

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
October 1, 2012 – December 31, 2012

February 27, 2013

Background and Introduction

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

The state of Vermont is a national leader in making affordable health care coverage available to low-income children and adults. Vermont was among the first states to expand coverage for children and pregnant women, through the 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).

A Global Commitment to Health Waiver Amendment, approved October 31, 2007 by CMS, allowed Vermont to implement the Catamount Health Premium Subsidy Program with the corresponding commercial Catamount Health Plan (implemented by state statute October 1, 2007) for incomes up to 200 percent of the FPL. The intent of this program is to reduce the number of uninsured citizens of Vermont. The Catamount Plan is a health insurance product offered in cooperation with Blue Cross Blue Shield of Vermont and MVP Health Care that provides comprehensive, quality health coverage at a reasonable cost regardless of how much an individual earns. Subsidies are available to those who fall at or below 300 percent of the FPL. On December 23, 2009 a second amendment was approved that allowed Federal participation for subsidies up to 300 percent of the FPL, and allowed for the inclusion of Vermont's supplemental pharmaceutical assistance programs in the Global Commitment to Health Waiver. Renewed January 1, 2011 the current waiver continues all of these goals.

CMS approved an amendment to Vermont's 1115 Demonstration, effective August 1, 2012, with a June 27, 2012 reissue date which provided Vermont with the authority to: 1) Eliminate the \$75 inpatient admission co-pay; and 2) Implement nominal co-payments for the Vermont Health Access Plan (VHAP) population as long as they do not exceed the co-payments charged to the state plan populations under the Medicaid State Plan. Premiums and Co-Payments for the Demonstration Populations were removed from the body of the Demonstration document and are now included as Attachment C.

The Global Commitment provides the state with the ability to be more flexible in the way it uses its Medicaid resources. Examples of this flexibility include new payment mechanisms (e.g., case rates, capitation, combined funding streams) rather than fee-for-service, to pay for services not traditionally

reimbursable through Medicaid (e.g., pediatric psychiatric consultation) and investments in programmatic innovations (e.g., the Vermont Blueprint for Health). The managed care model also requires inter-departmental collaboration and reinforces consistency across programs.

One of the Terms and Conditions of the Global Commitment Waiver requires the State “to submit progress reports 60 days following the end of each quarter. *This is the first quarterly report for waiver year eight, covering the period from October 1, 2012 through December 31, 2012.*

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 12/31/2012	Previously Reported Enrollees Last Day of Qtr 9/30/2012	Variance 09/30/12 to 12/31/12
Demonstration Population 1:	48,613	48,493	0.25%
Demonstration Population 2:	43,351	43,636	-0.65%
Demonstration Population 3:	9,623	9,601	0.23%
Demonstration Population 4:	N/A	N/A	N/A
Demonstration Population 5:	1016	961	5.72%
Demonstration Population 6:	3,299	3,266	1.01%
Demonstration Population 7:	35,138	35,711	-1.60%
Demonstration Population 8:	9,981	9,922	0.59%
Demonstration Population 9:	2,697	2,716	-0.70%
Demonstration Population 10:	N/A	N/A	N/A
Demonstration Population 11:	12,291	12,150	1.16%

Outreach/Innovation Activities

Member Relations

The DVHA Provider and Member Relations Unit developed two new survey tools designed to assess network adequacy and member satisfaction. Both surveys will be sent to a random list of members and providers in February and March 2013. Information will be collected about appointment wait times, travel distances, waiting room wait times and the overall member satisfaction with the provider network. For members who use Medicaid transportation services, additional questions will be sent to assess satisfaction with the transportation service.

Operational/Policy Developments/Issues

Health Benefit Exchange

Vermont continued to make significant progress in development of its Health Benefits Exchange. Vermont participated in a Design Review on October 1-2, 2012, and on November 7, 2012 submitted an application for approval to operate a state-based Exchange. Exchange staff finalized an outreach and education plan, and continued stakeholder engagement through an advisory board, public forums, and other outreach activities. Vermont launched an informational website for Vermont Health Connect at vermonthhealthconnect.gov. On November 14, 2012, Vermont also submitted an application for a Level One Establishment Grant, primarily to fund the operation of a program to provide in-person assistance to Vermonters in enrolling in plans offered on the Exchange. A Request for Proposal (RFP) was released for health insurers interested in offering certified health insurance plans and stand-alone dental plans, and the process was finalized for qualifying plans and selecting “choice” plans. Vermont finalized a decision to utilize the HHS risk adjustment and reinsurance programs. Vermont began the process of drafting administrative rules for small employer coverage options and finalized the employee choice models for small employers. On December 17, 2012, Vermont successfully procured a systems integrator for the Exchange by signing a contract with CGI.

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 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 provider. 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 local Community Health Teams (CHTs). The VCCI has expanded services to include all age groups accounting for the top 5% of expenses; and those with ambulatory sensitive conditions which are adversely impact utilization trends, such as Emergency Department (ED) and inpatient admissions and readmissions. The VCCI has expanded both its service scope as well as partners who support these new focus areas, as outlined in segments below.

The VCCI continues to expand upon the 2010 strategy to embed licensed staff within high volume Medicaid primary care sites and hospitals experiencing high volume ambulatory sensitive ED visits and

inpatient admissions/readmissions. Currently the VCCI has staff in 18 locations including 2 hospitals and 7 primary care provider locations; with expansion pending new hires. This approach fosters provider relationships, direct referral for high risk populations, and provides an opportunity for enhanced coordination and planned transitions in care between hospitals and primary care sites; as well as with Blueprint Community Health Team (CHT) members and the VCCI.

In FFY 2013 the VCCI is expanding the embedded staff model to additional FQHC sites and at 2 additional hospitals; with staff recruitment in process during this reporting period. The VCCI expansion has required 2 new managerial positions, with the second manager hired in December 2012. These positions are key to the hiring, orienting/training and oversight of the expanded VCCI as well as fostering and maintaining new partnerships to address high utilization patterns.

Pediatric Palliative Care:

The VCCI expanded to include a Pediatric Palliative Care Program (PPCP), which was launched in September of 2012; and enrolled its first patient in October 2012 in Chittenden County. The premise of implementing the PPCP is to address the unique needs of children who are living with a serious and potentially life threatening illness. Children who are medically eligible must be under age 21, have Vermont Medicaid, and be living with a life limiting or life threatening diagnosis from which they may not live into adulthood. Services for children who are medically eligible may include Care Coordination, Family Training, Expressive Therapy, Respite, and Counseling (including Bereavement if necessary).

A progressive statewide roll out of the PPCP is in progress; the PPCP expanded to Washington, Orange, Windsor, and Windham Counties, with a goal of statewide operation by the end of the second quarter 2013. New VCCI partners within the Agency of Human Services (AHS) engaged as a result of the PPCP expansion include Integrated Family Services (IFS) and Children's Integrated Services (CIS) within the Department for Children and Families (DCF) and Children with Special Health Needs (CSHN) within the Department of Health (VDH). An extensive network of 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 among new provider partners engaged in this important work. Home Health Agencies (hospice and palliative care units), the Vermont Ethics Network and the Vermont Family Network are also collaborating service providers and partners.

High Risk Pregnancy

Another VCCI expansion includes the addition of High Risk Pregnancy Case Management, which will align with ACA initiatives including high risk populations with substance abuse disorders; the Pediatric Palliative Care Program (PPCP); and the Department of Health (VDH) efforts for maternal/child health. This will be a centrally administered service focused on the system of care and coordination of services for the identified population with some local support by VCCI field staff. The High Risk Pregnancy positions remain under recruitment.

APS Contract

Since 2007, DVHA has contracted with APS Healthcare for assistance with providing disease management assessment and intervention services to Vermont Medicaid beneficiaries with chronic health conditions. DVHA is in the final year of its contract with APS and with the newest amendment had made a decision to shift from traditional telephonic disease management to care coordination services provided by VCCI. DVHA has found this approach more effective with its

highest cost/highest risk beneficiaries because VCCI staff are able to communicate directly at the local level with provider, partners, patients and their families.

