

State of Vermont
Agency of Human Services

Global Commitment to Health
11-W-00194/1

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

Quarterly Report for the period
October 1, 2013-December 31, 2013

Submitted Via Email on February 28, 2014

Background and Introduction

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

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

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

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

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

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

An extension effective January 1, 2011, was granted and included modifications based on the following amendments: 2006 - inclusion of Catamount Health to fill gaps in coverage for Vermonters by providing a health services delivery model for uninsured individuals; 2007 - a component of the Catamount program was added enabling the State to provide a premium subsidy to Vermonters who had been without health insurance coverage for a year or more, have income at or below 200 percent of the Federal Poverty Level (FPL), and who do not have access to cost effective employer-sponsored insurance, as determined by the State; 2009 - CMS processed an amendment allowing the State to extend coverage to Vermonters at or below 300 percent of the FPL; 2011 - inclusion of a palliative care program for children who are at or below 300 percent of the FPL, and have been diagnosed with life limiting illnesses that would preclude them from reaching adulthood. This program allows children to receive curative and palliative care services such as expressive therapy, care coordination, family training and respite for caregivers.

In 2012, CMS processed a cost-sharing amendment providing the authority for the State to eliminate the \$75 inpatient co-pay and to implement nominal co-pays for the Vermont Health Access Plan (VHAP). In 2013, CMS approved Vermont's Waiver Renewal for the period from October 2, 2013-December 31, 2016.

In 2013, CMS approved Vermont's correspondence, dated November 19, 2013, which requested authorization for expenditure authority for the period from January 1, 2014-April 30, 2014, to ensure temporary coverage for individuals previously eligible and enrolled as of December 31, 2013, in coverage through VHAP, Catamount Premium Assistance, and pharmacy assistance under Medicaid demonstration project authority.

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 9, covering the period from October 1, 2013 through December 31, 2013.***

Global Commitment to Health Waiver: Renewal

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

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

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

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

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

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

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

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

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

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

AHS received CMS approval of its Waiver renewal request effective as of October 2, 2013. The approval allows Vermont to sustain and improve its ability to provide coverage, affordability, and access to health care by making changes that conform to the new coverage opportunities created under the Affordable Care Act, such as adoption of the new adult group in the Medicaid State Plan, and the authority to provide hospice care concurrently with curative therapy for adults.

CMS and AHS continue to collaborate on review of Vermont’s requests related to use of modified adjusted gross income (MAGI) for MAGI exempt beneficiaries, and consolidation of the Choices for Care waiver and the Children’s Health Insurance Program (CHIP) into the Global Commitment to Health Waiver.

Enrollment Information and Counts

Table 1 presents point-in-time enrollment information and counts for Demonstration Populations for the Global Commitment to Health Waiver during the first quarter of Federal Fiscal Year (FFY) 2014. Due to the nature of the Medicaid program, beneficiaries may become retroactively eligible and may move between eligibility groups within a given quarter or after the end of a quarter. Additionally, since the Global Commitment to Health Waiver involves most of the State’s Medicaid program, Medicaid eligibility and enrollment in Global Commitment are synonymous, with the exceptions of the Choices for Care Waiver and CHIP.

Table 1 is populated based on reports run the Monday after the last day of the quarter. Results yielding less than or equal to a 5% fluctuation quarter to quarter are considered as illustrating normal deviations reflecting retroactive eligibility determinations and expected terminations. Results reflecting more than a 5% fluctuation between quarters are reviewed by DVHA and AHS staff for further detail and explanation.

Table 1. Point-in-time Enrollment Information and Counts for Demonstration Populations*, FFY 2014 Q1

Demonstration Population	Current Enrollees Last Day of Qtr 12/31/2013	Previously Reported Enrollees Last Day of Qtr 9/30/2013	Variance 9/30/13 to 12/31/13
Demonstration Population 1:	145,498	145,446	0.04%
Demonstration Population 2:	130,263	131,481	-0.93%
Demonstration Population 3:	28,998	29,618	-2.09%
Demonstration Population 4:	N/A	N/A	N/A

Demonstration Population 5:	2,598	2,657	-2.22%
Demonstration Population 6:	8,322	8,826	-5.71%
Demonstration Population 7:	105,494	107,354	-1.73%
Demonstration Population 8:	30,620	30,505	0.38%
Demonstration Population 9:	7,783	7,794	-0.14%
Demonstration Population 10:	N/A	N/A	N/A
Demonstration Population 11:	41,962	40,093	4.66%

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

Outreach Activities

Member Relations

The DVHA Provider and Member Relations Unit published a Banner in November to outreach all primary care physicians (PCPs) regarding standards for access to care and waiting time. This Banner reminded PCPs: of the standards for waiting times for access to care; to have provisions for access to coverage 24 hours per day/7 days per week in order to assure practitioner availability in person or by phone; and to maintain office-visiting hours at least four days per week for at least 25 hours per week for member appointments.

Operational/Policy Developments/Issues

Vermont Health Connect

The Vermont Health Connect (VHC), a state-based health insurance marketplace launched on October 1st. Between October 1 and December 31, over 15,000 Vermonters applied for coverage through VHC. In November, the Vermont launched premium processing functionality for individuals and worked with the insurance carriers to effectuate coverage for January 1, 2014. Delays in system functionality prompted Governor Shumlin to issue an order allowing individuals to extend their 2013 insurance coverage for three months and for small businesses to directly enroll through insurance carriers. Vermont continues to work closely with contracting partners to expand functionality and optimize system performance during the implementation of VHC.

VHC's Customer Support Center went live on September 3rd and is currently assisting Vermonters with eligibility questions and telephonic applications. VHC continues to implement an ambitious outreach and education campaign and to collaborate with key stakeholders, including insurance carriers, brokers, small business owners, and community partners. This outreach and education campaign will continue until March 31, 2014, which marks the end of the open enrollment period. Additionally, Vermont developed a comprehensive training plan and continues to work with agencies and departments to ensure that roles and responsibilities are clearly defined, business processes are fully mapped, and adequate resources are in place to support operations.

Marketplace Subsidy Program

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

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 and supporting improvement in medical and behavioral health, as well as socioeconomic issues that are often barriers to sustained health improvement (e.g. housing). 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 for ambulatory sensitive conditions (ACS). The VCCI uses both individual- and population-based approaches to identify and resolve gaps in evidence-based care, including pharmacy services. Ultimately, the VCCI aims to improve health outcomes by: supporting better self-care; utilizing motivational interviewing techniques to support behavioral change; and lowering health care expenditures through appropriate utilization of health care services (e.g. use of primary care medical home vs. ED). By targeting predicted high-cost beneficiaries, resources can be allocated to areas representing the greatest opportunities for cost savings.

Medicaid beneficiaries that are eligible for VCCI account for the top 5% of utilization of services; this population is projected to become 'super-utilizers' of services. There are about 32 chronic conditions that generate high service utilization patterns, and ultimately contribute to health care expenditures. Recent data provided by the DVHA/VCCI contracted vendor, APS Healthcare, indicate that the State's eligible cohort accounted for 39% of the Medicaid spend in calendar 2012. This includes: 20% of all ACS emergency department (ED) costs; approximately 60% of ACS inpatient costs; and 88% of hospital readmission costs. The VCCI's strategy of embedding staff in high-volume hospital and primary care sites continues to support population engagement at the point of need in these areas of high service utilization. VCCI's strategy also supports transitions of Medicaid beneficiaries between hospital and community care settings.

The VCCI is expanding its embedded staffing model with licensed staff in high volume Medicaid primary care sites and hospitals that experience high rates of ambulatory sensitive ED visits and inpatient admissions/readmissions for ambulatory care sensitive conditions. At the end of the quarter, the VCCI had staff in 19 locations including nine AHS district offices, three hospitals and seven primary care provider locations. The embedded approach offers several advantages. First, it fosters strong provider relationships and direct referral for high-risk populations. Second, it encourages 'real time' case findings at the point-of-service within PCP and hospital sites to assist in reducing readmission rates in high-risk populations. Third, it provides an opportunity for enhanced coordination and care transitions with hospital partners and primary care sites, as well as with home health agencies who may be delivering skilled nursing care post-discharge. All VCCI staff statewide interface with hospital discharge planners and case managers (hospital liaisons), as appropriate, to facilitate transitions in care for beneficiaries.

Data exchanges from partner hospitals via secure FTP site transfers provide the VCCI team with real-time, daily inpatient data for both hospital inpatient and ED admissions. Currently four hospitals including Vermont's tertiary care center provide these data sets electronically (FAHC, Copley, NWMC, and CVMC) while several other hospitals provide secure Excel reports that are downloaded locally or sent via fax transmittals. The VCCI aims to secure data from all 14 hospitals in Vermont.

The VCCI continues to experience challenges related to timely recruitment (and retention) of nurses with the applicable background and experience in case management. This is attributed to the pay rate available in state government, which is significantly less than available from other insurance carriers, hospitals and/or care management organizations.

As per earlier reports, the VCCI is strategically aligned with another important State health care reform effort known as the Blueprint for Health. The Blueprint for Health is the State's NCQA certified advance

practice medical homes and local Community Health Teams (CHTs), which are funded by a multi-payer demonstration. VCCI staff are members of the local CHT, supporting both patients and providers. This collaboration facilitates effective transitions between levels of care and reduces redundancies, as VCCI supports the highest risk population of Medicaid members and the CHT supports less acute members. The Blueprint for Health expanded its efforts to include ACA-funded Health Homes with a focus on substance abuse treatment. The VCCI is a partner in the resulting 'Hub and Spoke' teams and offers support, without duplication, for this vulnerable population. These efforts are becoming more linked to other specialty care management services, including the high risk pregnancy case management pilot as outlined below.

Pediatric Palliative Care Program

The Pediatric Palliative Care Program (PPCP) is a statewide program that maintains an active enrollment of approximately 35-40 children and families. VCCI recently drafted survey materials to assess quality and consumer satisfaction of the PPCP program. Dissemination of this survey is anticipated in the 2nd quarter of Federal Fiscal Year (FFY) 2014 in partnership with the VDH. Additionally, HHA partner auditing is underway as a quality improvement tool, and to identify and improve gaps in service or the consumer experience of care.

High Risk Pregnancy

The VCCI launched a pilot for the High Risk Pregnancy Case Management program on October 1, 2013 in Franklin and Grand Isle Counties. This new service for vulnerable pregnant women and their unborn child(ren) is a partnership between DVHA and the Vermont Department of Health (VDH). The program also must align with ACA Health Homes initiative to support individuals with substance abuse disorders, and VDH programs and services available for maternal and child health. The program is centrally administered and focuses on the system of care and coordination of services for the identified population. The High Risk Pregnancy Case Management program aims to facilitate early identification of at-risk women via various channels, including Medicaid enrollment data for pregnant women, pharmacy indicators, and direct referral from community partners.

At this time, it is challenging to demonstrate the outcomes of this new identification and outreach program during the first quarter of FFY 2014 as there were limited referrals to the service and challenges related to the collected data. After evaluating these issues, the VCCI decided to expand the pilot program to a larger hospital service area of Chittenden County, effective as of January 1, 2014. Additionally, VCCI staff will be meeting with data analysts at its contracted partner HP to create early enrollment and clinical reports for Medicaid members with associated claims for procedures linked to risk factors for high risk pregnancy.

APS Contract

Since 2007, DVHA has contracted with APS Healthcare for assistance in providing disease management assessment and intervention services to Vermont Medicaid beneficiaries with chronic health conditions. The VCCI has progressively migrated away from traditional telephonic disease management, and in 2011 implemented a combination of individual and population-based strategies with a primary focus on the top 5% of beneficiaries accounting for highest service utilization. The DVHA has found this to be an effective approach because VCCI staff are able to communicate with providers, partners, patients, and their families.

In 2011, DVHA's contract with APS Healthcare was 100% risk based with a guaranteed 2:1 ROI. In State FY 2012, the VCCI delivered a net \$11.5 million ROI which included both APS and DVHA staff efforts. These efforts resulted in DVHA effectively reducing rates of ED, IP and readmissions. Data related to FY 2013 are anticipated to be available in the second quarter, and pending a six-month claims lag for data analysis.

