

*State of Vermont*  
*Agency of Human Services*

**Global Commitment to Health**  
**11-W-00194/1**

**Section 1115**  
**Demonstration Year: 9**  
**(10/1/2013 – 9/30/2014)**

**Quarterly Report for the period**  
**April 1, 2014 – June 30, 2014**

**Submitted Via Email on August 28, 2014**

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## **I. 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 interdepartmental 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. AHS and DVHA have been working closely with Vermont's Medicaid Fiscal Agent HP to support all ACA reporting requirements, including identification of those services reimbursed at a different Federal match rate and in support of the revised MEG bucketing effective with the latest STC package.

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.

Monica Light, Financial Director within the AHS Central Office, has replaced Stephanie Beck as the AHS Director of Health Care Operations, Compliance and Improvement as of April 2014. The AHSCO Financial Director position has been filled by Tracy O'Connell as of June 2014.

One of the Terms and Conditions of the Global Commitment Waiver requires the State "to submit progress reports 60 days following the end of each quarter. ***This is the third quarterly report for waiver year 9, covering the period from April 1, 2014 through June 30, 2014.***

i. 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, 2013, 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<sup>th</sup>, 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, 2013, 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, 2013, 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, 2013, 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, 2013, 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, 2013; 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, 2013: 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, 2013, 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.

AHS and CMS are in negotiations regarding Vermont's waiver consolidation request, to move the Choices for Care demonstration under the Global Commitment 1115 waiver.

## **II. Enrollment Information and Counts**

### **Key updates from Q3 2014:**

- Significant decreases in enrollment seen in Demonstration Populations 3, 6, 7, and 11;
- Significant increases seen in Demonstration Populations 1 and 5.

Table 1 presents point-in-time enrollment information and counts for Demonstration Populations for the

Global Commitment to Health Waiver during the third quarter of 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, in this case on July 7, 2014. Results yielding ≤5% fluctuation quarter to quarter are considered as illustrating normal deviations reflecting retroactive eligibility determinations and expected terminations. Results reflecting >5% fluctuation between quarters are reviewed by staff from DVHA and AHS to provide further detail and explanation of the changes in enrollment. For explanation on substantial fluctuations observed in several Demonstration Populations during the third quarter (Q3) of FFY 2014, please see Section VII: Member Month Reporting.

**Table 1. Enrollment Information and Counts for Demonstration Populations\*, Q3 FFY 2014**

<b>Demonstration Population</b>	<b>Current Enrollees Last Day of Qtr 6/30/2014</b>	<b>Previously Reported Enrollees Last Day of Qtr 3/31/2014</b>	<b>Variance 3/31/2014 to 6/30/2014</b>
Demonstration Population 1:	278,325	263,544	5.61%
Demonstration Population 2:	143,188	138,633	3.29%
Demonstration Population 3:	34,252	40,892	-16.24%
Demonstration Population 4:	0	N/A	N/A
Demonstration Population 5:	5,049	3,466	45.67%
Demonstration Population 6:	0	5,617	-100.00%
Demonstration Population 7:	12	6,143	-99.80%
Demonstration Population 8:	29,976	30,501	-1.72%
Demonstration Population 9:	7,613	7,776	-2.10%
Demonstration Population 10:	0	N/A	N/A
Demonstration Population 11:	6	25,264	-99.98%

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

### III. Outreach Activities

#### i. Member Relations

**Key updates from Q3 2014:**

- The annual Green Mountain Care Member Newsletter project is underway with an early summer publication and mailing timeline.
- The Medicaid and Exchange Advisory Board (MEAB) held three monthly meetings during this quarter.
- The annual provider timely access survey was mailed in May.

The Provider and Member Relations (PMR) Unit is responsible for member relations, outreach and communication, including the GreenMountainCare.org member web site. The PMR Unit ensures an adequate network of providers for covered services, enrolls and manages the provider network, and has responsibility for the Medicaid Non-Emergency Medical Transportation Program.

PMR solicited ideas and articles for the annual Green Mountain Care Member Newsletter from the DVHA

Management Team during this quarter in anticipation of a publication date in July. Information on plans and benefit changes resulting from the current legislative session are typically included along with articles on preventative and other health issues to encourage members to be proactive in their personal health outcomes.