As DVHA transitions to the new approach, it required a different level of support from APS. APS presented a cost neutral proposal to provide services to DVHA that better align with DVHA's current needs. Specifically, APS is providing enhanced information technology and more sophisticated decision-support tool to assist VCCI to outreach the most costly and complex beneficiaries based on risk and ability to positively impact results. APS continues to provide supplemental population based supports to VCCI staff working within provider offices; as well as to support the work of the Blueprint Community Health Teams (CHT) addressing NCQA priorities. APS also has evidence based treatment guidelines.

APS has guaranteed a 2:1 return on investment by implementing these enhancements, which equates to roughly \$5 million dollars and will bear 100% of the investment if the agreed upon savings are not realized (i.e., full risk contract based upon agreed savings methodology). As a result, DVHA invoked its option to extend the contract with APS for the two additional years with a scheduled end date of June 30, 2013.

University of Vermont (UVM) Contract

The DVHA has contracted with the University of Vermont (UVM) for evaluation of the VCCI program, and for assistance with identifying and implementing quality improvement projects. A clinical performance improvement project (PIP) was developed, focusing on heart failure which is one of the high cost, high risk 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%. Interventions are being developed and implemented for Year 2 of the PIP.

Highlights of the Vermont Chronic Care Initiative (Quarter 1 of FFY 2013)

- VCCI continues to hire nursing staff to support the expanded VCCI including the addition of two (2) nurse case managers, an administrative support staff and the VCCI Manager for Program Operations and Quality. Five positions are under recruitment.
- A Market Factor for nursing positions has been recommended and is under review to foster both recruitment as well as retention of VCCI staff.
- Expansion of hours at an FQHC site in Rutland from part-time to full-time nurse case management on site; expansion of hours at Rutland Regional Medical Center to 24 hours/week of nursing and LADC staff time.
- The VCCI continues to implement the Heart Failure (HF) PIP with assignment of cases to VCCI staff on a priority basis; along with primary care provider (PCPs) and cardiology outreach on gaps in care. This priority effort continues to assure improvements are maintained. VCCI is planning to participate in academic detailing with the Blueprint in HF with local PCP's and CHT partners.

- Implemented new policy to support coverage of scales for beneficiaries with a diagnosis of HF to support self - monitoring of daily weights.
- Implemented a new benefit for Medicaid transportation coverage for beneficiaries attending evidence based self-management training courses.
- Completed a Depression registry outlining gaps in treatment for patients with this diagnosis. An asthma registry is planned for February 2013.
- Continuation of the ED data sharing between area hospitals and the VCCI to support early notification of patterns of utilization and case load assignment.
- VCCI drafted a hospital liaison role for staff to facilitate communication for ED and inpatient to foster transitions in care and case assignment to VCCI staff.
- The Pediatric Palliative Care Program (PPCP) expansion continued to include 5 counties; and had 10 children enrolled.
- APS data indicates that VCCI maintained an average monthly caseload of 605 with 413 unique beneficiaries served. Unique beneficiaries are those who have been assigned to VCCI staff and have had a Social Needs, Behavioral Risk or Transitions of Care Assessment completed.

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, its 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.

The five planned regional *Hubs* build upon the existing methadone OTPs and also will provide buprenorphine treatment to a subset of clinically complex buprenorphine patients. Working in partnership with primary care providers and *Blueprint* CHTs, *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 will be provided by the nurses and licensed addictions/mental health clinicians, who will be added to the existing *Blueprint* CHTs.

Highlights of the Hub and Spoke Initiative (Quarter 1 of FFY 2013)

- The Northwest regional *Hub* and *Spoke* providers completed their planning in preparation for implementation January 1, 2013. Recruiting and hiring also began for the Northwest regional *Blueprint* Community Health Team (CHT) *Spoke* RNs and clinician case managers.
- Negotiations occurred with potential *Hub* providers in the remaining regions of the state. The local *Blueprint* CHTs and buprenorphine providers in these regions continued their planning for scheduled implementations from July 2013 through January 2014.
- The two *Hub* and *Spoke* learning collaboratives with multidisciplinary provider teams that were established during the previous quarter continued their work. The learning collaboratives are provided through a partnership of the *Blueprint*, the Vermont Department of Health, and the Dartmouth Psychiatric Research Center.
- A series of technical consultation and review calls with CMS regarding the first draft of the Health Home SPA proposal were completed and the SPA is being revised.

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.

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

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. Specifically, we are developing a plan to support the oversight of the 340B program in Vermont. This plan includes the review and analysis of all 340B drug claims on a regular basis to determine several factors, including proper payment and reconciliation of the 340B claims, avoidance of

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

340B Reimbursement and Calculation of Incentive Payment

Determination of Dispensing Fee and Savings Sharing Amounts

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

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

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

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

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. In CY 2012, Vermont has realized approximately \$1,205,520 in savings through Medicaid participation of a relatively small number of eligible covered entities. DVHA is focused on outreach and education of all Vermont covered entities to encourage enrollment in the 340B discount program.

Catamount Health

In September 2012, MVP Health Care announced they were ending participation in Vermont's Catamount program effective December 31, 2012. Subsidized beneficiaries as well as direct pay subscribers were informed of this change. DVHA, in collaboration with the Department for Children and Families (DCF), Economic Services Division (ESD) and DCF's Information Services Division, successfully transitioned all subsidized MVP beneficiaries to Blue Cross Blue Shield of Vermont without a gap in coverage due to the transition process to Blue Cross Blue Shield.

Mental Health System of Care

State Hospital Inpatient Replacement Planning

This first quarter of the federal fiscal year 2013 marks the second quarter of additional general fund resources that became available, in state fiscal year 2013, for enhanced community-based support and treatment services. This additional funding followed the abrupt closure of Vermont's single state psychiatric hospital and leverages global commitment funding to support the under and uninsured hospitalization needs for persons who would otherwise have been served by the former state hospital.

These most acute, Level I patients as they have become known, are currently served by enrolled Medicare and Medicaid provider hospitals. These "designated" local hospitals, through renovation and program re-design, will serve individuals closer to their home communities and in substantially improved treatment settings when compared to the former state treatment facility. As referenced in earlier reports, an additional 28 inpatient beds to serve individuals who would otherwise have been treated at the former Vermont State Hospital was authorized via legislation while the new 25 bed hospital is under development. The emergency Certificate of Need Application for the new hospital construction was approved in November, 2012. In the meantime, facility renovations at the Brattleboro Retreat (14 beds), Rutland Regional Medical Center (6 beds), and an interim psychiatric hospital (8 beds) in Morrisville are in process and expected to come on line in the second and third quarters of federal fiscal year 2013.

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 to be developed to triage and manage the inpatient needs. Staffed by department care management personnel, 24/7 admissions personnel of the former state hospital, and an electronic bedboard of inpatient and crisis bed census information available to service providers, the care management system has been taking shape over several months. 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 implement 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 regarding overall contribution to the system of care and impacts to persons served. A full report of Act 79 funded initiatives and early outcomes is due the Vermont Legislature on January 15, 2013.

Given the anticipated and growing demand for mental health support services in a state experiencing a smaller capacity of acute psychiatric inpatient care, access to evaluation is an essential cornerstone of mental health service. Designated Agencies (DA's) throughout the state were provided resources to develop and further enhance emergency outreach and crisis support services at the local level. Mobile response capability and improved collaborations with local law enforcement are key components in meeting the challenges of effective engagement in a rural state. DA's have begun reporting on these new capacities, newly developed protocols, numbers served, and intervention outcomes through this collaborative work in their local areas.

Global Commitment resources in this fiscal year are targeting additional crisis beds capacity to divert unnecessary inpatient hospitalization where clinically appropriate and step-down individuals who are ready to transition from inpatient care back to community support services. Three regions of the state (Rutland, Lamoille, and Orange counties) have added six additional crisis bed stabilization capabilities where limited or no capacity existed before. Act 79 also supported the investment of global commitment resources into intensive residential recovery support programs. In addition to an 8-bed program developed in the previous quarter in the southern part of the state (Westminster), a new 8-bed program is moving through the Certificate of Approval (COA) process for development in the northern part of the state (Westford). A 7-bed secure residential recovery program also authorized for development is moving forward and has completed the Certificate of Need (CON) process. The program will be a state-run Therapeutic Recovery Residence (TCR) and be temporarily located in the town of Middlesex. This program will be designed to meet the needs of individuals who are clinically ready to step-down from hospitalization, but still require a secure treatment setting prior to re-entry into their home communities. All of these additional beds will likely come on board in the fourth quarter of state fiscal year 2013.