Currently, a RFP process is underway as DVHA anticipates procurement of an enterprise-level care management system. To assure continuity of VCCI business operations, DVHA extended its contract with APS Healthcare through June 30, 2014; there will be maintenance of the ROI during the current contract period. Given a delayed RFP release date of mid-December 2013, DVHA initiated discussions with APS Healthcare to exercise a final extension to assure onboarding of the new enterprise-level care management system. This onboarding process will begin with VCCI.

APS Healthcare provides several services to support DVHA staff and programs. First, APS Healthcare continues to provide enhanced information technology and sophisticated decision-support tools to assist DVHA's case management staff. These services from APS Healthcare aid DVHA's outreach to the most costly and complex beneficiaries based on risk factors and support DVHA's ability to positively impact the results of its programs. Second, APS Healthcare provides supplemental reports on population-based gap in care to DVHA's staff in the field. The field-based staff also supports the Blueprint NCQA providers and their Community Health Team staff. These supplemental reports from APS Healthcare will also support the impending Medicaid ACO partners. Per terms in the Medicaid ACO contract, Medicaid ACO partners will be required to collaborate with VCCI staff.

The following are highlights of the VCCI during the first quarter of FFY 2014:

- Launched our high risk pregnancy case management pilot in Franklin and Grand Isle Counties October 1st, 2013.
- Added a new embedded hospital site with the addition of Fletcher Allen Health Care (FAHC).
- The VCCI hosted colleagues from State of Maryland SIM team in early November for a two-day site visit including field visits and meetings with DVHA staff, CHT partners and embedded staff models at provider and hospital locations. The SIM team is designing a multi-payer medical home model that looks at high cost, high risk populations and strategies to engage and manage in partnership with providers.
- Teams from the Vermont Health Care Innovation Project (VHCIP) focused on care models and care management. The VCCI presented to the multidisciplinary group on its comprehensive, holistic model and interface with existing community models, providers and partners to gain significant clinical and financial savings.
- Collaboration with DVHA and VCCI is a contract requirement for the two successful Medicaid ACO applicants.
- A RFP for Care Management is in development, with the original release date of mid-December 2013 pushed back to mid-January 2014. Resultantly, VCCI initiated contract discussions with APS Healthcare for an extension to the current contract to ensure that service is not interrupted and data are effectively migrated to the new enterprise-level system.
- Per the current DVHA contract with APS Healthcare, provider education and outreach is underway in multiple high volume primary care provider organizations statewide. This provider education and outreach aims to endorse and facilitate adoption of VCCI tools for more effective care management, with a focus on eligible beneficiaries that account for the top 5% of those at risk. These tools and presentations will also support ACO adoption of Medicaid/VCCI data on high risk/cost members, including those with high utilization patterns and/or with gaps in care.
- With the launch of VHC, VCCI will have an additional 35,000 potential Medicaid member converting from VHAP to straight Medicaid. Work is underway with the COB unit and with APS Healthcare to assure new codes are appropriately tracked for eligible members.
- The VCCI is working with DVHA data unit and APS Healthcare to assure ICD-10 code readiness within the APS data analytic environment.

- The VCCI manager for Clinical Operations and Quality Services is the DVHA representative to a statewide ASTHO grant received by the Vermont Department of Health. The goal is to work with hypertensive patients to facilitate effective clinical management. The kick off meeting was in Arlington, Virginia in early December.
- A Market Factor Analysis for nursing positions remains under consideration. Turnover and recruitment of nurses continues to be a challenge. A meeting with DVHA nursing leadership, comprised of VCCI leadership and human resource representatives, is slated for early January 2014 to identify strategies to support recruitment and retention concurrent with the market factor review.
- The VCCI caseload was 732; with 443 unique members served for the quarter.
- Interim clinical management tracking systems and tools for both the PPCP and HRP efforts have been adopted to support operation, pending the new MMIS/Care Management system procurement.

Hub and Spoke Initiative: Integrated Treatment for Opioid Dependence

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

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

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

clinicians for Health Home services.

A total of five regional Hubs are planned that build upon the existing methadone OTPs and also provide buprenorphine treatment to a subset of clinically complex buprenorphine patients, as well as serve as the regional consultants and subject matter experts on opioid dependence and treatment. Hubs are replacing episodic care based exclusively on addictions illness with comprehensive health care and continuity of services. The first Hubs were implemented under the first Health Home SPA on July 1, 2013. Two additional regional Hubs will be implemented through the second SPA beginning in January 1, 2014.

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

The following are highlights of the Hub and Spoke Initiative during the first quarter FFY 2014:

- Negotiations with CMS were completed for the first final Hub and Spoke Health Home SPA. The SPA was submitted to CMS in December 2013. Hub and Spoke Health Homes now cover ten counties in the Northwest, Central, and Southeast regions of Vermont.
- A new Hub program opened in November 2013 serving Rutland and Bennington Counties. This Hub, along with the fifth program serving Essex, Orleans, and Caledonia Counties will be included in the second SPA (scheduled for the first quarter in calendar year 2014).
- In addition to providing methadone MAT as they have traditionally done, Hubs now also provide buprenorphine MAT to complex patients (approximately 20% of the total caseload), allowing Spoke physicians to focus on patients who are most appropriate for office-based care. In October, the Hubs participating in the first SPA served 1,151 patients and of these, 243 received dispensed Buprenorphine from the Hub.
- 76% of the 40 new Spoke staff for statewide implementation of the program (SPA 1 and 2) are now hired, working with 57 buprenorphine providers serving 1,919 Medicaid beneficiaries receiving MAT with buprenorphine. Spoke staffing is scaled at 1 RN and 1 licensed clinician for every 100 MAT patients.
- Two Regional Learning Collaboratives for Spoke physicians and practice teams were completed in the Southwest and Northwestern regions of Vermont.
- Two Regional Learning Collaboratives for Spoke physicians and practice teams were convened this quarter in Central and Southeastern Vermont.
- Statewide Learning Collaboratives for Hubs, and one for the Spoke staff (RNs and licensed clinicians) who provide the Health Home services, began this quarter.
- Practice facilitators are working extensively with Hub and Spoke providers on common measurement, practice-level quality improvement, and implementation of evidence-based care.

Table 2. Hub Caseload

Regional Hub Programs	Total Served	# Receiving Buprenorphine
Chittenden/Franklin/Grand Isle/Addison Counties	592	147
Windham/Windsor Counties	411	51
Washington/Lamoille/Orange Counties	148	45
Total	1,151	243

Table 3. Buprenorphine Providers, Spoke Funding & Staff Recruitment, and Medicaid MAT Beneficiaries by Region

Region	Providers	Medicaid Beneficiaries	Staff FTE Funding	Staff FTE Hired
Bennington	6	151	3	3
St. Albans	7	249	5	3.8
Rutland	5	242	4.5	2.1
Chittenden	12	408	7.35	7.25
Brattleboro	6	238	5	5
Springfield	3	54	1.5	1.5
Windsor	1	64	1.5	1.5
Randolph	3	91	2	1.8
Barre	8	201	4.5	2.5
Lamoille	6	125	2.5	2
Newport & St Johnsbury	3	98	2	0
Total	57	1,652	40	30.45

Manage Substance Abuse Services

In 2012, DVHA established a Substance Abuse Unit to consolidate its substance abuse services into a single, unified structure and point of contact for prescribers, pharmacists, and beneficiaries. This unit provides seamless and integrated care to beneficiaries receiving 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 Care Alliance for Opioid Addiction (Hub and Spoke model), the VCCI and the DVHA Pharmacy Unit to provide beneficiary oversight and outreach. All beneficiaries receiving MAT services with buprenorphine have a Pharmacy Home that dispenses all their prescriptions. In addition to overseeing these programs, the Substance Abuse Unit coordinates and facilitates prescriber reconsideration requests and appeals when prior authorizations for controlled substances are denied.

Team Care Program

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

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

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

Buprenorphine Program

The DVHA, in collaboration with the Vermont Department of Health’s Alcohol and Drug Abuse Programs (ADAP), maintains a Capitated Program for the Treatment of Opiate Dependency (CPTOD). The CPTOD provides an enhanced remuneration for physicians in a step-wise manner depending on the number of beneficiaries treated by a physician enrolled in the program. The Capitated Payment Methodology is depicted in the following table (Table 4).

Table 4. Capitated Program for Treatment of Opiate Dependency (CPTOD)

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

The total for the first quarter of 2014 (October 2013- December 2013) is \$29,729.72 (Table 5).

Table 5. Buprenorphine Program Payment Summary FFY 2014

FIRST QUARTER, FFY 2014	
Oct-13	\$12,041.22
Nov-13	\$17,688.50
Dec-13	(No data at this time)
1st Quarter Total	\$29,729.72

The development of the Vermont *Buprenorphine Practice Guidelines* continues to be a collaborative effort with the Vermont Department of Health, Division of Alcohol and Drug Abuse Programs (VDH/ADAP) and other community partners. The Buprenorphine Practice guidelines are also reviewed and updated every two years. The DVHA has revised the guidelines and they were submitted and approved by the Managed Care Medical Committee (MCMC) in November 2012.

340B Drug Discount Program

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

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

Covered entities include:

- Certain nonprofit disproportionate share hospitals (DSH), critical access hospitals (CAH), and sole community hospitals owned by or under contract with state or local government, as well as certain physician practices owned by those hospitals, including Rural Health Clinics
- Federally qualified health centers (FQHCs) and FQHC "look-alikes"
- State operated AIDS drug assistance programs (ADAPs)

- The Ryan White CARE Act Title 1, Title 11, and Title III programs
- Tuberculosis clinics
- Black lung clinics
- Family planning clinics
- Sexually transmitted disease clinics
- Hemophilia treatment centers
- Public housing primary care clinics
- Homeless clinics
- Urban Indian clinics
- Native Hawaiian health centers

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

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

In 2010, 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. The 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
- Indian Stream Health Center (NH)
- 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 DVHA applied for, and on January 10, 2012 received, federal approval for a Medicaid pricing 340B methodology.

To encourage participation in the Vermont Medicaid 340B program, providers will receive an incentive payment. The methodology for the 340B incentive payment is the lesser of 10% of the total Medicaid savings or \$3/per claim for non-compound drugs and \$30/per claim for compound drugs.

Claims are paid at the regular rates and a monthly true-up process calculates the 340B acquisition cost, dispensing fees, savings, and what is owed back to the State with payments due 30 days after the invoices are mailed. Currently, Community Health Pharmacy and its five FQHCs continue to participate. In addition, Notch Pharmacy, Central Vermont Medical Center, Planned Parenthood of Northern New England, 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 and in 2013 Springfield Hospital and Indian Stream Health Care enrolled with Medicaid. The 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, 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 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. The DVHA's DUR programs take a multilevel approach to identifying, filtering, and communicating important information pertaining to the prescribing and/or consumption of medications. It is an approach that analyzes patterns of utilization at a patient-specific level, as well as the unique prescribing habits and the pharmaceutical care provided by the physician. The criteria, research and compilation of data, and recommended actions are reviewed and approved by consensus of Vermont's DUR board.

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

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

conjunction with any other investigation initiated by MFRAU, Vermont Medical Practice Board and/or OPR. Standard Program Integrity guidelines and protocols are utilized to ensure appropriate steps are taken.

340B Reimbursement and Calculation of Incentive Payment

Determination of Dispensing Fee and Savings Sharing Amounts

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

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

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

Vermont’s proposed reimbursement methodology 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 entities to share in Medicaid savings. We believe the proposed approach represents an innovative payment strategy that reasonably reimburses pharmacies, encourages covered entity participation and promotes program savings. 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 greater participation in the program.

Because of federal laws prohibiting “duplicate discounts” on Medicaid drug pricing related to the interaction of 340B and manufacturer rebate programs, Medicaid participation in 340B has been limited both in Vermont and nationally. Vermont put in place an innovative, first in the nation methodology to maximize Medicaid participation in 340B pricing for Medicaid beneficiaries served by eligible prescribers at 340B enrolled covered entities. This methodology can enable substantial expansion participation in 340B. Using the Global Commitment authority, DVHA provides incentive payments to providers for their 340B participation that recognizes the additional administrative burden of the program. Because of the beneficial 340B pricing, both Vermont and CMS benefit from higher 340B covered entity-employed prescriber and Medicaid beneficiary participation in the program. For the reporting period, Vermont has realized \$506,152.07 for Q4 2013 Net Cost savings through Medicaid participation of a relatively small number of eligible covered entities. Total savings to-date for CY 2013 is \$1,743,518.64. The DVHA is focused on outreach and education of all Vermont covered entities to encourage enrollment in the 340B discount program.