The annual Provider Timely Access Survey resulted in only 4 providers being required to complete a Corrective Action Plan (CAP). Based on a random sample of primary care providers (PCPs) who see at least 25 unique individuals per year, PMR mailed 315 surveys on May 15. By May 29, we received 116 responses, resulting in a return rate of 37%. This number was down a bit from last year but is still seen as a success beyond the initial expectation of 12%-20% return rate. A banner regarding timely access for members will be communicated to all providers in October, making it about a year since the previous banner on this topic.

The Medicaid and Exchange Advisory Board (MEAB) held meetings on April 14, May 12, and June 9. Agendas and minutes are publicly posted at <http://gmcbboard.vermont.gov/meetings>.

#### **IV. Operational/Policy Developments/Issues**

##### *i. Vermont Health Connect*

###### **Key updates from Q3 2014:**

- To date, VHC has enrolled 42,853 individuals in Medicaid and 30,691 in the Qualified Health Plan (QHP) of their choice.
- VHC is now focused on successfully transitioning Medicaid renewals to the Marketplace and preparation for 2015 open enrollment.
- VHC continues to face challenges in processing its change of circumstance backlog. To address this issue, it has engaged an additional contractor, OptumInsight, to provide staff augmentation and to assist in the development of operational efficiencies as VHC prepares for open enrollment.

Vermont Health Connect (VHC), a state-based health insurance marketplace, launched on October 1, 2013. Between October 1, 2013 and March 31, 2014, nearly 88,000 individuals in Vermont applied for coverage through VHC. To date, VHC has enrolled 42,853 individuals in Medicaid and 30,691 in the Qualified Health Plan (QHP) of their choice. In November of 2013, Vermont launched premium processing functionality for individuals and worked with insurance carriers to effectuate coverage for January 1, 2014. This functionality was expanded to include credit card processing in March, 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 through 2015. Many of these individuals in Vermont transitioned to VHC by March 31, enrolling in QHPs with financial assistance. The State continued to work with members of the transition population throughout April and May to ensure that they had the opportunity to take advantage of a special enrollment period for which they were eligible and avoid gaps in coverage. Vermont Health Connect is now focused on successfully transitioning the 80,000 Medicaid individuals who need to transition from the State's legacy Access eligibility system to the Marketplace upon renewal of their coverage.

VHC's Customer Support Center, operated by Maximus, went live on September 3, 2013 and continues to assist customers in navigating the website, processing phone applications, and responding to requests for updates on changes of circumstances that have been delayed due to system functionality shortcomings. The high volume of interest in Vermont Health Connect, combined with operational challenges, resulted in extended wait times at the call center from October to December. In January, the State worked with

Maximus to expand its staff of Customer Service Representatives (CSRs) to include additional workers trained specifically to process phone applications. Specializing the work of CSRs has allowed the State to train other staff to answer the most common pre- and post-application questions. Based on the information gleaned during the grant period, the State worked with the Maximus call center to expand staffing by an additional 70 CSRs in Chicago beginning in January of 2014, almost doubling the available staff to answer VHC phone calls.

The State continues to work with its contracting partners to expand marketplace functionality, with a current focus on implementing an automated change of circumstance process. This will allow enrollees to themselves modify the information contained in their application, support eligibility for special enrollment periods, and facilitate plan selection change when allowable. VHC continues to face challenges in processing its change of circumstance backlog. To address this issue, it has engaged an additional contractor, OptumInsight, to provide staff augmentation and to assist in the development of operational efficiencies as VHC prepares for open enrollment for 2015.

At the close of 2014 open enrollment, VHC concluded its ambitious outreach and education campaign for year one but continues to actively collaborate with key stakeholders, including insurance carriers, brokers, small business owners, and community partners. The Outreach and Education team is now focused on successfully transitioning Medicaid renewals and preparation for 2015 open enrollment. Vermont continues to deploy its 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 daily operations. VHC plans to expand its functionality to include enrollment for small businesses during the open enrollment period for 2016.