The realities of a rural state, with remote or geographic distance between points of service, require that transportation also be a consideration for access of any crisis stabilization, residential, or inpatient treatment capacities established. Throughout this quarter, the flexible application of global commitment resources has supported further development of both trauma sensitive and least restrictive modes of transportation consistent with safety needs being increased throughout the state. Collaboration with law enforcement and training in alternative transport options, when clinically appropriate, have already had a positive influence on reducing the use of hard restraints for acute emergency mental health transports as the norm. During this quarter, the use of restraints during involuntary transports fell below the 50% threshold; and, if restraints were used, the use of metal restraints fell below 20%.

Inroads for the outpatient services population are also being made via the expansion of service planning and coordination supports beyond the severe and persistently mentally ill population. More responsive, hands-on case management support services to stabilize individuals who might

otherwise further decompensate from mental health stressors or exhaust existing coping mechanisms were supported through Act 79. What has been called “non-categorical” case management is an expanded service capacity that is no longer reserved for the most incapacitated individuals served in community-based programs. Earlier supportive intervention available to individuals struggling with mental health issues will further reduce potential need for limited acute inpatient resources. A population targeted for these support services, which are at risk for higher cost public and health care resource utilization, are individuals transitioning between periods of incarceration and re-entry to the community. Individuals at risk for recidivism, law enforcement involvement and incarceration, are a continuing priority group for expanded mental health and community support services. In preparation for reporting to the Vermont legislature, the increase in non-categorical case management service has dramatically increased in total for state fiscal year 2012 and further increasing in the first two quarters of state fiscal year 2013. This service capacity is now being reported in nine out of the ten DA’s statewide.

Act 79 also provided for new investment in housing supports and coordinated treatment supports to provide greater stabilization in the community for individual at higher risk for homelessness. The pairing of both treatment and stable housing resources increases the likelihood of individuals with mental health needs remaining more engaged with services and less likely to destabilize requiring acute inpatient treatment. Augmenting these formal support services with peer support services is also being promoted in FY 13. Act 79 also supported investments in peer services to broaden the array and options for recovery supports to individuals with mental illness. Efforts continue to operationalize a statewide peer “warmline” as an alternative for individuals needing active listening and problem-solving supports on issues that do not rise to the level of mental health crisis contacts. This initiative will likely be fully implemented by the fourth quarter of state fiscal year 2013. The state’s peer community is also working collaboratively with the DMH to further develop a proposal for a peer supported residential program, also supported by Act 79, for individuals seeking an alternative course of recovery that minimizes reliance on medications. Slow planning and development progress and budgetary shortfalls may delay this initiative in state fiscal year 2014.

All of the initiatives that are under way have begun preliminary reporting and continue to formalize data collection and reporting capabilities consistent with Act 79 provisions regarding: access to emergency room and inpatient services, mobile outreach supports, crisis bed and intensive residential recovery bed utilization, alternative transportation availability, housing stability, and adverse event and emergency involuntary procedures. A legislative report of early outcomes and cost-saving initiatives for the service system is being developed for the January 15, 2013 reporting requirements as outlined in Act 79.

Integrated Family Services (IFS) Initiative

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

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

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.

Financial/Budget Neutrality Development/Issues

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

AHS 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 expediently 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 December 31, 2013, and that Federal financial participation will be available for premium assistance for the current Catamount population when the Affordable Care Act becomes fully effective on January 1, 2014.

AHS’ Financial Manager responsible for quarterly CMS-64/CMS-21/CMS-37/CMS-21B reporting, Connie Harrison, left AHS Central Office in December 2012 to accept a position at DVHA as Medicaid Fiscal Analyst. The AHS Financial Manager position has been filled by Ben Black, who previously served as a Financial Administrator within the AHS Central Office. Connie will be working with Ben for the next several quarters to ensure a smooth transition for CMS reporting.

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

Demonstration Population	Month 1	Month 2	Month 3	Total for Quarter Ending					
	10/31/12	11/30/12	12/31/12	1st Qtr FFY '13	4th Qtr FFY '12	3rd Qtr FFY '12	2nd Qtr FFY '12	1st Qtr FFY '12	4th Qtr FFY '11
Demonstration Population 1:	48,620	48,385	48,613	145,618	145,197	142,952	142,365	141,300	139,591
Demonstration Population 2:	43,932	43,686	43,351	130,969	131,709	132,537	132,285	132,095	130,715
Demonstration Population 3:	9,860	9,819	9,623	29,302	29,326	29,076	28,869	29,054	29,396
Demonstration Population 4:	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Demonstration Population 5:	998	1,010	1,016	3,024	2,955	3,012	2,999	3,325	3,246
Demonstration Population 6:	3,322	3,442	3,299	10,063	9,795	9,536	9,646	9,704	9,888
Demonstration Population 7:	35,563	35,572	35,138	106,273	107,004	107,528	106,610	105,833	105,932
Demonstration Population 8:	9,843	9,984	9,981	29,808	29,086	30,939	30,730	30,174	23,287
Demonstration Population 9:	2,699	2,705	2,697	8,101	7,970	7,874	7,889	7,875	7,512
Demonstration Population 10:	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Demonstration Population 11:	12,088	12,323	12,291	36,702	35,797	35,175	33,674	33,464	33,207

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

Consumer Issues

The AHS and DVHA have several mechanisms whereby consumer issues are tracked and summarized. The first is through 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 Managed Care Entity. 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

The AHS Quality Improvement Manager (QIM) worked with the External Quality Review Organization (EQRO) to produce a final report of the Performance Improvement Project (PIP) validation activity. The Increasing Adherence to Evidence-Based Pharmacy Guidelines in Members with Congestive Heart Failure PIP received a Met score for 100 percent of critical evaluation elements, as well as 100 percent of the overall evaluation elements in the Study Design and Implementation and Evaluation stages. The performance of this PIP suggests a thorough application of the PIP design. DVHA's documentation provided evidence that the plan appropriately conducted the data collection activities of the Implementation

stage. These activities ensured that the study properly defined and collected the necessary data to produce accurate study indicator rates. Additionally, DVHA documented appropriate improvement strategies that were targeted to overcome barriers identified by the plan. Targeted interventions are critical for bringing about improvement in performance improvement studies and should be developed to specifically address and overcome barriers. The identification of barriers through barrier analysis and the subsequent selection of appropriate interventions to address these barriers are necessary steps to improve outcomes. DVHA's choice of interventions, the combination of intervention types, and the sequence of implementing the interventions are essential to the PIP's overall success. The study indicator did not achieve statistically significant improvement. To increase the measurable effects of its quality improvement activities, DVHA should conduct further drilldown analysis to ensure that the barriers identified are specific to its population and that targeted interventions are implemented which directly address the barriers. As the study progresses, HSAG recommends that DVHA do the following: 1) Continue to review interim evaluations of results in addition to the annual evaluation. DVHA should determine if the interventions are having the desired effect or if modifying current interventions or implementing new interventions are necessary to improve results based on the interim evaluation results; 2) Continue to conduct a drill-down type of analysis before and after the implementation of any intervention to determine if any subgroup within the population has a disproportionately lower rate that negatively affected the overall rate. DVHA should target the identified subgroups with the lowest study indicator rates for interventions, allowing the implementation of more precise, concentrated interventions.

The AHS Quality Improvement Manager (QIM) worked with the External Quality Review Organization (EQRO) to produce a final report of the Performance Measure Validation (PMV) activity. DVHA staff demonstrated their commitment to performance measure reporting in many ways this year. The team worked to submit a thoroughly completed ISCAT and all supporting documentation prior to the on-site visit. In addition, appropriate staff members were available during the audit to answer questions and provide demonstrations. Also, the final rates were submitted prior to the on-site visit for review and benchmarking that allowed for discussion during the on-site visit on how the plan performed. DVHA operates in a highly electronic environment, and providers are all paid using a fee for service model. Both of these factors enhance the accuracy and completeness of submitted claims data. The use of certified software to generate HEDIS rates allowed for consistent interpretation of reporting requirements and specifications, and led to reliable and accurate rates. DVHA made great strides in preparing for the performance measure validation activities this year. The submitted documentation and on-site discussion demonstrated that DVHA had a good grasp on the process. In reviewing the performance measure rates, specifically for the diabetes measure, it was evident that there are missing lab data that if received could help to improve performance. It is recommended that DVHA consider working with one or two large local laboratories to see if a process could be built to receive a lab results data file feed on a regular basis. These lab results data would greatly improve performance on the diabetes indicators. Also, as DVHA prepares to report the diabetes measure through hybrid reporting, it should be prepared to provide documentation of the entire process for next year's audit.