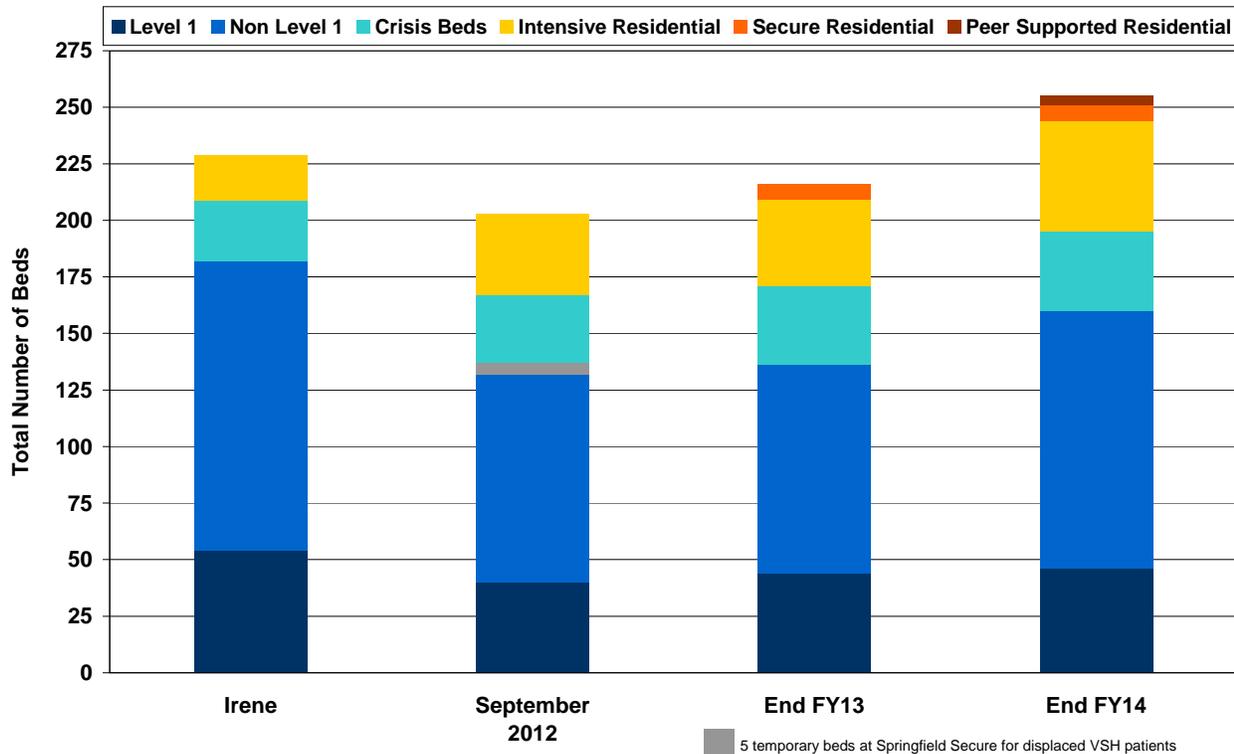
Mental Health System of Care

State Hospital Inpatient Replacement Planning

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

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

**Vermont Department of Mental Health
Psychiatric Beds in System of Care**



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

Development of two additional residential programs continue to move forward. Pathways Vermont filed their Certificate of Need application on October 23rd to develop Soteria Vermont at a residential property in Burlington’s Old North End. The application is under review by the Green Mountain Care Board, which has regulatory authority for the CON process. Pathways Vermont seeks to develop a 5-bed therapeutic care residence for persons experiencing an initial episode of psychosis. Soteria is a program component of the continuum of care modal for delivery of mental health services outlined in Act 79 of 2012. The new framework includes alternative treatment options for individuals seeking to avoid or reduce reliance on medications. The legislation states that the Soteria “residence shall be peer supported and noncoercive, and treatment shall be focused on a nontraditional, interpersonal, and psychosocial approach, with minimal use of psychotropic medications to facilitate recovery in individuals seeking an alternative to traditional hospitalization.” Pathways Vermont chose the Chittenden County location due to

its many younger people, a target population of the project. Read application here: http://gmcboard.vermont.gov/sites/gmcboard/files/Soteria_Application_2013_10_23.Pdf.

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

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

Community System Development

Act 79 authorized significant investments in a more robust publicly funded mental health services system for Vermont. Fiscal Year 14 funding supports the implementation of service expansion in several support and services areas that will offer a stronger continuum of care for the public mental health system. Each new initiative carries reporting requirements to inform the Department of Mental Health (DMH) regarding overall contribution to the system of care and impacts to persons served. A full report of Act 79 funded initiatives and early outcomes will be submitted to the Vermont Legislature on January 15, 2014. The report will provide an overview of the significant program development areas and preliminary data collection and outcomes findings.

Integrated Family Services (IFS) Initiative

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

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

childhood programs and others.

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

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

The initial IFS pilot, in Addison County, finished the first full state fiscal year. This included 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.
- Initial numbers indicate an ability to serve more children and families with the same amount of resources.

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

This shift continues to be addressed both programmatically and financially. There is a review of the method used to establish the PMPM to see if there is a more effective method. There are currently three other regions interested in undertaking this model. The second pilot region will be in effect April 1, 2014 with a third potential in effect July 1, 2014.

The AHS applied for a CMMI grant to bring resources to IFS to more fully develop the funding and service delivery model but have yet to hear of a decision. The interest in moving statewide continues and more providers, including Federally Qualified Health Centers (FQHCs) are expressing interest in being a part of IFS. Additionally IFS continues to work on statewide healthcare reform and aligning approaches to achieve an integrated behavioral health and physical health system.

Financial/Budget Neutrality Development/Issues

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

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

AHS has begun to work with its actuarial consultant, Milliman, on a one year contract extension for FFY15 PMPM rate development, to become effective on April 1, 2014.

On December 17, 2013, AHS received notice from CMS that the QE1212, QE0313, and QE0613 GlobalRx MEG deferrals had been released and not further deferral action would be taken.

AHS, DVHA and CMS have worked throughout QE1213 to prepare for the new reporting requirements, effective with the QE0314 CMS-64 submission, per the October 2, 2013 STCs.

Member Month Reporting

Demonstration Populations are not synonymous with Medicaid Eligibility Group reporting in the following table. The numbers presented in the below table (Table 6) may represent duplicated population counts. 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.

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

Table 6. Demonstration Populations, by Quarter for FFY 2013 and 2014

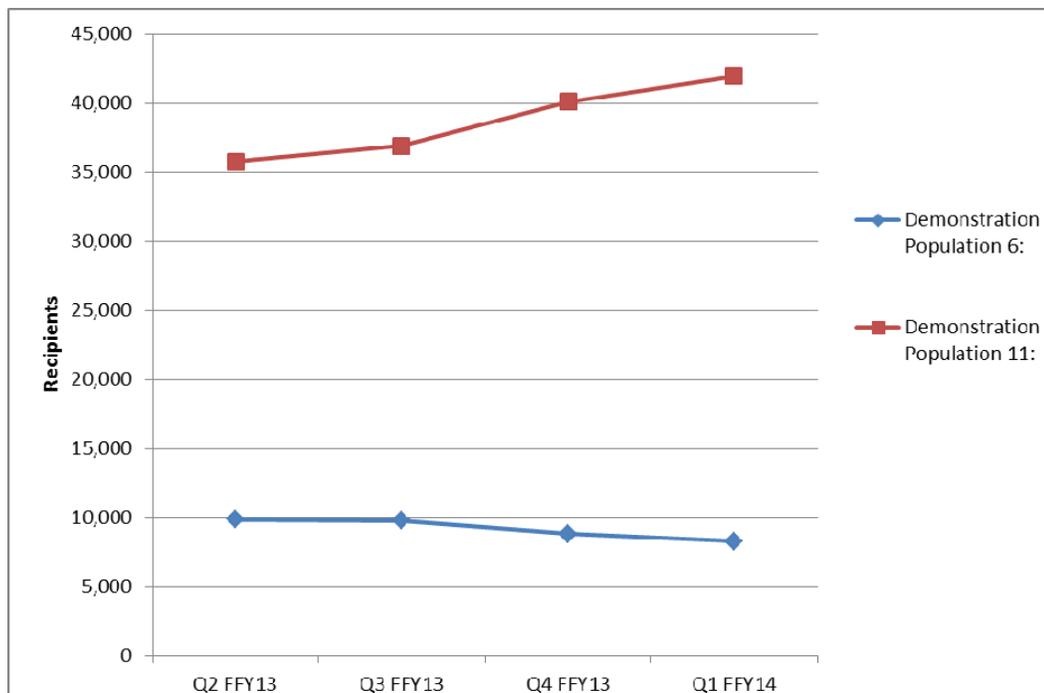
Demonstration Population	Total for Quarter Ending 1st Qtr FFY '14	Total for Quarter Ending 4th Qtr FFY '13	Total for Quarter Ending 3rd Qtr FFY '13	Total for Quarter Ending 2nd Qtr FFY '13

Demonstration Population 1:	145,498	145,446	145,178	146,690
Demonstration Population 2:	130,263	131,481	132,125	136,453
Demonstration Population 3:	28,998	29,618	29,439	29,377
Demonstration Population 4:	N/A	N/A	N/A	N/A
Demonstration Population 5:	2,598	2,657	2,748	2,769
Demonstration Population 6:	8,322	8,826	9,790	9,871
Demonstration Population 7:	105,494	107,354	109,242	108,099
Demonstration Population 8:	30,620	30,505	30,450	30,236
Demonstration Population 9:	7,783	7,794	7,833	7,962
Demonstration Population 10:	N/A	N/A	N/A	N/A
Demonstration Population 11:	41,962	40,093	36,909	35,775

Two Demonstration Populations had a fluctuation greater than 5%, Demonstration Population 6 and 11. As the State launched VHC, it was anticipated that fluctuations would be observed due to eligibility changes. The overall population, in sum, between FFY13 Q3 and FFY13 Q4 is different by 0.44% (n=2,236).

As shown in the below figure (Figure 1), during the previous four quarters Demonstration Population 6 had a gradual decline in the number of recipients while Demonstration Population 11 had a gradual increase in the number of recipients.

Figure 1. Number of Recipients, by Quarter for FFY 2013 and 2014



Consumer Issues

The AHS and DVHA have several mechanisms whereby consumer issues are tracked and summarized. The first is through Health Access Member Services. This is a contracted function for providing information on health care programs, assisting with the eligibility process, and helping beneficiaries to understand the benefits and responsibilities of their particular program. The complaints received by Member Services are based on reports provided to DVHA (see Attachment 3). Member Services works to resolve the issues raised by beneficiaries, and their data helps DVHA look for any significant trends. The reports are seen by several management staff at DVHA and staff ask for additional information on complaints that may appear to need follow-up to ensure that the issue is addressed.

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

The third mechanism to track consumer issues is the Office of Health Care Ombudsman (HCO) report which is a comprehensive report of all contacts with beneficiaries (see Attachment 5). These include inquiries, requests for information, and requests for assistance. The HCO's role is to assist individuals to navigate health care insurance systems, and help to resolve eligibility and coverage problems.

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 for Members Diagnosed with Congestive Heart Failure* PIP received an overall *Met* validation status. Through its quality improvement processes, DVHA was able to strengthen the relationship between VCCI and providers who may be more likely to refer not only their Medicaid patients with CHF for VCCI services, but also others with high-risk conditions. Other entities and reform initiatives have also focused their efforts on treating CHF. Such efforts have led to improved collaboration within VCCI. In addition, the processes used to develop and evaluate interventions for CHF have become the model for developing interventions for other high-risk and high-cost members served by VCCI.

