Health plans; and
- **23.44%** (165) were categorized as **Other**, which includes Medicare Part D, communication problems with providers or plans, access to medical records, changing providers or plans, enrollment problems, confidentiality issues, and complaints about insurance premium rates.

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 175 cases had Eligibility as the primary issue, there were actually a total of 334 calls in which we spent a significant amount of time assisting consumers regarding access to health 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.]

VIII. Table of all calls by month and year

All Cases

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
January	241	252	178	313	280	309	240	218	329	282	289
February	187	188	160	209	172	232	255	228	246	233	283
March	177	257	188	192	219	229	256	250	281	262	263
April	161	203	173	192	190	235	213	222	249	252	253
May	234	210	200	235	195	207	213	205	253	242	228
June	252	176	191	236	254	245	276	250	286	223	240
July	221	208	190	183	211	205	225	271	239	255	
August	189	236	214	216	250	152	173	234	276	263	
September	222	191	172	181	167	147	218	310	323	251	
October	241	172	191	225	229	237	216	300	254	341	
November	227	146	168	216	195	192	170	300	251	274	
December	226	170	175	185	198	214	161	289	222	227	
Total	2578	2409	2200	2583	2560	2604	2616	3077	3209	3105	1556

Investment Criteria #	Rationale
1	Reduce the rate of uninsured and/or underinsured in Vermont
2	Increase the access of quality health care to uninsured, underinsured, and Medicaid beneficiaries
3	Provide public health approaches and other innovative programs to improve the health outcomes, health status and quality of life for uninsured, underinsured, and Medicaid-eligible individuals in Vermont
4	Encourage the formation and maintenance of public-private partnerships in health care, including initiatives to support and improve the health care delivery system.

SFY12 Final MCO Investments

8/21/12

MCO Investment Expenditures

Criteria	Department	Investment Description
2	DOE	School Health Services
4	GMCB	Green Mountain Care Board
2	BISHCA	Health Care Administration
2	VVH	Vermont Veterans Home
2	VSC	Health Professional Training
2	UVM	Vermont Physician Training
3	VAAFM	Agriculture Public Health Initiatives
2	AHSCO	Designated Agency Underinsured Services
4	AHSCO	2-1-1 Grant
2	VDH	Emergency Medical Services
2	VDH	TB Medical Services
3	VDH	Epidemiology
3	VDH	Health Research and Statistics
2	VDH	Health Laboratory
4	VDH	Tobacco Cessation: Community Coalitions
3	VDH	Statewide Tobacco Cessation
2	VDH	Family Planning
4	VDH	Physician/Dentist Loan Repayment Program
2	VDH	Renal Disease
4	VDH	Vermont Blueprint for Health
4	VDH	Area Health Education Centers (AHEC)
4	VDH	Community Clinics
4	VDH	FQHC Lookalike
4	VDH	Patient Safety - Adverse Events
4	VDH	Coalition of Health Activity Movement Prevention Program (CHAMPPS)
2	VDH	Substance Abuse Treatment
4	VDH	Recovery Centers
2	VDH	Immunization
2	VDH	DMH Investment Cost in CAP
4	VDH	Poison Control
4	VDH	Challenges for Change: VDH
3	VDH	Fluoride Treatment
4	VDH	CHIP Vaccines
2	DMH	Special Payments for Treatment Plan Services
2	DMH	MH Outpatient Services for Adults
4	DMH	Mental Health Consumer Support Programs
2	DMH	Mental Health CRT Community Support Services
2	DMH	Mental Health Children's Community Services
2	DMH	Emergency Mental Health for Children and Adults
2	DMH	Respite Services for Youth with SED and their Families
2	DMH	Recovery Housing
4	DMH	Challenges for Change: DMH
2	DMH	Seriously Functionally Impaired
2	DMH	Acute Psychiatric Inpatient Services
4	DVHA	Vermont Information Technology Leaders/HIT/HIE
4	DVHA	Vermont Blueprint for Health
1	DVHA	Buy-In
1	DVHA	HIV Drug Coverage
1	DVHA	Civil Union
2	DVHA	Patient Safety Net Services
2	DCF	Medical Services
2	DCF	Residential Care for Youth/Substitute Care
2	DCF	Aid to the Aged, Blind and Disabled CCL Level III
2	DCF	Aid to the Aged, Blind and Disabled Res Care Level III
2	DCF	Aid to the Aged, Blind and Disabled Res Care Level IV
2	DCF	Essential Person Program
2	DCF	GA Medical Expenses
2	DCF	CUPS/Early Childhood Mental Health
2	DCF	Therapeutic Child Care
2	DCF	Lund Home
2	DCF	GA Community Action
3	DCF	Prevent Child Abuse Vermont: Shaken Baby
3	DCF	Prevent Child Abuse Vermont: Nurturing Parent
4	DCF	Challenges for Change: DCF
2	DCF	Strengthening Families
2	DCF	Lamoille Valley Community Justice Project
2	DDAIL	Mobility Training/Other Svcs.-Elderly Visually Impaired
2	DDAIL	DS Special Payments for Medical Services
2	DDAIL	Flexible Family/Respite Funding
4	DDAIL	Quality Review of Home Health Agencies
4	DDAIL	Support and Services at Home (SASH)
2	DOC	Intensive Substance Abuse Program (ISAP)
2	DOC	Intensive Sexual Abuse Program
2	DOC	Intensive Domestic Violence Program
2	DOC	Community Rehabilitative Care
4	DOC	Challenges for Change: DOC