The AHS Quality Improvement Manager (QIM) worked with the External Quality Review Organization (EQRO) to produce a final report of the Compliance with Standards review activity. In its examination of DVHA's documents and DVHA staff members' responses to the interview questions and discussions during the interview, HSAG identified and was impressed with the significant continued improvements DVHA had implemented in its processes, documentation, and performance results since the previous review. This was clearly evident and impressive, notwithstanding the challenges the MCE, its IGA partners, and AHS had experienced during the past year (e.g., loss and relocation of staff and resources from the severe flooding and increased budget restraints and limitations). As in prior years, HSAG continued to experience AHS' and DVHA's strong commitment to building care and services and

designing policies and processes that meet the applicable CMS and State requirements, but always with the goal of embracing enrollee-focused decisions, processes, and services. DVHA's commitment to taking care of enrollees' health care needs and providing quality, timely, and accessible services and easy-to-navigate processes for the enrollee was evident during the on-site interviews and in the documentation reviewed. While not a required corrective action, HSAG found the content of DVHA's provider manual to be largely focused on administrative processes such as provider enrollment, billing, coding, and claims payment. In comparison to provider manuals of other Medicaid managed care organizations with which HSAG is familiar, DVHA's provider manual was significantly and substantively more limited in terms of information and requirements for the providers' clinical practice, patient engagement, quality of care provided, and performance results. HSAG encouraged DVHA to consider expanding and strengthening its provider manual.

The AHS Quality Improvement Manager worked with the EQRO to develop the Annual Technical Report. This document combines the results of all three external quality review activities and identifies strengths and challenges associated with the three activities as well as making recommendations to improve the timeliness, access, and quality of services provided by the MCE. Since 2007, The Vermont Agency of Human Services (AHS) has contracted with Health Services Advisory Group, Inc. (HSAG), an External Quality Review Organization (EQRO), to both conduct the three CMS required activities (i.e., Compliance with Medicaid Managed Care Regulations, Validation of Performance Improvement Projects, and Validation of Performance Measures) and to prepare the EQR annual technical report bringing together the results from the activities it conducted. During the past five years, HSAG has been able to observe and evaluate Vermont's performance over time and draw conclusions about their policies and procedures; processes; documentation; and the results and outcomes of its performance, including areas of strength and those requiring, or with continued room for, improvement.

Over the past five years, HSAG has observed tremendous growth, maturity, and substantively improved performance results across all three activities. During this time, Vermont's Medicaid Managed Care Model has achieved the following scores relative to its ability to conduct the three mandatory EQRO activities:

- Average Overall Percentage of Compliance Score of 93.8%;
- Average Performance Improvement Validation scores for Evaluation Elements Met of 98.4%, Critical Elements Met of 100%, and an Overall Validation Status of Met for each year - indicating high confidence in the reported results; and
- Performance Measures Validation finding of Fully Compliant and a determination that measures were valid and accurate for reporting for each year.

In addition, with each successive EQR contract year, HSAG has found that for the three activities conducted, Vermont had increasingly followed up on HSAG's prior year recommendations and has initiated numerous additional improvement initiatives. They found that Vermont's Medicaid Managed Care Model regularly conducted self-assessments and, as applicable, makes changes to its internal organizational structure and key positions to more effectively align staff skills, competencies, and strengths with the work required and unique challenges associated with each operating unit within the organization. They also said that Vermont's continuous quality improvement focus and activities and the steady improvements over the five years have been substantive and have led to demonstrated performance improvements, notable strengths, and commendable and impressive outcomes across multiple areas and performance indicators. Finally, HSAG has concluded that over the past five years Vermont has demonstrated incremental and substantive growth and maturity which has led to its current role and functioning as a strong, goal-oriented, innovative, continuously improving Medicaid managed care model organization.

Quality Assurance Performance Improvement Committee (QAPI)

The DVHA Quality Improvement Director and the AHS Quality Manager met with the IGA partner representatives individually to review compliance activities, ongoing performance improvement efforts, and opportunities for cross-departmental quality initiatives. The DVHA Quality Improvement Director and the AHS Quality Manager met several times throughout this quarter to develop a new structure and focus for the QAPI Committee and to identify the appropriate committee members. As part of the ongoing oversight activities, the DVHA Quality Unit worked with the QAPI representatives in gathering the evidence of compliance with the CFR regulations around authorization of services. Meetings were held with with Department of Mental Health and the Vermont Department of Health to update their authorization manuals.

The QAPI Committee Chair met with the AHS Quality Improvement Manager to review the compliance activities. Conversations around the QAPI program centered on the activities related to the Quality Work Plan and ongoing meetings with the IGA partners. Areas of improvement were identified but no recommendations were made to the AHS Quality Manager for corrective action from any of the IGA Partners.

Quality Strategy

No issues with the Quality Strategy were identified by members of the QAPI committee. As a result, no action was taken on the strategy during this quarter. However, the QIM spent time this quarter reviewing the National Strategy for Quality Improvement in Health Care (National Quality Strategy). The QIM will look to engage members of the QAPI committee in a discussion re: the National Quality Strategy to determine where Global Commitment and national quality assessment and improvement efforts might align for maximum results.

Transportation Quality Assurance & Coordination

The DVHA transitioned the Non-Emergency Medical Transportation (NEMT) contracts to a per-member per-month (PMPM) payment methodology, which encourages service coordination and efficiencies. After prolonged negotiations, an existing broker discontinued its participation in the NEMT program, requiring DVHA to work with bordering established brokers to provide coverage for the affected service area with no breaks in service for beneficiaries. Letters were mailed to beneficiaries notifying them of the change. Through better case management and coordination between Provider and Member Relations and the Program Integrity unit, DVHA is progressing toward its goals to slow the growth in NEMT costs and improve service quality.

Effective October 1, 2012, DVHA also implemented several improvements to the bus pass program. DVHA is partnering with its Member Services contractor Maximus to monitor bus pass use and verify appointments prior to authorizing the services.

Transition to the PMPM model interrupted direct cost growth but administrative costs were slightly higher than expected during implementation. Stability in the system going forward should allow for additional administrative savings.

Demonstration Evaluation

The AHS Quality Improvement Manager worked with evaluation staff at the Pacific Health Policy Group (PHPG) to initiate the demonstration evaluation. The document will determine the Demonstration's

progress toward accomplishing its three goals of increasing access, improving quality, and controlling costs and will include both quantitative and qualitative analyses of enrollment statistics, quality of health care measurement information, and beneficiary survey results. A full evaluation report will accompany Vermont's waiver renewal application.