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. DVHA enjoyed a high degree of electronic claims data and automated processes, enhancing the validity of data, while the payment structure facilitated data completeness. DVHA continued to look for new opportunities to expand its role in the changing health care environment, for example, obtaining a grant for CMS adult core set measure reporting, and has invested time and resources to understand and implement the measures. DVHA's HEDIS team collaborates well with the common goal of obtaining complete and accurate data. New this year, DVHA's quality team began reviewing performance measure rates in detail in an effort to identify mechanisms for improving the quality of care and outcomes for its members.

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. DVHA's performance represented a substantive improvement from its performance in HSAG's 2009–2010 review of the same standards. Through both the documentation review and the on-site review, HSAG reviewers experienced a DVHA staff that was passionate about doing the right thing for enrollees and constantly

vigilant in identifying and taking advantage of opportunities to improve the access to, and the quality and timeliness of, services. DVHA and AHS were also committed to assessing the unique leadership and content area, and the expert skills, of DVHA's staff members when assigning them to key positions within the MCE. In collaboration with and under the leadership of AHS, DVHA was on the cutting edge of innovation in its service delivery models, financing, and programs. AHS and DVHA also continued to be nationally recognized by CMS, health care associations and organizations, and HSAG as health care innovators that were among the most proactive, member-focused, and leading health care systems in the nation in providing services to the MCE's enrollees. AHS and DVHA regularly took advantage of opportunities to secure grants and funding beyond the State Medicaid allocation to support their programs and to design and implement new ones. They also worked collaboratively with other states to obtain grants to support and enhance their ongoing programs and operations, and to design new delivery and care management models. With its information system vendor, DVHA also constantly reviewed, identified, and implemented enhancements to the data it captured and the sophistication of its information systems data collection and reporting capabilities.

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. With each successive EQR contract year, HSAG found that for the three activities HSAG conducted, DVHA had increasingly followed up on HSAG's prior year recommendations and had initiated numerous additional improvement efforts. DVHA, in consultation with AHS, regularly conducts self-assessments and, as applicable, modifies 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. DVHA's continuous quality improvement focus and activities, along with the steady improvements made across the years HSAG has conducted the EQR activities, have been substantive and led to demonstrated performance improvements, notable strengths, and commendable and impressive outcomes across multiple areas and performance indicators. As previously noted, AHS is frequently spotlighted in health care publications for the work that the Agency, DVHA, and DVHA's IGA partners are doing; the models they use to structure and fund the delivery systems; and the innovative approaches and models they use in financing and providing the services to beneficiaries, including being one of the first Medicaid managed care programs to implement a medical home model of care. HSAG continues to experience DVHA's impressive growth, maturity, and drive to continually improve its performance results across the EQR contract years.

DVHA Quality Improvement

The DVHA Quality Committee held three meetings during the first quarter of FFY 2014, and the DVHA Quality Improvement Director attended three meetings of the AHS Performance Accountability Committee. Three new members were identified for the DVHA Quality Committee, including a new DVHA Medical Director; a meeting was held to orient the new members. The DVHA Medical Director will co-chair the Committee.

The DVHA Quality Committee met on several initiatives and topics:

- The Committee focused on the CMS Adult Core Measures list and received updates regarding the work of the Adult Measures Grant. The Committee reviewed the measures, focusing on the following areas: those that are part of the current performance improvement projects, those that are collected using the hybrid methodology, and how the performance percentile needs to be placed in context to the national mean.
- The Committee received an update on the VCCI's pharmacy adherence project, which focuses on the VCCI heart failure population.

- The DVHA Quality Committee followed up with the DVHA Policy Unit regarding the Committee's recommendations for regular HIPAA trainings for staff in DVHA. The recommendation will be brought to the AHS Privacy Workgroup that coordinates HIPAA training activities.
- Members of the DVHA Quality Unit met with representatives of IGA partners to assist with the development of their Quality Plans. The DVHA Quality Committee continues to work on identifying the quality indicators that each IGA partner will be reporting to the Committee.
- The Committee continued to work on a quality page for the Green Mountain Care website, which focuses on how to inform Global Commitment beneficiaries about the quality of care that is provided to them. The Committee discussed the common components that comprise the quality of health care by reviewing the Institute of Medicine's (IOM) six quality categories: effectiveness, efficiency, equity, safety, timeliness and patient centeredness. The Committee discussed the components of quality of care in relation to the health care reform's Triple Aim initiatives: 1) improving the patient experience, 2) improving the health of populations, and 3) reducing the per capita of cost of health care.

DVHA began a new PIP that focuses on improving follow-up care for beneficiaries after psychiatric hospitalization. A team is being developed to include staff from DVHA and the IGA partners, and work began on identifying the study topic. Also, the DVHA Quality Unit made significant progress on the two PIPs funded by the Adult Quality Measures Grant. The two projects focus on increasing breast cancer screenings and improving initiation and engagement in substance abuse treatment. Both projects include partners from AHS as well as community partners and stakeholders. In addition to the three formal PIPs, DVHA continues to participate in the Agency Improvement Model (AIM) trainings and implement process improvement projects.

Quality Strategy

The AHS Quality Improvement Manager engaged members of the Performance Accountability Committee (PAC) in a review of the Quality Strategy. Once the final EQRO Annual Technical Report is published, the AHS Performance Accountability Committee (PAC) will re-evaluate the strategy using the findings. In addition to modifying the document, the group will continue to consider how state quality strategy initiatives might align with separate yet related federal and state quality documents to ensure maximum results.

Compliance

The Managed Care Medical Committee made updates to its charter and approved a new work plan. The work plan sets a schedule for reviewing/updating current practices such as prior authorizations, review of clinical practice guidelines and provider network review. The plan also creates a timeline for the development of new clinical practice guidelines and documentation standards. We are currently considering a process for reviewing certain HEDIS measures with this Committee in order to ensure that our clinical policies are data-driven. The Managed Care Medical continues to work on clinical documentation standards and we expect to have an approved update to these standards by the end of March, 2014.

The Compliance Director continued to meet with our IGA partners (including AHS) to develop updates to IGA documents. These documents will match the terms of the newest IGA between AHS and DVHA and will clarify the responsibilities of the IGA partners and DVHA.

Demonstration Evaluation

The AHS QIM reviewed a number of evaluation plans/frameworks associated with various health reform activities taking place in Vermont (e.g., Blueprint for Health, Choices for Care, HIT/HIE, Exchange, and SIM). As AHS continues to work with staff at the Pacific Health Policy Group (PHPG) on the Global

Commitment waiver evaluation, it will be important to identify any areas of overlap between the various evaluation activities.

Reported Purposes for Capitated Revenue Expenditures

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

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

Attachment 6 is a summary of Managed Care Entity Investments, with applicable category identified, for State Fiscal Year 2013.

Enclosures/Attachments

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

Attachment 1: Enrollment and Expenditures 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: 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 28, 2014

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
All AHS YTD '14
 Friday, January 31, 2014

	SFY '14 Appropriated			SFY '14 Actuals thru Dec. 31, 2013			% of Approp. Spent to Date
	Caseload	Expenses	PMPM	Caseload	Expenses	PMPM	
ABD Adult	14,360	\$ 179,018,321	\$ 1,038.85	14,524	\$ 86,831,022	\$ 996.41	48.50%
ABD Dual	17,800	\$ 204,134,462	\$ 955.68	17,273	\$ 90,952,104	\$ 877.58	44.55%
General Adult	11,993	\$ 78,498,571	\$ 545.46	11,104	\$ 38,799,444	\$ 582.38	49.43%
VHAP	37,652	\$ 102,350,924	\$ 453.06	37,049	\$ 87,375,265	\$ 393.06	85.37%
VHAP ESI	785	\$ 718,777	\$ 152.54	752	\$ 687,305	\$ 152.33	95.62%
Catamount	12,372	\$ 31,247,379	\$ 420.94	12,775	\$ 36,570,187	\$ 477.09	117.03%
ESIA	789	\$ 617,260	\$ 130.39	721	\$ 447,941	\$ 103.55	72.57%
New Adult	34,490	\$ 86,353,450	\$ 418.10		N/A		
Exchange Premium Assistance	40,748	\$ 6,586,587	\$ 13.47		N/A		
Exchange Cost Sharing	44,954	\$ 1,484,460	\$ 2.75		N/A		
ABD Child	3,740	\$ 90,359,755	\$ 2,013.24	3,637	\$ 43,439,507	\$ 1,990.63	48.07%
General Child	55,762	\$ 234,168,217	\$ 349.95	55,107	\$ 107,876,531	\$ 326.26	46.07%
Underinsured Child	993	\$ 2,137,306	\$ 179.38	895	\$ 910,127	\$ 169.42	42.58%
CHIP	4,180	\$ 9,928,458	\$ 197.95	3,885	\$ 4,144,655	\$ 177.81	41.75%
Pharmacy Only	12,669	\$ 2,795,616	\$ 18.39	12,730	\$ 2,536,809	\$ 33.21	90.74%
Choices for Care	3,850	\$ 200,240,791	\$ 4,333.90	3,905	\$ 100,318,499	\$ 4,281.99	50.10%
Total Medicaid	297,138	\$ 1,230,640,335	\$ 345.14	174,358	\$ 600,889,394	\$ 574.38	48.83%



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The Department of Vermont Health Access
Caseload and Expenditure Report ~ DVHA Only Medicaid Spend
DVHA YTD '14
 Friday, January 31, 2014

	SFY '14 Appropriated			SFY '14 Actuals thru Dec. 31, 2013			% of Approp. Spent to Date
	Caseload	Expenses	PMPM	Caseload	Expenses	PMPM	
ABD Adult	14,360	\$ 103,769,271	\$ 602.18	14,524	\$ 51,254,107	\$ 588.15	49.39%
ABD Dual	17,800	\$ 49,420,740	\$ 231.37	17,273	\$ 24,199,670	\$ 233.50	48.97%
General Adult	11,993	\$ 70,661,558	\$ 491.00	11,104	\$ 35,052,527	\$ 526.14	49.61%
VHAP	37,652	\$ 90,183,196	\$ 350.51	37,049	\$ 81,918,086	\$ 368.51	90.84%
VHAP ESI	785	\$ 718,777	\$ 150.76	752	\$ 686,750	\$ 152.21	95.54%
Catamount	12,372	\$ 31,247,379	\$ 411.99	12,775	\$ 36,570,187	\$ 477.09	117.03%
ESIA	789	\$ 617,260	\$ 130.34	721	\$ 447,941	\$ 103.55	72.57%
New Adult	34,490	\$ 86,353,450	\$ 418.10		N/A		
Exchange Premium Assistance	40,748	\$ 6,586,587	\$ 13.47		N/A		
Exchange Cost Sharing	44,954	\$ 1,484,460	\$ 2.75		N/A		
ABD Child	3,740	\$ 29,286,530	\$ 652.51	3,637	\$ 19,718,008	\$ 903.58	67.33%
General Child	55,762	\$ 122,779,838	\$ 183.49	55,107	\$ 63,789,223	\$ 192.92	51.95%
Underinsured Child	993	\$ 650,907	\$ 54.63	895	\$ 335,173	\$ 62.39	51.49%
CHIP	4,180	\$ 7,019,478	\$ 139.95	3,885	\$ 3,871,984	\$ 166.11	55.16%
Pharmacy Only	12,669	\$ 2,795,616	\$ 18.39	12,730	\$ 2,666,705	\$ 34.91	95.39%
Choices for Care	3,850	\$ 200,240,791	\$ 4,393.62	3,905	\$ 100,318,499	\$ 4,281.99	50.10%
Total Medicaid	297,138	\$ 803,815,839	\$ 225.43	174,358	\$ 420,828,859	\$ 402.27	52.35%