## **V. Expenditure Containment Initiatives**

### *i. Vermont Chronic Care Initiative (VCCI)*

#### **Key updates from Q3 2014:**

- The MMIS/CM procurement process generated 4 responses, with 2 vendors unable to meet minimum State requirements. DVHA will revise and repost the RFP based on the inability of the remaining vendors to meet established thresholds and related timelines for implementation. A new RFP will be released mid-July and will reflect feedback from vendors who submitted a 'letter of intent' but who did not submit a proposal. VCCI supplemental support services have been removed from the updated RFP.
- The APS Healthcare contract for the VCCI analytical and clinical support services has been renegotiated with a new expiration date of June 30, 2015 in anticipation of full 'on-boarding' of the new CM solution for the VCCI in June, 2015.
- Two targeted consumer mailings were completed, including one in April to 2,800 members in high risk communities on 'pain killer safety,' covering security and disposal. A second mailing was sent in June to over 2,000 women of child bearing age with complex health histories on the importance of pre-conception counseling and planning.
- The VCCI leadership has been invited to speak at the NASHP conference in October on the VCCI model and the positive results it's garnered for high risk populations.

The goal of the VCCI is to improve health outcomes of Medicaid beneficiaries by addressing the increasing prevalence of chronic illness through various support and care management strategies. Specifically, the program is designed to identify and assist Medicaid members 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. Medicaid members that are eligible for the VCCI account for the top 5% of service utilization, or who are on a trajectory to become ‘super-utilizers’ of services. The VCCI’s strategy of embedding staff in high-volume hospitals and primary care sites continues to support population engagement at the point-of-need in areas of high service utilization. By targeting predicted high-cost members, resources can be allocated to areas representing the greatest opportunities for clinical improvement and cost savings.

The VCCI had expanded the embedded staffing model with licensed staff in high volume Medicaid primary care sites and hospitals that experience high rates of ambulatory care sensitive (ACS) Emergency Department (ED) visits and inpatient admissions/readmissions. Due to challenges at some provider sites concurrent with staff attrition last quarter, the VCCI partner footprint has been reduced to only six locations (4 PCP’s and 2 hospitals). This has been augmented with a ‘liaison’ role while looking at longer term strategies and opportunities as new staff is brought on and as Accountable Care Organization (ACO) partnerships begin to take form.

The embedded approach continues to offer 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 primary care physician (PCP) and hospital sites to assist in reducing hospital readmission rates in high-risk populations. The VCCI has access to hospital data on inpatient and ED admissions through data exchanges from partner hospitals (via secure FTP site transfers). The VCCI aims to eventually secure data from all 14 hospitals in Vermont. While some hospitals have not supported these strategies in the past, the advent of Medicaid ACOs may help facilitate new relationships based on common goals. Third, the embedded staffing model provides an opportunity for enhanced coordination and care transitions with hospital partners and primary care sites, as well as with home health agencies that may be delivering skilled nursing care post-discharge. This enhanced service coordination is a goal of the Vermont Health Care Innovation Project care management and care models (CMCM) workgroup which is currently working on a learning collaborative to be piloted in 3 locations.

The VCCI continues to experience challenges related to both timely recruitment and retention of skilled nurse care managers. Due to their Medicaid knowledge and experience, nurse care managers have been frequently hired by partners of the VCCI, and at a higher pay scale than provided by the State. The VCCI is continuing to work with senior DVHA leadership on methods to incentivize nurses to work for DVHA, and an AHS leadership team has been assigned to this work.

In Q3, the VCCI had turnover in all of the medical social worker positions. This change has offered the VCCI the opportunity to reevaluate staffing structure and licensure requirements to support the most efficient, effective and holistic approach to case management based on member needs. Subsequently, several existing positions are being converted to RN positions that have more versatility in practice than non-licensed social workers.

The VCCI remains strategically aligned with the Blueprint for Health, which is further described in *Section V.ii.*

#### *Pediatric Palliative Care Program*

The Pediatric Palliative Care Program (PPCP) is a statewide program that maintains active enrollment of approximately 35-40 children and families at any time. The VCCI is engaged with home health agencies for quality monitoring. However, due to very low volumes and/or less than one year of program operation, this is not yet a highly robust effort with measurable data. The VCCI likely needs to redesign the audit tool based on early testing and will continue to advocate for DVHA PPCP staff to have access to the partner data system for more efficient quality monitoring. Consumer satisfaction surveys are now being disseminated concurrent with the six-month reassessment for program eligibility and service authorization process. A follow-up clinical training session for pediatric palliative care nurses is scheduled for September, 2014 in partnership with the Vermont Assembly of Home Health Agencies (VAHHA) and the Vermont Department of Health (VDH).