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

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: February 27, 2013

ATTACHMENTS



State of Vermont
Department of Vermont Health Access
 312 Hurricane Lane, Suite 201
 Williston VT 05495-2807
dvha.vermont.gov

Agency of Human Services
 [Phone] 802-879-5900
 [Fax] 802-879-5651

The Department of Vermont Health Access
Caseload and Expenditure Report - All AHS Medicaid Spend
 AHS YTD '13
 Friday, February 22, 2013

	SFY '13 Appropriated			SFY '13 Budget Adjustment			SFY '13 Actuals thru December 31, 2012			% of Approp. Spent to Date	% of BAA Spent to date
	Caseload	Expenses	PMPM	Caseload	Expenses	PMPM	Caseload	Expenses	PMPM		
ABD Adult	14,445	\$ 171,838,251	\$ 991.36	14,189	\$ 168,678,573	\$ 990.65	14,141	\$ 78,931,016	\$ 930.29	45.93%	46.79%
ABD Dual	17,155	\$ 194,934,351	\$ 946.93	17,215	\$ 192,935,162	\$ 933.93	16,978	\$ 86,312,782	\$ 847.32	44.28%	44.74%
General Adult	11,686	\$ 79,100,241	\$ 564.08	11,614	\$ 73,162,753	\$ 524.96	11,483	\$ 35,930,860	\$ 521.51	45.42%	49.11%
VHAP	38,799	\$ 173,502,508	\$ 372.65	37,340	\$ 159,569,907	\$ 356.12	37,147	\$ 79,431,261	\$ 356.38	45.78%	49.78%
VHAP ESI	810	\$ 2,006,576	\$ 206.35	807	\$ 1,429,801	\$ 147.62	813	\$ 622,363	\$ 127.59	31.02%	43.53%
Catamount	11,440	\$ 62,002,768	\$ 451.65	11,582	\$ 59,153,214	\$ 425.61	11,352	\$ 24,679,228	\$ 362.32	39.80%	41.72%
ESIA	874	\$ 2,270,715	\$ 216.52	766	\$ 1,000,629	\$ 108.80	702	\$ 396,913	\$ 94.19	17.48%	39.67%
ABD Child	3,614	\$ 93,601,570	\$ 2,158.44	3,727	\$ 87,208,278	\$ 1,950.14	3,720	\$ 39,226,387	\$ 1,757.45	41.91%	44.98%
General Child	55,564	\$ 228,797,327	\$ 343.14	55,519	\$ 226,071,854	\$ 339.33	55,437	\$ 96,509,870	\$ 290.15	42.18%	42.69%
Underinsured Child	943	\$ 2,088,216	\$ 184.56	1,029	\$ 2,101,240	\$ 170.14	1,011	\$ 926,250	\$ 152.65	44.36%	44.08%
SCHIP	4,017	\$ 10,358,905	\$ 214.90	4,017	\$ 9,289,125	\$ 192.69	3,882	\$ 4,866,851	\$ 208.93	46.98%	52.39%
Pharmacy Only	12,698	\$ 4,777,918	\$ 31.36	12,565	\$ (440,929)	\$ (2.92)	12,273	\$ 1,999,035	\$ 27.15	41.84%	-453.37%
Choices for Care	3,758	\$ 201,312,266	\$ 4,464.65	3,859	\$ 205,732,892	\$ 4,443.09	3,880	\$ 98,671,065	\$ 4,238.81	49.01%	47.96%
Total Medicaid	175,802	\$ 1,226,591,614	\$ 581.43	174,230	\$ 1,185,892,499	\$ 567.21	172,820	\$ 548,503,882.48	\$ 528.97	44.72%	46.25%



State of Vermont
Department of Vermont Health Access
 312 Hurricane Lane, Suite 201
 Williston VT 05495-2807
dvha.vermont.gov

Agency of Human Services
 [Phone] 802-879-5900
 [Fax] 802-879-5651

The Department of Vermont Health Access
 Caseload and Expenditure Report - DVHA Only Medicaid Spend
 DVHA YTD '13
 Friday, February 22, 2013

	SFY '13 Appropriated			SFY '13 Budget Adjustment			SFY '13 Actuals thru December 31, 2012			% of Approp. Spent to Date	% of BAA Spent to Date
	Caseload	Expenses	PMPM	Caseload	Expenses	PMPM	Caseload	Expenses	PMPM		
ABD Adult	14,445	\$ 100,440,442	\$ 579.46	14,189	\$ 97,260,433	\$ 571.21	14,141	\$ 46,634,195	\$ 549.63	46.43%	47.95%
ABD Dual	17,155	\$ 48,138,865	\$ 233.84	17,215	\$ 46,097,874	\$ 223.14	16,978	\$ 21,832,692	\$ 214.33	45.35%	47.36%
General Adult	11,686	\$ 71,664,326	\$ 511.06	11,614	\$ 65,724,721	\$ 471.59	11,483	\$ 32,644,290	\$ 473.81	45.55%	49.67%
VHAP	38,799	\$ 161,957,523	\$ 347.86	37,340	\$ 148,021,635	\$ 330.34	37,147	\$ 74,430,873	\$ 333.95	45.96%	50.28%
VHAP ESI	810	\$ 2,006,576	\$ 206.35	807	\$ 1,429,801	\$ 147.62	813	\$ 620,820	\$ 127.27	30.94%	43.42%
Catamount	11,440	\$ 62,002,768	\$ 451.65	11,582	\$ 59,153,214	\$ 425.61	11,352	\$ 24,679,228	\$ 362.32	39.80%	41.72%
ESIA	874	\$ 2,270,715	\$ 216.52	766	\$ 1,000,629	\$ 108.80	702	\$ 396,913	\$ 94.19	17.48%	39.67%
ABD Child	3,614	\$ 35,654,068	\$ 822.18	3,727	\$ 29,244,275	\$ 653.96	3,720	\$ 16,896,490	\$ 757.01	47.39%	57.78%
General Child	55,564	\$ 123,109,797	\$ 184.64	55,519	\$ 120,354,228	\$ 180.65	55,437	\$ 54,809,971	\$ 164.78	44.52%	45.54%
Underinsured Child	943	\$ 677,890	\$ 59.91	1,029	\$ 690,513	\$ 55.91	1,011	\$ 336,408	\$ 55.44	49.63%	48.72%
SCHIP	4,017	\$ 7,598,806	\$ 157.64	4,017	\$ 6,528,240	\$ 135.42	3,882	\$ 3,618,134	\$ 155.32	47.61%	55.42%
Pharmacy Only	12,698	\$ 4,777,918	\$ 31.36	12,565	\$ (440,929)	\$ (2.92)	12,273	\$ 1,899,992	\$ 25.80	39.77%	-430.91%
Choices for Care	3,758	\$ 201,312,266	\$ 4,464.65	3,859	\$ 205,732,892	\$ 4,443.09	3,880	\$ 98,671,065	\$ 4,238.81	49.01%	47.96%
Total Medicaid	175,802	\$ 821,611,963	\$ 389.46	174,230	\$ 780,797,524	\$ 373.45	172,820	\$ 377,471,070	\$ 364.03	45.94%	48.34%