Glossary of Terms

PMPM – Per Member Per Month

MEG – Medicaid Eligibility Group

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

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

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

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

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

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

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

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

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

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

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

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

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

Global Commitment Expenditure Tracking

QE	Quarterly Expenditures										Net Program PQA	Net Program Expenditures as reported on 64	non-MCO Admin Expenses	Total columns J:K for Budget Neutrality calculation	Cumulative Waiver Cap per 1/1/11 STCs	Variance to Cap under/(over)	
	PQA: WY1	PQA: WY2	PQA: WY3	PQA: WY4	PQA: WY5	PQA: WY6	PQA: WY7	PQA: WY8	PQA: WY9	PQA: WY9							
1205	\$ 178,493,793											\$ 178,493,793					
0306	\$ 189,414,365	\$ 14,472,838										\$ 14,472,838	\$ 203,887,203				
0606	\$ 209,647,618	\$ (14,172,165)										\$ (14,172,165)	\$ 195,475,453				
0906	\$ 194,437,742	\$ 133,350										\$ 133,350	\$ 194,571,092				
WY1 SUM	\$ 771,993,518	\$ 434,023										\$ 434,023	\$ 782,159,845	\$ 4,620,302	\$ 786,780,147	\$ 841,266,663	\$ 54,486,516
1206	\$ 203,444,640	\$ 8,903										\$ 8,903	\$ 203,453,543				
0307	\$ 203,804,330	\$ 8,894,097										\$ 8,894,097	\$ 212,698,427				
0607	\$ 186,458,403	\$ 814,587	\$ (68,408)									\$ 746,179	\$ 187,204,582				
0907	\$ 225,219,267	\$ -	\$ -									\$ -	\$ 225,219,267				
WY2 SUM	\$ 818,926,640	\$ 9,717,587	\$ (68,408)									\$ 9,649,179	\$ 802,884,359	\$ 6,464,439	\$ 809,348,797	\$ 1,684,861,317	\$ 88,732,372
Cumulative																	
1207	\$ 213,871,059	\$ -	\$ 1,010,348									\$ 1,010,348	\$ 214,881,406				
0308	\$ 162,921,830	\$ -	\$ -									\$ -	\$ 162,921,830				
0608	\$ 196,466,768	\$ 14,717	\$ -	\$ 40,276,433								\$ 40,291,150	\$ 236,757,918				
0908	\$ 228,593,470	\$ -	\$ -	\$ -								\$ -	\$ 228,593,470				
WY3 SUM	\$ 801,853,126	\$ 14,717	\$ 1,010,348	\$ 40,276,433								\$ 41,301,498	\$ 881,729,256	\$ 6,457,896	\$ 888,187,152	\$ 2,604,109,308	\$ 119,793,211
Cumulative																	
1208	\$ 228,768,784	\$ -	\$ -									\$ -	\$ 228,768,784				
0309	\$ 225,691,930	\$ (16,984,221)	\$ 38,998,635	\$ (4,144,041)								\$ 17,870,373	\$ 243,562,303				
0609	\$ 204,169,638	\$ -	\$ 686,851	\$ 5,522,763								\$ 6,209,614	\$ 210,379,252				
0909	\$ 235,585,153	\$ -	\$ 30,199	\$ 34,064,109								\$ 34,094,308	\$ 269,679,461				
WY4 SUM	\$ 894,215,505	\$ -	\$ (16,984,221)	\$ 39,715,685	\$ 35,442,831							\$ 58,174,295	\$ 935,368,819	\$ 5,495,618	\$ 940,864,437	\$ 3,606,430,571	\$ 181,250,037
Cumulative																	
1209	\$ 241,939,196			\$ 5,192,468								\$ 5,192,468	\$ 247,131,664				
0310	\$ 246,257,198			\$ 531,141	\$ 4,400,166							\$ 4,931,306	\$ 251,188,504				
0610	\$ 253,045,787			\$ 248,301	\$ 5,260,537							\$ 5,508,838	\$ 258,554,625				
0910	\$ 252,294,668		\$ (115,989)	\$ (261,426)	\$ 3,348,303							\$ 2,970,888	\$ 255,265,556				
WY5 SUM	\$ 993,536,849	\$ -	\$ -	\$ (115,989)	\$ 5,710,484	\$ 13,009,006						\$ 18,603,501	\$ 1,012,990,839	\$ 5,939,459	\$ 1,018,930,298	\$ 4,700,022,174	\$ 255,911,342
Cumulative																	
1210	\$ 262,106,988			\$ -	\$ 6,444,984							\$ 6,444,984	\$ 268,551,972				
0311	\$ 257,140,611											\$ -	\$ 257,140,611				
0611	\$ 277,708,043					\$ (121,416)						\$ (121,416)	\$ 277,586,627				
0911	\$ 243,508,248					\$ 5,528,143						\$ 5,528,143	\$ 249,036,391				
WY6 SUM	\$ 1,040,463,890	\$ -	\$ -	\$ -	\$ 6,444,984	\$ 5,406,727						\$ 11,851,711	\$ 1,045,342,616	\$ 6,071,553	\$ 1,051,414,168	\$ 5,865,213,737	\$ 369,688,737
Cumulative																	
1211	\$ 253,147,037					\$ (531,744)						\$ (531,744)	\$ 252,615,293				
0312	\$ 267,978,672					\$ 3,742	\$ 49,079					\$ 52,821	\$ 268,031,493				
0612	\$ 302,958,610						\$ 6,393,928					\$ 6,393,928	\$ 309,352,538				
0912	\$ 262,406,131						\$ 7,750,994					\$ 7,750,994	\$ 270,157,125				
WY7 SUM	\$ 1,086,490,450	\$ -	\$ -	\$ -	\$ -	\$ (528,002)	\$ 14,194,000					\$ 13,665,998	\$ 1,134,526,550	\$ 5,751,066	\$ 1,140,277,616	\$ 7,113,290,903	\$ 477,488,286
Cumulative																	
1212	\$ 282,701,072						\$ 3,036,447					\$ 3,036,447	\$ 285,737,519				
0313	\$ 285,985,057						\$ 991,340					\$ 991,340	\$ 286,976,397				
0613	\$ 336,946,361						29,814,314	\$ (125,679)				\$ 29,688,635	\$ 366,634,996				
0913	\$ 286,067,548							\$ 2,162,772				\$ 2,162,772	\$ 288,230,320				
WY8 SUM	\$ 1,191,700,038	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 33,842,100	\$ 2,037,093				\$ 35,879,193	\$ 1,197,389,898	\$ 6,187,003	\$ 1,203,576,901	\$ 8,450,684,486	\$ 611,304,968
Cumulative																	
1213	\$ 319,939,651							\$ 3,652,767				\$ 3,652,767	\$ 323,592,418				
WY9 SUM	\$ 319,939,651	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 3,652,767	\$ -			\$ 3,652,767	\$ 319,939,651	\$ 1,214,631	\$ 321,154,282	\$ 8,955,886,798	\$ 795,352,999
Cumulative	\$ 7,919,119,667	\$ 10,166,327	\$ (16,042,281)	\$ 79,876,130	\$ 41,153,315	\$ 19,453,990	\$ 4,878,725	\$ 48,036,100	\$ 5,689,860	\$ -		\$ 8,112,331,833	\$ 48,201,967				

**Questions, Complaints and Concerns Received by Health Access Member Services
October 1, 2013 – December 31, 2013**

October 1 – October 5:

- No questions, complaints or concerns on file.

October 7 – October 12:

- No questions, complaints or concerns on file.

October 14 – October 19:

- The Customer Support Center (CSC) heard from callers who were frustrated that they received a Review Reminder notice even though their review form was received by the 1st. Customer Service Representatives (CSRs) verified the receipt of the application and explained that these notices generated automatically if eligibility has not yet been re-determined.

October 21 – October 26:

- This week, the CSC continued to hear from callers who are currently on GMC programs and wondering what they will need to do next. CSRs confirmed which plan the individual is currently on and explained the process and timeline for applying through Vermont Health Connect (VHC) if appropriate.
- The CSC heard from callers checking to see if their November premium that was due on 10/15 had been received. CSRs researched each case to confirm the receipt of their premium and/or explained the premium process as appropriate.

October 28 – November 2:

- The CSC continued to hear from callers who are currently on GMC programs and wondering what they will need to do next. CSRs confirmed which plan the individual is currently on and explained the process and timeline for applying through VHC if appropriate.

November 4 – November 9:

- The CSC continued to hear from callers who are currently on GMC programs and wondering what they will need to do next. CSRs confirmed which plan the individual is



currently on and explained the process and timeline for applying through VHC if appropriate.

- The CSC heard from callers who had paid their November premium payment after the October 15th deadline but prior to November 1st; however, coverage was still showing as closed. CSRs escalated these calls to HAEU if there was urgent access to care issues.

November 11 – November 16:

- The CSC heard from callers who were reporting new Prescription Drug Plans (PDPs) or changes to their Medicare Part D plans. CSRs gathered the appropriate information to forward to the DVHA PDP Team for verification.
- The CSC heard from VPharm recipients who were reporting that they had applied for LIS in response to a verification request. CSRs updated this information and notified HAEU of the change.

November 18 – November 23:

- The CSC heard from callers who were questioning how long their current program will continue. CSRs confirmed current coverage and used approved instructions and advised the caller as to how they could apply for VHC if necessary.

November 25 – November 30:

- The CSC heard from callers asking if their coverage is going to continue if their premium is sent late in the month. CSRs confirmed if their premium had been received and the current status of coverage.
- The CSC heard from callers checking on their receipt of premium as they received a closure notice. CSRs confirmed if their premium had been received and, if not, provided the caller with the necessary information to mail in the payment.
- The CSC heard from callers asking about the status of their health care as they received a review close notice. CSRs confirmed if their information has been received and then advised the caller to call back after the 1st if a new notice has not been received.
- The CSC heard from callers requesting extensions to provide information requested by the eligibility workers. CSRs transferred callers to HAEU to request an extension.

December 2 – December 7:

- Questions about paying CHAP premiums if the callers are enrolling for January 1. CSRs advised callers to pay the bill and that they may be reimbursed if they are enrolled in a VHC program
- Questions about possible changes to the Dr. Dynasaur program. CSRs advised callers that Dr. Dynasaur premiums remained unchanged.
- Questions about needing new cards/UIDs if they continue on Medicaid through VHC. CSRs advised callers that they will not need a new card/UID if they are transitioning into Medicaid.

- Questions from callers who did not receive premium bills. CSRs advised callers of the amount due and provided the address to mail the payment.

December 9 – December 14:

- Questions about premium invoicing and payments. CSRs advised callers how much was due and provided the address to mail the payment.
- Concerns from callers who received a second review notice despite previously submitting a review application. CSRs advised the callers about application status and that they will receive a notification if further information is necessary.
- Questions about coverage extensions and transitions. CSRs advised callers of their current coverage and possible extensions. CSRs also informed callers of any future transitions and actions needed by the caller.

December 16 – December 21:

- Questions about coverage extensions and transitions. CSRs advised callers of their current coverage and possible extensions. CSRs also informed callers of any future transitions and actions that may be required by the caller.
- Questions about premium bills that have not been received. CSRs either advised callers how much was due and where to send payments or explained why they did not owe a bill.
- Coverage reviews. CSRs advised callers if applications have been received and are being processed and that they will receive a notification if anything else is necessary.

December 23 – December 28:

- Duplicate premium bills: CSRs explained options to customers who received bills for both their GMC and QHP programs and escalated callers as appropriate.



**Grievance and Appeal Quarterly Report
Medicaid MCE All Departments Combined Data
October 1, 2013 – December 31, 2013**

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

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

During this quarter, there were 11 grievances filed with the MCE; with four of them being addressed during the quarter. Grievances must be addressed within 90 days of filing, so having pending cases at the end of the quarter is to be expected. Acknowledgement letters of the receipt of a grievance must be sent within five days; the average was two days. Of the grievances filed, 55% were filed by beneficiaries, 36% were filed by a representative of the beneficiary, and 9% were filed by a provider. Of the 11 grievances filed, DMH had 82% and DVHA had 18%. There were no grievances filed for the DAIL, DCF, or VDH during this quarter.

There were six cases that were pending from all previous quarters, with none of them being resolved this quarter.

There were no Grievance Reviews filed this quarter.