Global Commitment Expenditure Tracking

QE	Quarterly Expenditures	PQA: WY1	PQA: WY2	PQA: WY3	PQA: WY4	PQA: WY5	PQA: WY6	PQA: WY7	PQA: WY8	PQA: WY9	Net Program PQA	Net Program Expenditures as reported on 64	non-MCO Admin Expenses	Total columns J:K for Budget Neutrality calculation	Cumulative Waiver Cap per 1/1/11 STCs	Variance to Cap under/(over)
1205	\$ 178,493,793											\$ 178,493,793				
0306	\$ 189,414,365	\$ 14,472,838									\$ 14,472,838	\$ 203,887,203				
0606	\$ 209,647,618	\$ (14,172,165)									\$ (14,172,165)	\$ 195,475,453				
0906	\$ 194,437,742	\$ 133,350									\$ 133,350	\$ 194,571,092				
WY1 SUM	\$ 771,993,518	\$ 434,023									\$ 434,023	\$ 782,159,845	\$ 4,620,302	\$ 786,780,147	\$ 841,266,663	\$ 54,486,516
1206	\$ 203,444,640	\$ 8,903									\$ 8,903	\$ 203,453,543				
0307	\$ 203,804,330	\$ 8,894,097									\$ 8,894,097	\$ 212,698,427				
0607	\$ 186,458,403	\$ 814,587	\$ (68,408)								\$ 746,179	\$ 187,204,582				
0907	\$ 225,219,267	\$ -	\$ -								\$ -	\$ 225,219,267				
WY2 SUM	\$ 818,926,640	\$ 9,717,587	\$ (68,408)								\$ 9,649,179	\$ 802,884,359	\$ 6,464,439	\$ 809,348,797	\$ 1,684,861,317	\$ 88,732,372
Cumulative														\$ 1,596,128,945	\$ 3,369,128,134	\$ 477,460,744
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	\$ 1,770,918,469	\$ 119,793,211
Cumulative														\$ 2,484,316,097	\$ 5,140,046,603	\$ 689,256,932
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	\$ 2,071,882,856	\$ 181,250,037
Cumulative														\$ 3,425,180,534	\$ 7,211,939,465	\$ 960,536,894
1209	\$ 241,939,196				\$ 5,192,468						\$ 5,192,468	\$ 247,131,664				
0310	\$ 246,257,198				\$ 531,141	\$ 4,400,166					\$ 4,931,306	\$ 251,188,504				
0610	\$ 253,045,787				\$ 248,301	\$ 5,260,537					\$ 5,508,838	\$ 258,554,625				
0910	\$ 252,294,668		\$ (115,989)	\$ (261,426)	\$ 3,348,303						\$ 2,970,888	\$ 255,265,556				
WY5 SUM	\$ 993,536,849	\$ -	\$ -	\$ (115,989)	\$ 5,710,484	\$ 13,009,006					\$ 18,603,501	\$ 1,012,990,839	\$ 5,949,605	\$ 1,018,940,444	\$ 2,283,822,310	\$ 255,901,196
Cumulative														\$ 4,444,120,978	\$ 9,495,761,775	\$ 1,236,728,090
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	\$ 2,535,286,524	\$ 369,678,591
Cumulative														\$ 5,495,535,146	\$ 11,031,048,299	\$ 1,606,466,681
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	\$ 1,103,720,897	\$ 5,751,066	\$ 1,109,471,963	\$ 3,064,573,117	\$ 508,283,794
Cumulative														\$ 6,605,007,109	\$ 14,095,641,416	\$ 1,814,751,875
1212	\$ 282,701,072						\$ 3,036,447				\$ 3,036,447	\$ 285,737,519				
0313											\$ -	\$ -				
0613											\$ -	\$ -				
0913											\$ -	\$ -				
WY8 SUM	\$ 282,701,072	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 3,036,447	\$ -		\$ 3,036,447	\$ 282,701,072	\$ 1,251,283	\$ 283,952,355	\$ 3,348,525,471	\$ 1,561,725,022
Cumulative														\$ 6,888,959,464	\$ 17,444,166,887	\$ 3,376,250,907
1213											\$ -	\$ -				
WY9 SUM	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Cumulative	\$ 6,690,181,050	\$ 10,166,327	\$ (16,042,281)	\$ 79,876,130	\$ 41,153,315	\$ 19,453,990	\$ 4,878,725	\$ 17,230,447	\$ -	\$ -	\$ -	\$ 6,846,897,703	\$ 42,061,762	\$ 6,888,959,464	\$ 17,461,628,416	\$ 3,937,978,324

**Complaints Received by Health Access Member Services
October 1, 2012 – December 31, 2012**

Eligibility forms, notices, or process	39
ESD Call-center complaints (IVR, rudeness, hold times)	4
Use of social security number as identifiers	1
General premium complaints	5
Catamount Health Assistance Program premiums, process, ads, plans	3
Coverage rules	8
Member services	5
Eligibility rules	7
Eligibility local office	1
Prescription drug plan complaint	0
Copays/service limit	0
Pharmacy coverage	0
Provider issues (perceived rudeness, refusal to provide service, prices) (variety of provider types)	2
Provider enrollment issues	0
Chiropractic coverage change	0
Shortage of enrolled dentists	0
Green Mountain Care Website	0
DVHA	2
Total	77

**Grievance and Appeal Quarterly Report
Medicaid MCE All Departments Combined Data
October 1, 2012 – December 31, 2012**

The MCE is composed of various administrative areas within the Agency of Human Services (AHS). These include: the Department of Vermont Health Access (DVHA), the Department for Children and Families (DCF), the Department of Mental Health (DMH), the Department of Disabilities, Aging and Independent Living (DAIL), and the Department of Health (VDH). Also included in the MCE are the Designated Agencies (DA) and Specialized Service Agencies (SSA) that provide service authorizations for DMH and DAIL. Each entity should have at least one assigned grievance and appeal coordinator who enters data into the MCE database. This report is based on data compiled on January 2, 2013, from the centralized database for grievances and appeals that were filed from October 1, 2012 through December 31, 2012.

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

During this quarter, there were 11 grievances filed with the MCE; five 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, 64% were filed by beneficiaries, and 36% were filed by a representative of the beneficiary. Of the 11 grievances filed, DMH had 64%, DVHA had 27% and DCF had 9%. There were no grievances filed for the DAIL, or VDH during this quarter.

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

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

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

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

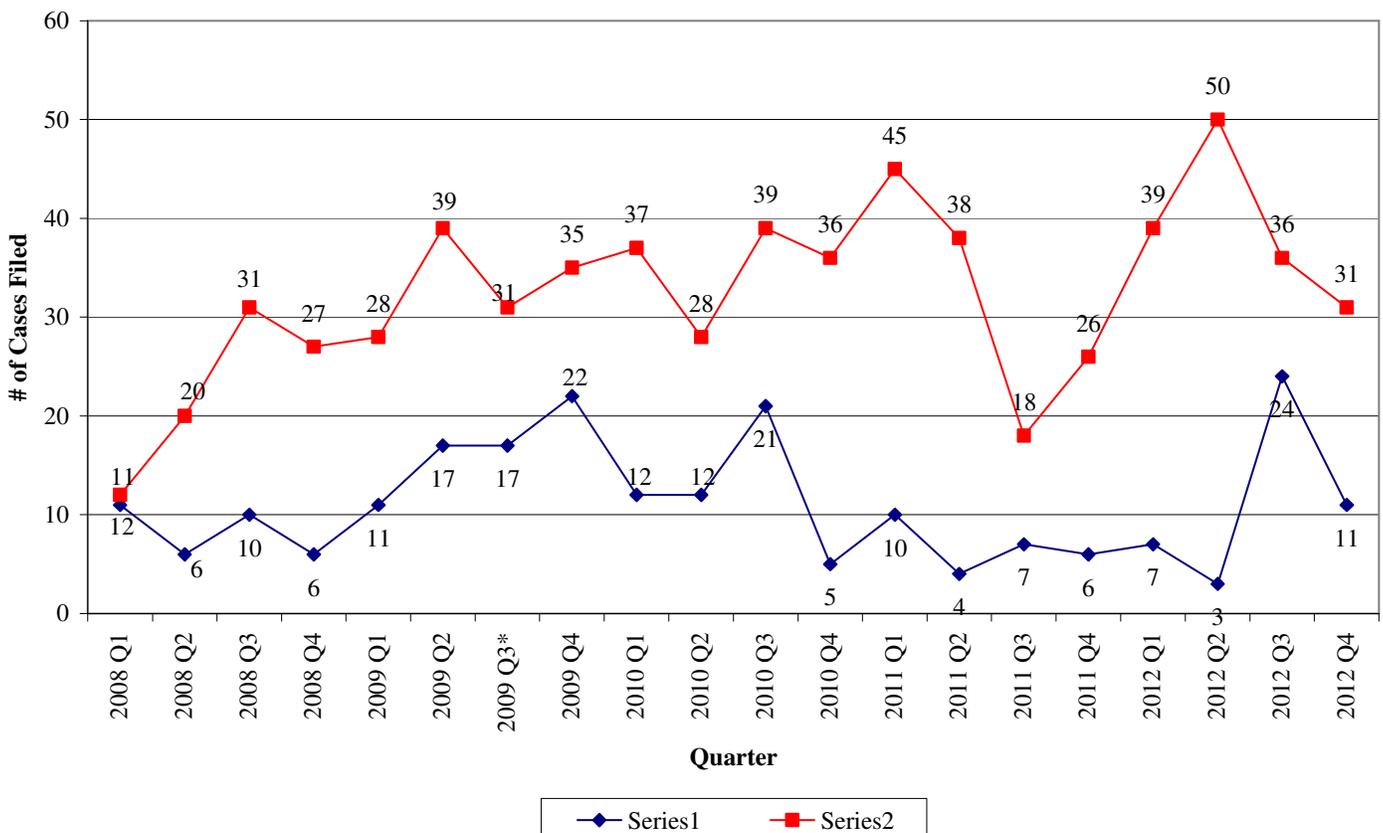
During this quarter, there were 31 appeals filed with the MCE; 10 requested an expedited decision with eight of them meeting criteria. Of these 31 appeals, 21 were resolved (68% of filed appeals), 8 were still pending (26%), and 2 were filed too late (6%). In nine cases (42% of those resolved), the original decision was upheld by the person hearing the appeal, six cases (29% of those resolved) were reversed, one had a modified approval (5%), and five were approved by the applicable department/DA/SSA before the appeal meeting (24% of those resolved).