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

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

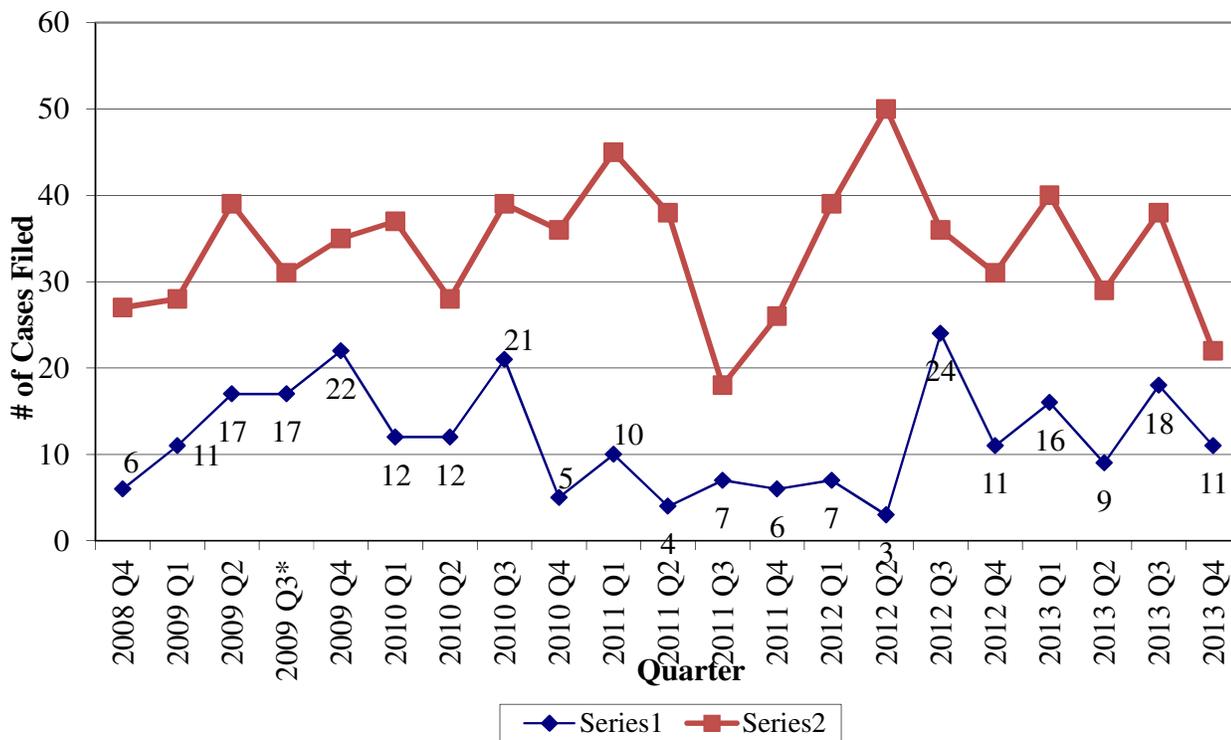
During this quarter, there were 22 appeals filed with the MCE; 1 requested an expedited decision, but did not meet the criteria. Of these 22 appeals, 5 were resolved (23% of filed appeals), 17 were still pending (77%). In three cases (60% of those resolved), the original decision was upheld by the person hearing the appeal, two cases (40% of those resolved) were approved by the applicable department/DA/SSA before the appeal meeting.

Of the 5 appeals that were resolved this quarter, 100% were resolved within the statutory time frame of 45 days; 80% were resolved within 30 days. The average number of days it took to resolve these cases was 20 days. Acknowledgement letters of the receipt of an appeal must be sent within five days; the average was four days, with two of them being late.

Of the 22 appeals filed, 14 were filed by beneficiaries (64%), and 8 were filed by a representative of the beneficiary (36%). Of the 22 appeals filed, DVHA had 27%, DAIL had 59%, VDH had 14% and DMH had 0%.

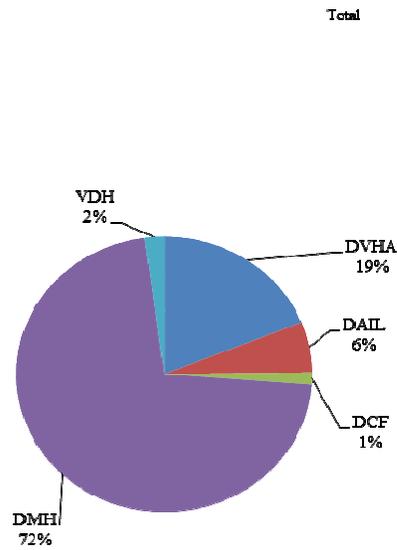
Beneficiaries can file an appeal and a fair hearing at the same time, and they can file a fair hearing if their appeal is not decided in their favor. There were four fair hearing filed this quarter.

Medicaid MCE Grievances & Appeals

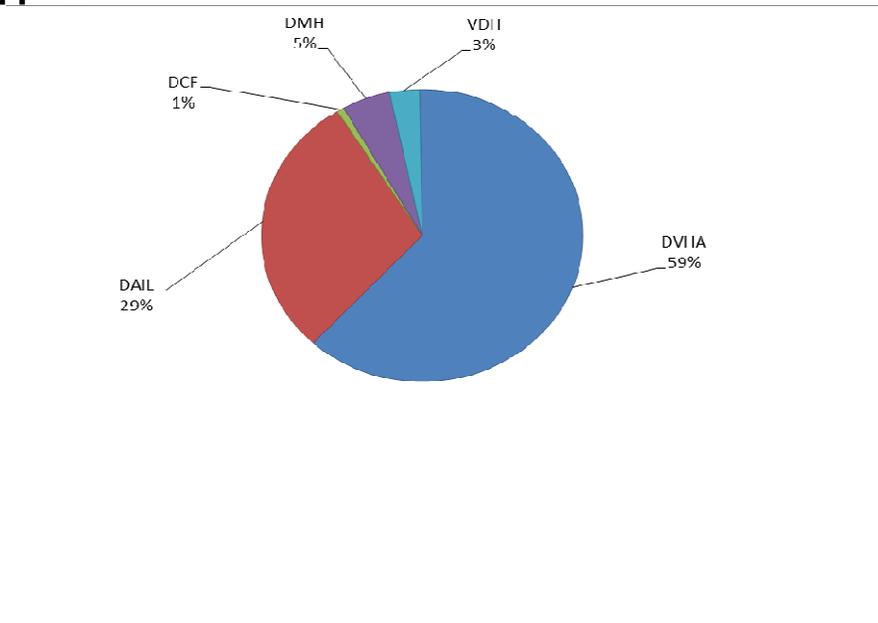


MCE Grievance & Appeals by Department From October 1, 2008 through December 31, 2013

Grievances



Appeals



VERMONT LEGAL AID, INC.

OFFICE OF HEALTH CARE ADVOCATE

264 NORTH WINOOSKI AVE.

P.O. BOX 1367

BURLINGTON, VERMONT 05402

(800) 917-7787 (VOICE AND TTY)

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(802) 863-2316

OFFICES:

BURLINGTON
RUTLAND
ST. JOHNSBURY

OFFICES:

MONTPELIER
SPRINGFIELD

QUARTERLY REPORT

October 1, 2013 – December 31, 2013

to the

Agency of Administration

submitted by

Trinka Kerr, Vermont Health Care Advocate

January 21, 2014

I. Introduction

This is the Office of Health Care Advocate's (HCA) report to the Agency of Administration (AoA) for the quarter October 1, 2013, through December 31, 2013. Prior to January 1, 2014, our quarterly report was submitted to the Department of Financial Regulation (DFR) and the Department of Vermont Health Access (DVHA). On January 1, 2014, the Office of Health Care Ombudsman became the Office of Health Care Advocate pursuant to 18 V.S.A. §9601 *et seq* and began a new contract with AoA. Therefore, we are submitting this report to AoA, but will also send it to DFR, DVHA and the Green Mountain Care Board (GMCB).

The HCA provides consumer assistance to Vermonters on questions and problems related to health insurance and health care. The HCA also engages in consumer protection activities on behalf of the public before the GMCB, other state agencies and the state legislature.

The following information is contained in this quarterly report:

- This narrative which includes sections on **Individual Consumer Assistance**, **Consumer Protection Activities** and **Outreach**
- Five data reports
 - **All calls/all coverages:** 949 calls
 - **DVHA beneficiaries:** 417 calls or **44%** of total calls
 - **Commercial plan beneficiaries:** 146 calls or **15%**
 - **Uninsured Vermonters:** 114 calls or **12%**
 - **Vermont Health Connect:** 249 calls or **26%** (this is a new data report which draws from the three other data sets).

II. Individual Consumer Assistance

The HCA provides assistance to consumers mainly through our statewide hotline (**1-800-917-7787**) and now through our new Online Help Request feature on our website, www.vtlawhelp.org/health. We have a team of advocates located in Vermont Legal Aid's Burlington office which provides this help to any Vermonter free of charge. In December we moved into renovated space which accommodates our expanded staff of seven advocates.

We have a customized case management system. This system allows us to track more than one issue per case, so that we can see the total number of calls that involved a particular issue. For example, although 290 cases had Eligibility for state health care programs as the primary issue, there were actually a total of 589 calls in which we spent a significant amount of time assisting consumers regarding access to health insurance. In each section of this narrative we record whether we are referring to data based on just primary issues, or primary and secondary issues combined. One call can involve multiple secondary issues. [See the breakouts of the issue numbers in the individual data reports for a more detailed look at how many callers had questions about issues in addition to the primary reason for their call.]

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

The HCA received 949 calls this quarter. We divided these calls into five issue categories. The figures below are based on the All Calls data. See the other data reports for a similar breakdown based on the insurance status of the caller, or whether the call was connected to a Vermont Health Connect issue. The breakout by issue category in this quarter based on the caller's primary issue was as follows:

- **19.28%** (183) of our total calls were regarding **Access to Care**;
- **12.64%** (120) were regarding **Billing/Coverage**;
- **2.63%** (25) were questions regarding **Buying Insurance**;
- **14.75%** (140) primarily involved **Consumer Education**;
- **30.56%** (290) were regarding **Eligibility** for state programs and Medicare; and
- **20.13%** (191) were categorized as **Other**, which includes Medicare Part D, communication problems with providers or plans, access to medical records, changing providers or plans, confidentiality issues, and complaints about insurance premium rates, as well as other issues.

A. The launch of Vermont Health Connect was extremely rocky, resulting in a 26% increase in our call volume.

The state launched its health benefit exchange, Vermont Health Connect (VHC), on October 1, 2013 as required by the federal Affordable Care Act. The VHC website was plagued with

glitches and problems for consumers, and the VHC customer support call center was unable to handle the increase in its call volume.

The problems with the website and the call center caused the HCA's call volume to increase by 26%. We received 949 calls this quarter, compared to 751 in the previous quarter. By comparison, we received 842 calls in the same quarter of 2012. Because 26% of our calls this quarter were directly related to Vermont Health Connect (VHC), it seems safe to assume that the big increase was directly attributable to the exchange launch.

December in particular was very busy. It was, in fact, our busiest December ever. We received 339 calls, compared to 227 in December 2012, a 49% increase.

Our call volume probably would have been even higher but for the fact that VHC was unable to send written Notices of Decision (NODs) to applicants. The HCA phone number is on DVHA NODs and is one of the main ways that consumers find out about our services. We complained repeatedly about the lack of notices during this period. Our understanding is that VHC is just starting to send out NODs as of this writing. Although we commented on early drafts of the NODs, we have still not seen the final versions of the notices.

B. The top issues generating calls

This section includes both primary and secondary issues. The most common issues raised by callers were requests for information about VHC, requests for information about applying for state programs and problems related to the high costs of health care.

All Calls (949, compared to 751 last quarter)

1. Information about VHC 167 (this is a new code)
2. Information about DVHA programs 156 (compared to 127 last quarter)
3. Affordability of health care 146 (137 last quarter)
4. Medicaid eligibility 102 (64 last quarter)
5. MAGI Medicaid eligibility 89 (this is a new code)
6. Complaints about Providers 88 (105 last quarter)
7. Communication Problems with ESD (DSW/HAEU) 83 (56 last quarter)
8. Access to Prescription Drugs 74 (51 last quarter)
9. VHAP eligibility 73 (79 last quarter)
10. Information about Medicare 67 (33 last quarter)
11. Buying QHPs through VHC 51 (this is a new code)
12. Buy In programs 45 (36 last quarter)
13. Information about the ACA 60 (30 last quarter)
14. Premium Tax Credit 37 (this is a new code)
VHC Complaints 37 (this is a new code)
15. Information about HCA 34 (21 last quarter)
16. Medicaid Spend Down program 31 (31 last quarter)
17. Premium Assistance 28 (39 last quarter)

- Premium Billing 28 (25 last quarter)
- 18. Medicare Billing 27 (22 last quarter)
- 19. ESD (DCF) Eligibility Mistake 26 (23 last quarter)
 - Access to Primary Care Doctor 26 (18 last quarter)
- 20. Transportation to medical care 22 (25 last quarter)
 - Billing problems with providers 22 (16 last quarter)

DVHA Beneficiary Calls (417, compared to 367 last quarter)

- 1. Information re VHC 65 calls (this is a new code)
- 2. Complaints about Providers 48 (66 last quarter)
- 3. Information about VHC 65 (this is a new code)
- 4. Information about DVHA programs 62 (56 last quarter)
- 5. Affordability of health care 50 (43 last quarter)
 - Medicaid eligibility 50 (24 last quarter)
- 6. MAGI Medicaid eligibility 42 (this is a new code)
- 7. Communication Problems with ESD 38 (27 last quarter)
- 8. Access to Prescription Drugs 35 (23 last quarter)
- 9. VHAP eligibility 25 (25 last quarter)
- 10. Transportation to medical care 22 (24 last quarter)

Commercial Plan Beneficiary Calls (146, compared to 103 last quarter)

- 1. Information about VHC 52 calls (this is a new code)
- 2. Information about DVHA programs 28
- 3. Affordability of health care 24
- 4. Buying QHPs through VHC 21 (this is a new code)
- 5. Information about the ACA 20
- 6. MAGI Medicaid eligibility 17
- 7. Information about Medicare 16
- 8. Premium Tax Credit eligibility 14
- 9. VHC complaints 12 (this is a new code)
- 10. Premium billing 11
 - Medicaid eligibility 11

Vermont Health Connect Calls (249)

- 1. Information about VHC 164 calls
- 2. MAGI Medicaid eligibility 85
- 3. Information about the ACA 59
- 4. Information about applying for DVHA programs 51
- 5. Buying QHPs through VHC 49
- 6. Affordability of health care 38
- 7. VHC complaints 37
- 8. Premium Tax Credit eligibility 31
- 9. Medicaid eligibility 27
 - Communication Problems with ESD 27

10. Information about Medicare 14

C. Hotline call volume by type of insurance:

The HCA received 949 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%** (417 calls), compared to 49% (367) last quarter;
- **Medicare** (Medicare only, Medicare Advantage Plans, Medicare and a Medicare Supplemental Plan aka Medigap, Medicare and Medicaid aka dual eligibles, Medicare and Medicare Savings Program aka Buy-In program, Medicare and Part D, or Medicare and VPharm) insured **31%** (295), compared to 31% (236) last quarter;
- **Commercial plans** (employer sponsored insurance, individual or small group plans, and Catamount Health plans) insured **15%** (146), compared to 14% (103) last quarter; and
- **Uninsured** callers made up **12%** (114) of the calls, compared to 11% (85) last quarter.
- In the remainder of calls the insurance status was either unknown or not relevant.

D. Dispositions of closed cases

All Calls

We closed 936 cases this quarter, compared to 746 last quarter.

- 28% (261 cases) were resolved by brief analysis and advice;
- 27% (250) were resolved by brief analysis and referral;
- 20% (184) of the cases were complex interventions, which involves complex analysis, usually direct intervention, and more than two hours of an advocate's time;
- 16% (153) were resolved by direct intervention, including calling an insurance company, calling providers, writing letters, gathering supporting medical documentation, etc.;
- 5% (50) of the cases were resolved in the initial call.
- In the remaining cases, clients withdrew, resolved the issue on their own, or had some other outcome
- Appeals: 22 cases involved direct help with appeals, and 32 involved consumer education about appeals.

DVHA Beneficiary Calls

We closed 424 DVHA cases this quarter, compared to 353 last quarter.

- 26% (110 cases) were resolved by brief analysis and advice;
- 27% (116) were resolved by brief analysis and referral;
- 19% (82) were considered complex intervention, which involves complex analysis, usually direct intervention, and more than two hours of an advocate's time;

- 20% (83) were resolved by direct intervention on the caller's behalf, including advocacy with DVHA and providers, writing letters, and gathering medical information;
- Less than 6% of calls (24) from DVHA beneficiaries were resolved in the initial call.
- In the remaining cases, clients withdrew, resolved the issue on their own, or had some other outcome.
- Appeals: 10 cases involved appeals: 8 Fair Hearings and 2 Medicare appeals.

Commercial Plan Beneficiary Calls

We closed 134 cases involving individuals on commercial plans,, compared to 110 last quarter.

- 41% (55 cases) were resolved by brief analysis and advice;
- 21% (28) were resolved by brief analysis and referral;
- 22% (30) were considered complex intervention, which involves complex analysis, usually direct intervention, and more than two hours of an advocate's time;
- 10% (13) were resolved by direct intervention on the caller's behalf, including advocacy with the carrier and providers, writing letters, and gathering medical information;
- 5% of calls (7) from commercial plan beneficiaries were resolved in the initial call.
- In the one remaining case the client withdrew.
- Appeals: 12 cases involved appeals: 7 commercial plan appeals, 5 DVHA program appeals and 3 Medicare appeals. (One case could involve several appeals if the beneficiary had more than one type of insurance.)

E. Case outcomes

All Calls

The HCO helped 84 people get enrolled in insurance plans and prevented 13 insurance terminations or reductions. We obtained coverage for services for 18 people. We got 32 claims paid, written off or reimbursed. We assisted 10 people complete applications and estimated program eligibility for 65 more. We provided other billing assistance to 19 individuals. We obtained hospital patient assistance for 9 people. We provided 482 individuals with advice and education. We obtained other access or eligibility outcomes for 79 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 **HCA saved individual consumers \$24,523.51.**

F. Case examples

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

1. Ms. A called the HCA because she had questions about the changes in health insurance she had heard about, and she was worried what would happen to her in the new system. When her HCA advocate investigated her current coverage, she discovered that Ms. A had been on the wrong plan for nearly six months. She had been paying

premiums for VHAP when she actually should have been on Medicaid without a premium. When the advocate pointed out the error, the Economic Services Division switched Ms. A to Medicaid and reimbursed her for the premiums she had paid, over \$1,000. Ms. A will also continue to be eligible for Medicaid in 2014, so she did not need to take any action regarding her 2014 coverage.

2. Mr. B had recently gotten out of jail and was uninsured. He called the HCA because he had been struggling to enroll in a health plan for over a month through VHC and had pressing medical needs. He needed immediate coverage. He had completed an online application with the help of a navigator more than a month earlier but still did not have coverage. The HCA advocate looked into the situation, and in one day was able to get Mr. B onto VHAP. The advocate also ensured that Mr. B would be able to get his prescriptions that day, and that the coverage was appropriately backdated so that it would cover a hospital emergency room visit during the period Mr. B's application was pending. The advocate also let Mr. B know that he would transition to Medicaid for 2014.
3. Mr. C called the HCA because he was unable to get necessary medication. His insurance had been terminated for non-payment of premium. Mr. C had very high medical needs, and his prescriptions costs alone were over \$10,000 a month. He had been told that he had lost his coverage because his premium had not been paid. Mr. C had set up his health insurance premium payments to be made automatically by his bank, so he could not understand how this had happened. When the HCA advocate investigated, he learned that the premium had not been withdrawn from Mr. C's bank due to a computer glitch. When the advocate reported this to the Economic Services Division, Mr. C's insurance was reinstated, saving him thousands of dollars a month.

G. Recommendations to DVHA

1. *Maximus should increase its training for customer service representatives in its Customer Support Call Center.*

This is a repeat of last quarter's recommendation. Last quarter we expressed the concern that the Maximus CSRs were not being sufficiently trained to handle the complexity and length of calls related to Vermont Health Connect. After VHC began operations on October 1, 2014, the problems became worse. Their call volume drastically increased, the calls became longer as consumers sought assistance, and the time it took for CSRs to answer questions increased.

The HCA has been meeting with Maximus and VHC staff every two weeks to discuss these and other issues that we are hearing about from our clients. This has been a collaborative and worthwhile effort, but the call center wait times remained very high which was frustrating to many consumers. We applaud Maximus for its recent announcement that it is doubling the number of CSRs, but remain concerned that the level of training for each CSR may be insufficient. We do recognize the difficulty of getting more CSRs to the frontline quickly while

simultaneously ensuring that they are adequately trained. However, sufficient training is imperative so that incorrect information is not given out and calls can be handled more quickly.

2. *The Health Access Eligibility Unit also needs increased training and more staff to answer the phone.*

This quarter we saw an increase in mistakes by HAEU staff, 26 compared to 23 last quarter. In addition to the mistakes that caused consumers to call the HCA, we also had conversations with HAEU during which we were given incorrect information, which is not reflected in our data.

HCA advocates frequently have problems getting through to HAEU. Sometimes the phone continues to ring and no one answers and there is no opportunity to leave a voicemail. Sometimes when we talk to HAEU staff and they tell us they will research the issue and call us with the answer, we never get called back. This is probably the result of an insufficient staffing level.

3. *The best pathways for communication between the HCA and VHC should be clarified.*

We would welcome a discussion about whom we should contact about different types of issues to improve our efficiency.

4. *ESD should assign designated HAEU workers to assist individuals with Medicaid Spenddowns.*

This is a repeat request. We continue to get calls from Vermonters struggling with the Medicaid Spenddown, or Medically Needy, program. This quarter we received 19 calls in which the primary reason for the call was a Spenddown problem, and 12 in which it was a secondary issue. This was about the same number as in the previous quarter.

H. Table of all calls by month and year

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
January	241	252	178	313	280	309	240	218	329	282	289
February	187	188	160	209	172	232	255	228	246	233	283
March	177	257	188	192	219	229	256	250	281	262	263
April	161	203	173	192	190	235	213	222	249	252	253
May	234	210	200	235	195	207	213	205	253	242	228
June	252	176	191	236	254	245	276	250	286	223	240
July	221	208	190	183	211	205	225	271	239	255	271
August	189	236	214	216	250	152	173	234	276	263	224
September	222	191	172	181	167	147	218	310	323	251	256
October	241	172	191	225	229	237	216	300	254	341	327
November	227	146	168	216	195	192	170	300	251	274	283
December	226	170	175	185	198	214	161	289	222	227	339
Total	2578	2409	2200	2583	2560	2604	2616	3077	3209	3105	3256

III. Consumer protection activities

A. Rate review work

The HCA filed notices of appearance and legal memoranda in ten new rate cases which were ready for review by the Green Mountain Care Board (GMCB) in this calendar quarter. No contested hearings were held during the quarter. In three cases the HCA supported modifications recommended by the Commissioner of DFR and the GMCB adopted these changes. In seven cases, the HCA supported modifications recommended by DFR and suggested additional reductions in rates. The GMCB accepted the DFR recommendations but did not adopt the HCA's additional suggested modifications in three of these cases. The GMCB went beyond the DFR recommendations and accepted some but not at all of the reductions recommended by the HCA in four cases.

The HCA continued to review and comment on the new GMCB proposed rate review regulations which the GMCB promulgated pursuant to changes in statute made in Act 79 of 2013. These rules took effect on January 1, 2014. We provided written comments to the GMCB on the proposed version of the regulations filed with the Legislative Committee on Administrative Rules, supplementing our comments on an earlier draft. After holding a public hearing on the proposed regulations on September 30, 2013, and reviewing written comments, the GMCB decided to make changes in the final proposed version of the regulations submitted to the LCAR. We reviewed these changes and provided feedback to the GMCB's Legal Counsel. We also reviewed further changes in the regulations proposed by the staff attorney for LCAR. We attended the two meetings of LCAR where the regulations were considered.