Of the 21 appeals that were resolved this quarter, 95% were resolved within the statutory time frame of 45 days, with one (4%) being extended by the beneficiary; 71% were resolved within 30 days. The average number of days it took to resolve these cases was 15 days. Acknowledgement letters of the receipt of an appeal must be sent within five days; the average was two days.

Of the 31 appeals filed, 22 were filed by beneficiaries (68%), 5 were filed by a representative of the beneficiary (16%) and 5 were filed by the provider (16%). Of the 31 appeals filed, DVHA had 68%, DAIL had 23%, DMH had 6%, and VDH had 1%.

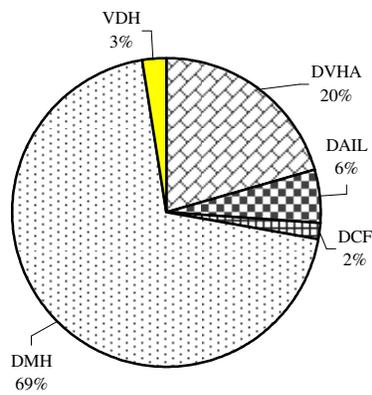
Beneficiaries can file an appeal and a fair hearing at the same time, and they can file a fair hearing if their appeal is not decided in their favor. There were two fair hearing filed this quarter one for DVHA (50%), and one for DAIL (50%).

Medicaid MCE Grievances & Appeals

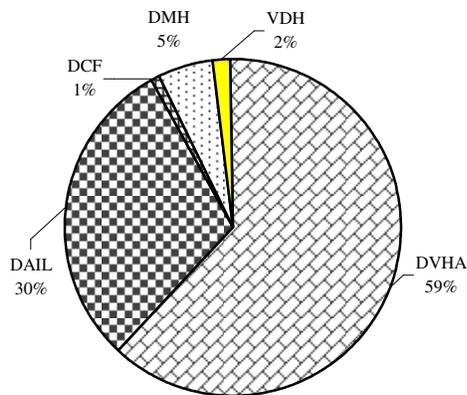


MCE Grievance & Appeals by Department From January 1, 2008 through December 31, 2012

Grievances



Appeals



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

QUARTERLY REPORT

October 1, 2012 – December 31, 2012

to the

DEPARTMENT OF FINANCIAL REGULATION

and the

DEPARTMENT OF VERMONT HEALTH ACCESS

submitted by

Trinka Kerr, Vermont Health Care Ombudsman

January 12, 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 October 1, 2012 through December 31, 2012. In addition to operating a hotline to provide individual consumer assistance, the HCO also does policy work and represents the public in Green Mountain Care Board (GMCB) activities and rate review proceedings.

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

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

A. Total call volume increased 9.49% compared to last quarter.

All Calls

The HCO received 842 calls this quarter, compared to 769 calls in the previous quarter, a 9.49% increase. This is also slightly more than in the third quarter of 2011, when we received 838 calls mainly due to Tropical Storm Irene. The increase was mainly in October, but it is unclear why.

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

B. The top ten issues generating calls were:

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

All Calls

1. Affordability 149 (compared to 120 last quarter, a 24.16% increase)
2. Information about applying for DVHA programs 136 (106 last quarter, a 28.30% increase)
3. Complaints about Providers 97 (100 last quarter, a 3% decrease)
4. Eligibility for VHAP 82 (82 last quarter, no change)
Access to Prescription Drugs 82 (67 last quarter, a 22.38% increase)
5. Eligibility for Medicaid 77 (65 last quarter, a 18.46% increase)
6. Communication Problems with DCF 73 (69 last quarter, a 5.79% increase)
7. Consumer Education on Medicare 72 (43 last quarter, a 67.44% increase)
8. Eligibility for Premium Assistance 55 (57 last quarter, a 3.50% decrease)
9. **Buy-In Programs** 39 (16 last quarter, a **143.75% increase**)
10. **Hospital Billing** 36 (17 last quarter, a **111.76% increase**)
Information about HCO 36 (4 last quarter, a **800% increase**)

DVHA Beneficiary Calls

1. Affordability 62 (42 last quarter, a 47.61% increase)
2. Complaints about Providers 47 (49 last quarter, a 4.08% decrease)
3. Access to Prescription Drugs 43 (29 last quarter, a 48.27% increase)
4. Information about applying for DVHA programs 41 (32 last quarter, a 28.12% increase)
5. Communication Problems with DCF 40 (40 last quarter, no change)
6. **Eligibility for Buy-In Programs** 20 (7 last quarter, a **185.71% increase**)
7. Eligibility for VHAP 34 (29 last quarter, a 17.24% increase)
8. Fair Hearings 27 (28 last quarter, a 3.57% decrease)
9. Eligibility for Medicaid 25 (31 last quarter, a 19.35% decrease)
10. Transportation 24 (23 last quarter, a 4.34% increase)

C. Cost remains the largest barrier to consumer access to health care.

This quarter the HCO had 149 calls in which the consumer identified affordability as a barrier to access to health care, a 24.16% increase from last quarter when we had 120 such calls. Among consumers on DVHA health care programs, 62 consumers identified affordability as a barrier to accessing health care, a 47.61% increase from the 42 calls the HCO received the last quarter. This quarter, 17.69% of all callers identified difficulty paying for care as a total or significant barrier to getting care. The inability to access care is an issue for consumers across all groups, those insured by state programs, federal programs, private companies, and persons who are uninsured.

Consumers generally do not call the HCO primarily due to the problem of affordability. It is typically a secondary problem, one that consumers mention in relation to what they identify as their primary problem or it arises as an issue when the HCO staff talks to consumers. The

problem of affordability has continued to increase as a consumer complaint since the HCO started tracking this issue in late 2009.

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

- DVHA programs: 62 calls; 5 calls as a primary issue, 57 as a secondary;
- Commercially insured: 23 calls; 1 calls as a primary issue, 22 as a secondary;
- Uninsured: 34 calls; 1 calls as a primary issue, 33 as a secondary; and
- In the remaining calls we did not get the caller's insurance status.

D. Access to prescription drugs remains a problem and access to specialty care may be an emerging problem.

There was a 22.38% increase from last quarter in access to prescription medication calls, an increase from 67 to 82 calls. The increase is even more notable in DVHA calls. There was a 48.27% increase in access to prescription drug calls, an increase from 29 to 43 calls. Access to prescription drugs was a major problem for all consumer groups throughout 2012. There was a 59.09% increase from last quarter in access to specialty care calls, an increase from 23 to 35. Among DVHA calls the increase in specialty calls was 13 to 20, a 53.84% increase.

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

- A table showing monthly totals for All Calls at the end of this narrative, and
- Four data reports based on type of insurance coverage:
 - **All calls/all coverages:** 842 calls;
 - **DVHA beneficiaries:** 373 calls or **44.29%** of total calls;
 - **Commercial plan beneficiaries:** 150 calls or **17.81%**; and
 - **Uninsured Vermonters:** 94 calls or **11.16%**.

II. Green Mountain Care Board activities

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

- Participation in nine meetings of the Green Mountain Care Board, one meeting of the Payment Reform Advisory Group and one meeting of the Health Care Professional Technical Advisory Group.

III. Rate review activities

In addition, the HCO represents the public in rate review proceedings.

- In this quarter, the HCO filed appearances in 16 new rate filings, appeared at eight contested hearings and filed memoranda in 15 cases.
- We attended the Board's November 28, 2012 forum on rate review issues in South Burlington.
- We met with staff from the Vermont Public Interest Research Group to continue to explore ways that VPIRG can help to encourage more public comment in rate review cases.

- We commented on the Green Mountain Care Board’s public outreach and engagement plan with suggestions on how to increase public comment on rate filings and met with the Board’s Stakeholder Engagement Coordinator.
- We provided feedback on the draft Green Mountain Care Board brochure on Health Insurance Rate Review prepared by the Stakeholder Engagement Coordinator.
- We attended the November 15, 2012 Legislative Committee on Administrative Rules meeting on the Board’s rate review regulations, Rule 2.000. As a result of an analysis of the proposed regulation by Legislative Council, the Board agreed to change the rule on party status in rate review cases, making the HCO’s participation in contested cases before the Board optional rather than mandatory.