B. Green Mountain Care Board and Vermont Health Innovation Project

Pursuant to 18 V.S.A. § 9374(f), the Green Mountain Care Board is required to consult with the HCA about various health care reform issues. This quarter we:

- Attended ten GMCB meetings;
- Met monthly with General Counsel for the GMCB;
- Participated in a joint meeting of the Accountable Care Organization (ACO) Measures Work Group and the ACO Standards work Group and commented on the proposed new Process for Review and Modification of Measures Standards
- Participated in the state's Vermont Health Care Innovation Project (VHCIP, formerly called the State Innovation Model or SIM project) in the following ways:
 - Participated as a member of the project Steering Committee in two meetings
 - Participated, along with representatives from other projects of Vermont Legal Aid, as "active members" in four of the seven VHCIP work groups: the Payment Models Work Group, the Quality and Performance

Measures Work Group, the Duals Demonstration Work Group and the Care Models Work Group

- Attended two meetings of the Core Team
- Submitted three sets of comments on the proposed Commercial and Medicaid ACO Shared Savings Measures to the VHCIP Core team, staff of the Quality and Performance Measures Work Group and the GMCB

C. DVHA and Vermont Health Connect

In addition to work related to the GMCB, the HCA engaged in administrative advocacy related to Vermont's new Health Benefit Exchange, Vermont Health Connect (VHC) in the following ways:

- The Health Care Advocate (the Health Care Ombudsman at the time) participated in three Medicaid and Advisory Board (MEAB) meetings
- The Health Care Advocate chaired a MEAB workgroup on Improving Access to Medicaid services. This workgroup was created to give consumers a way to give DVHA feedback and suggestions. The workgroup developed a "roadmap" for consumers seeking durable medical equipment, a process that many consumers have found frustrating. The workgroup raised a number of other access issues which are still being discussed.
- Continued to monitor and participate in the development of rules related to VHC and submitted comments on the emergency rules.
- Continued to comment on notices as developed by VHC and DVHA.
- Submitted numerous questions and suggestions to VHC as the rollout of VHC caused problems for consumers.
- Shared information and coordinated with several Navigators to try to improve Vermonters' experience using VHC and resolve problems.
- Met several times and communicated with BlueCross BlueShield and MVP to strategize about how to help consumers.
- Starting October 30th, met every two weeks with Maximus (the VHC call center vendor), VHC, and Economic Services Division staff to give feedback on the problems we were seeing and discuss possible solutions.

D. Other Activities

- The Health Care Advocate gave a presentation on consumer assistance programs at the National Health Law Program annual conference in Washington, D.C. in December.
- Submitted a final report to the federal Center for Consumer Information and Insurance Oversight (CCIIO) at the conclusion of our Consumer Assistance Program funding under the ACA.

- Participated in a work group pursuant to Act 150 of 2012 which came up with recommendations to improve the accessibility and comprehensibility of filings required by health insurers.
- Participated in the Palliative Care and Pain Management Task Force, created pursuant to Act 25 of 2009, and led by the Vermont Ethics Network.
- Participated in the Unified Pain Management System Advisory Council, created by Act 75 of 2013, which advises the Commissioner of the Vermont Department of Health (VDH) on matters relating to the appropriate use of controlled substances in treating chronic pain and addiction and in preventing prescription drug abuse.
- Participated in the Surrogate Consent workgroup run by VDH, which is working to resolve issues surrounding Do Not Resuscitate orders, Clinical Orders of Life Sustaining Treatment, and admission to hospice for individuals who have not designated an agent through an advance directive.

Our new health care policy analyst, Julia Shaw, started working with us on November 4, 2013.

IV. Outreach

Website

The HCA has a new website which is part of Vermont Law Help. This statewide website is maintained by Vermont Legal Aid and Law Line of Vermont. The site includes a substantial Health section with more than 150 pages of consumer-focused information maintained by the HCA. Please visit it at www.vtlawhelp.org/health.

With the many changes that have occurred since the launch of Vermont Health Connect on October 1, 2013, we have worked diligently to keep the site updated in order to provide the latest and most accurate information to Vermont consumers. We run our VHC related content by VHC staff to ensure consistency.

Comparing the health site's Google Analytics with Q2 of the prior year, we continue to see large increases in the number of pageviews (+143.5% - 2,042 vs. 830) and the number of unique pageviews (+168.63% - 1,370 vs. 510). Unique page views counts only the first view of a page by each user; repeat views of the same page are not counted. The bounce rate (the percentage of single-page visits in which the user entered on the page and left without clicking on any links within the page) decreased by 36% (50.99% vs. 79.78%). Decreases in the bounce rate indicate a higher level of engagement with the site.

The average time spend on a page decreased slightly (9.16% - 1:47 vs. 1:57), but the new health section features much shorter, more focused pages that don't overwhelm consumers, particularly those with lower reading levels.

The most frequently visited pages reflect Vermonters' interest in finding more information about Vermont Health Connect and health care reform, generally. During this quarter, 14 of the 20 most visited health-related pages were about health care reform or Vermont Health Connect. The following were the 10 most visited pages within the Health section:

Page	# of Visits
Health main page	873
Vermont Health Connect page	195
Health care reform	177
Health insurance	70
Vermont Health Connect Coverage	64
Vermont health care reform	55
Health care changes in Vermont and what they mean to you	51
Medicare authorization to disclose personal health info form	42
More VHC enrollment and extension information available...	42
Vermont's health insurance marketplace opens	34

The new website features an online intake form that enables Vermonters to request help at a time that is convenient for them. Ten requests for assistance were received via the Online Help Request form after it was deployed in mid-October.

Presentations

During this quarter, the HCA presented six programs to groups ranging from public meetings and events to staff trainings, reaching approximately 95 Vermonters directly. In several of these meetings, members of the audience included people who refer Vermonters who need assistance with health care/insurance issues to the HCA, increasing the potential impact of the presentations significantly.

- **Burlington Ward 6 Neighborhood Planning Assembly Meeting (October 3)**
 Attended by 20-25 people. Provided brief overview of HCA.
- **Senior Solutions, Springfield (October 9)**
 Attended by 8 Senior Solutions (Area Agency on Aging) employees. Presentation about the HCA; handed out new brochures.
- **Burlington Ward 5 Neighborhood Planning Assembly Meeting (October 17)**
 Attended by 12 people. Discussed HCA; fielded questions about upcoming changes to health insurance/programs and sunseting programs; distributed new brochure.
- **We All Belong AmeriCorps Team Meeting (October 21)**
 Attended by 14 AmeriCorps members/former AmeriCorps members. Distributed new brochure, list of navigator organizations; presented what HCA does and who should be referred to us.

- **RISPNet (Refugee & Immigrant Service Providers Network) Meeting, Burlington (October 24)**
Attended by 25-30 people from various immigrant service provider organizations. Distributed brochures; answered questions.
- **Library Program, Burlington, Arlington, Newport (December 14)**
Presentation about HCA at the Fletcher Free Library (Burlington), with two libraries [Martha Canfield (Arlington) and Goodrich Memorial Library (Newport)] participating via videoconference. Turnout was low due to the Christmas season and extreme weather, but the response from those presenting, attending and the librarians was very positive.

Brochure

We published a new brochure explaining what the Health Care Advocate's office does and how Vermonters can get help with health care access/insurance issues. We distributed all 250 copies within two months and re-published the brochure using our new name. The brochure includes instructions in eight languages telling New Americans living in Vermont how to get help from the HCA through an interpreter. We emailed a PDF of the brochure to the HCA's partner organizations/agencies and to the Vermont Congressional delegation offices.

Email Outreach

We sent an email to 470 UVM social work undergraduate and graduate students/alumnae to explain what the HCA is and how Vermonters can get help with health care access/insurance issues.

Additionally, we sent a branded email campaign about the new Health website to 40 HCA partners who may refer Vermonters to the HCA or to the website. A total of 177 recipients opened the email, suggesting that the email was passed along to many others with an interest in the HCA's work. A branded email about the entire Vermont Law Help website, including the health section, was sent to more than 200 friends of Vermont Legal Aid, netting more than 400 opens.

We also sent a traditional email to 40 HCA partners and 32 Navigator organizations with a PDF of the new brochure and a link to our website.

Television

On November 13, 2013, we produced a 30-second video PSA focusing on the HCA's new website, the types of help that can be found, and how to contact us for assistance. The program was distributed to cable access stations across Vermont and has aired numerous times.

On December 11, 2013, we produced a half-hour television program at CCTV about the HCA, what we do and how Vermonters can get help from us. The program was distributed to cable

access stations across Vermont and has aired numerous times. One caller specifically stated that she called the HCA after hearing the program and that she found it to be “very helpful.”

Press Releases

We issued a total of seven press releases this quarter. Six were targeted to specific audiences located where the library presentations were to be held, one about Vermont Legal Aid being selected to manage the Office of Health Care Advocate services, and one about the Health Care Ombudsman name change.

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

SFY13 Final MCO Investments

9/4/13

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
2	VDH	WIC Coverage
4	VDH	Vermont Blueprint for Health
4	VDH	Area Health Education Centers (AHEC)
4	VDH	Community Clinics
4	VDH	FQHC Lookalike
4	VDH	Patient Safety - Adverse Events
4	VDH	Coalition of Health Activity Movement Prevention Program (CHAMPSS)
2	VDH	Substance Abuse Treatment
4	VDH	Recovery Centers
2	VDH	Immunization
4	VDH	Poison Control
4	VDH	Challenges for Change: VDH
3	VDH	Fluoride Treatment
4	VDH	CHIP Vaccines
4	VDH	Healthy Homes and Lead Poisoning Prevention Program
2	DMH	Special Payments for Treatment Plan Services
2	DMH	MH Outpatient Services for Adults
4	DMH	Mental Health Consumer Support Programs
2	DMH	Mental Health CRT Community Support Services
2	DMH	Mental Health Children's Community Services
2	DMH	Emergency Mental Health for Children and Adults
2	DMH	Respite Services for Youth with SED and their Families
2	DMH	Recovery Housing
4	DMH	Challenges for Change: DMH
2	DMH	Seriously Functionally Impaired: DMH
2	DMH	Acute Psychiatric Inpatient Services
2	DMH	Institution for Mental Disease Services: DMH
4	DVHA	Vermont Information Technology Leaders/HIT/HIE/HCR
4	DVHA	Vermont Blueprint for Health
1	DVHA	Buy-In
1	DVHA	HIV Drug Coverage
1	DVHA	Civil Union
2	DVHA	Patient Safety Net Services
2	DVHA	Institution for Mental Disease Services: DVHA
2	DVHA	Family Supports
2	DCF	Medical Services
2	DCF	Residential Care for Youth/Substitute Care
2	DCF	Aid to the Aged, Blind and Disabled CCL Level III
2	DCF	Aid to the Aged, Blind and Disabled Res Care Level III
2	DCF	Aid to the Aged, Blind and Disabled Res Care Level IV
2	DCF	Essential Person Program
2	DCF	GA Medical Expenses
2	DCF	CUPS/Early Childhood Mental Health
2	DCF	Therapeutic Child Care
2	DCF	Lund Home
2	DCF	GA Community Action
3	DCF	Prevent Child Abuse Vermont: Shaken Baby
3	DCF	Prevent Child Abuse Vermont: Nurturing Parent
4	DCF	Challenges for Change: DCF
2	DCF	Strengthening Families
2	DCF	Lamoille Valley Community Justice Project
3	DCF	Building Bright Futures
2	DDAIL	Mobility Training/Other Svcs.-Elderly Visually Impaired
2	DDAIL	DS Special Payments for Medical Services
2	DDAIL	Flexible Family/Respite Funding
4	DDAIL	Quality Review of Home Health Agencies
4	DDAIL	Support and Services at Home (SASH)
4	DDAIL	HomeSharing
4	DDAIL	Self-Neglect Initiative
2	DDAIL	Seriously Functionally Impaired: DAIL
2	DOC	Intensive Substance Abuse Program (ISAP)
2	DOC	Intensive Sexual Abuse Program
2	DOC	Intensive Domestic Violence Program
2	DOC	Community Rehabilitative Care
2	DOC	Return House
2	DOC	Northern Lights
4	DOC	Challenges for Change: DOC
4	DOC	Northeast Kingdom Community Action
2	DOC	Pathways to Housing