IV. Hotline call volume by type of insurance:

The HCO received 842 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 **44%** (373 calls), compared to 47% (364) 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 **28%** (233), compared to 36% (275) last quarter;
 - **14% of all callers** (119) had **Medicare only**;
 - **13%** (109) had both **Medicare coverage and coverage through a state program** such as Medicaid, a Medicare Savings Program aka a Buy-In program, or VPharm;
 - **<1%** (3) had a **Medicare Supplemental** plan;
 - **<1%** (2) had a **Medicare Advantage (Medicare Part C)** plan; and
 - The remaining could have had Medicare along with a retiree plan, but our data is not clear on this.
- **Commercial carriers** (employer sponsored insurance, individual or small group plans, and Catamount Health plans) insured **17.81%** (150), compared to 16% (124) last quarter; and
- **Uninsured** callers made up **11.16%** (94) of the calls, compared to 12% (95) 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 872 cases this quarter, compared to 760 last quarter.

- 34.05% (297 cases) were resolved by brief analysis and advice;
- 23.16% (202) were resolved by brief analysis and referral;
-
- 16.51% (144) of the cases were complex interventions, which involves complex analysis, usually direct intervention, and more than two hours of an advocate’s time;

- 12.38% (108) were resolved by direct intervention, including calling an insurance company, calling providers, writing letters, gathering supporting medical documentation, etc.;
- 8.60% (75) 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 (4 “other” outcomes).

Almost 3 %, (2.75%), 24 of the cases, involved appeals.

DVHA Beneficiary Calls

We closed 391 DVHA cases this quarter, compared to 337 last quarter.

- 30.43% (119 cases) were resolved by brief analysis and advice;
- 23.78% (93) were resolved by brief analysis and referral;
- 18.92% (74) were considered complex intervention, which involves complex analysis, usually direct intervention, and more than two hours of an advocate’s time;
- 17.90% (70) were resolved by direct intervention on the caller’s behalf, including advocacy with DVHA and providers, writing letters, and gathering medical information;
- 6.90% of calls (27) 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 (2 “other” outcomes).

A little over 2%, (2.04%), 8 of the cases, involved Fair Hearings.

VI. Case outcomes

All Calls

The HCO got 48 people onto insurance and prevented 23 insurance terminations or reductions. We helped 7 people obtain reimbursements and helped 8 people get claims paid. We assisted 2 people with applications and provided billing assistance to 28 people. We estimated the eligibility for other programs for 43 individuals. We obtained patient assistance for 3 people. We obtained coverage for services for 14 people. As a result of our intervention, 2 claims were written off. We provided other billing assistance to 28 people. We provided 461 individuals with advice and education. We obtained other access or eligibility outcomes for 54 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 consumers \$110,276.44. In calendar year 2012, the HCO saved consumers \$149,122.67.**

An example of an especially good outcome due to the HCO’s intervention involved the “D” family. Mr. D contacted the HCO about his inability to afford \$360 in medicine he required following his recent discharge from the hospital where he had emergency surgery. His situation was urgent when he contacted the HCO. The D family of three had income well below the federal poverty level, even though both parents worked. Only Mrs. D had health insurance, with very limited coverage, through her employer. Their HCO advocate was able to get the whole

family onto Medicaid, enabling Mr. D to get his medication immediately. Additionally, the state insurance was retroactive and covered his recent hospital bill.

Another example of a good result involved a child with Type 1 diabetes who was unable to get his insulin pump supplies due to a billing problem. The HCO advocate was able to resolve the billing problem within three days, and the family was able to get the supplies.

DVHA Beneficiary Calls

We prevented 21 terminations or reductions in coverage for DVHA beneficiaries, and got 7 more people onto different DVHA programs. We assisted 1 individual with an application or review. We estimated the eligibility for other programs for 14 DVHA beneficiaries. We got 7 claims paid or written off, and obtained reimbursement for 2 people. We got other billing assistance for 14 people, and patient assistance for 2 people. We obtained coverage for services for 11 individuals. We provided 192 DVHA beneficiaries with advice or education. We obtained other access or eligibility outcomes for 34 more people.

VII. Issues

The HCO database allows us to track more than one issue per case, so we can see the total number of calls that involved a particular problem. For example, although 216 cases had Eligibility as the primary issue, there were actually a total of 470 calls in which we spent a significant amount of time assisting consumers in obtaining access to health care. See the breakouts of the issue numbers in the individual data reports for a more detailed look at how many callers had questions about issues other than the primary reason for their call.

The information in this section is for All Calls and includes calls in which the issue listed was the caller's primary issue. See the DVHA data report for a similar breakdown for the DVHA beneficiaries who called us.

- **26.60%** (224) of our total calls were regarding **Access to Care**;
- **13.66%** (115) were regarding **Billing/Coverage**;
- **1.43%** (12) were questions regarding **Buying Insurance**;
- **10.69%** (90) were **Consumer Education**;
- **25.65%** (216) were regarding **Eligibility** for state programs, Medicare and Catamount Health plans; and
- **21.97%** (185) were categorized as **Other**, which includes Medicare Part D, communication problems with providers or plans, accessing medical records, changing providers or plans, enrollment problems, confidentiality issues, and now complaints about rates.

A. Access to Care (26.60% of all calls)

We received 224 calls from individuals for whom the primary issue was difficulty getting specific health care, an increase from last quarter's 208 calls. The top eight Access to Care issues, out of over 35 codes were, in descending order:

- 45 calls were for problems obtaining Prescription Drugs, not including Medicare Part D, compared to 35 last quarter;

- 22 Dental, Dentists, Dentures or Orthodontic care, compared to 29;
- 22 Specialty Care, compared to 10;
- 19 Transportation to medical appointments, compared to 18;
- 17 Mental Health (not including Substance Abuse), compared to 9;
- 13 Durable Medical Equipment (DME), Supplies and Wheelchairs, compared to 18;
- 11 Affordability of health care, compared to 14; and
- 10 Pain Management, compared to 11.

B. Billing/Coverage (13.66%)

We received 115 calls related to primary issues with billing, compared to 112 last quarter. The top six billing related issues were:

- 21 Hospital billing, compared to 17 last quarter;
- 13 Claim denials by insurers, compared to 16;
- 11 Provider problems, compared to 5;
- 8 Hospital financial assistance, compared to 2;
- 7 DVHA premiums, compared to 3; and
- 7 Premiums, compared to 4.

C. Consumer Education (10.69%)

We received 90 calls in which consumer education was the primary issue, compared to 78 last quarter. The top four consumer education issues were:

- 38 Information about applying for DVHA programs, compared to 30 last quarter;
- 15 Medicare, compared to 12;
- 13 General questions about insurance, compared to 7; and
- 13 Catamount, compared to 6.

D. Eligibility (25.65%)

We received 216 calls from individuals for whom eligibility for state programs was the primary issue, as compared to 219 last quarter. The top six issues in this category were:

- 44 VHAP, compared to 39 last quarter;
- 42 Medicaid, compared to 43;
- 34 Catamount and Premium Assistance, compared to 36;
- 18 Medicaid Spend Down, compared to 23;
- 11 Long Term Care Medicaid, compared to 11; and
- 11 Medicare, compared to 6.

E. Other (21.97%)

We received 185 calls in this category for which the primary issue was categorized as Other, compared to 150 last quarter. The top six issues in this category were:

- 36 Communication/Complaints: Providers, compared to 39 last quarter;
- 10 Communication Problems with DCF, compared to 11;

- 9 Provider Error/Medical Malpractice, compared to 9;
- 6 Access to Medical Records, compared to 3;
- 6 Information about the HCO, compared to 4; and
- 5 Choosing/Changing Providers, compared to 4.

VIII. Table of All Calls by Month and Year

All Cases	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
January	241	252	178	313	280	309	240	218	329	282
February	187	188	160	209	172	232	255	228	246	233
March	177	257	188	192	219	229	256	250	281	262
April	161	203	173	192	190	235	213	222	249	252
May	234	210	200	235	195	207	213	205	253	242
June	252	176	191	236	254	245	276	250	286	223
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

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