#### *Pregnancy Care Connection*

The VCCI launched a pilot program for the High Risk Pregnancy (HRP) Case Management service in October 2013. The service, recently renamed Pregnancy Care Connection (PCC), focuses on direct case management as well as the system of care for at-risk/vulnerable pregnant women and their unborn child(ren). PCC was able to complete a consumer mailing targeting 2000 at risk women of child bearing age to advise of pre-conception counseling (One Key Question/ State of Oregon approved). This is consistent with Vermont Maternal and Child Health data, which demonstrates a high rate of unplanned pregnancies, especially in women under 24. The mailing has generated some early referrals to the VCCI, including women who had already become pregnant. DVHA is also moving forward to assure alignment between the VCCI/ HRP nurses and the Medicaid Health Homes Initiative for substance abuse treatment services (Hub and Spoke, as described in the following section). This was deemed important given the prevalence; risk factors and related cost of care for mothers and infants with substance use/abuse and/or treatment history; and associated prematurity/low birth weight and/or neonatal intensive care unit stays for withdrawal. Early data suggests a need for service targeted at this cohort as well as those with mental health diagnoses. The VCCI will continue to review the data, model, and feedback provided by field workers to assess the efficacy of PCC, and will work in partnership with DVHA leadership to allow for a strategic approach to program development and resource allocation.

#### *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. In SFY 2012, the contract migrated to a focus on the top 5% of Medicaid utilizers. APS Healthcare provides several services to support the VCCI, including supplemental professional staffing and data analytics. APS Healthcare delivers enhanced information technology and sophisticated decision-support tools to assist case management staff outreach to the most costly and complex beneficiaries based on risk factors. Additionally, APS Healthcare provides supplemental reports on population-based gaps in care to the VCCI field-based staff, which support ACO providers working with patients who are considered high utilizers.

In 2011, the VCCI implemented a combination of individual- and population-based strategies for disease management, with a primary focus on the top 5% of beneficiaries accounting for the highest service utilization. That same year, DVHA's contract with APS Healthcare was 100% risk-based with a guaranteed 2:1 return on investment (ROI). In SFY 2012, the VCCI delivered a net \$11.5 million ROI, which included both the APS and DVHA staff efforts. In SFY 2013, the VCCI significantly exceeded its 2012 results, with a \$23.5 million net savings over anticipated expense for this population. Consistent with these results, the VCCI demonstrated a 17% reduction in ACS ED usage, a 37% reduction in ACS hospitalizations, and a 34% reduction in 30-day readmission rates among the top 5% of members. SFY 2013 was the first year that it was feasible to conduct a comparative analysis on the top 5% of members.

To assure continuity of the VCCI business operations during the MMIS/CM procurement process, the DVHA has extended its contract with APS Healthcare through June 30, 2015. This will allow for a thoughtful procurement, contracting and onboarding process, without interruption of the VCCI services, should APS not be the selected vendor.

Activities supported by APS in Q3 include:

- Completed the VCCI/APSMITA self-assessment for case/care management
- Contract renegotiated for 1 year extension through June 30, 2015
- Recruitment for RN (2 FTE) and analyst vacancies (.6 FTE)
- Average VCCI case load (DVHA/APS): 513; unique members: 1003
- Data secured on hypertensive members eligible for VDH/ASTHO grant activities
- Provider Health Registry development and dissemination for diabetes gaps in care
- PDSA for case load development initiated
- Action Plans updated consistent with NCQA requirements to foster adoption by APMCs
- Updated VCCI Brochures and Referral Forms
- Drug therapy overviews for COPD and diabetes completed

ii. Hub and Spoke Initiative: Integrated Treatment for Opioid Dependence

**Key updates from Q3 2014:**

- In June, the Vermont Supreme Court issued a ruling finding in favor of the Chittenden Center’s zoning permit to operate an Opioid Treatment Program (Hub) in a South Burlington neighborhood zoned for commercial/medical. The South Burlington School Board opposed the zoning permit. The program has been open at the South Burlington location for almost a year without any incidents.
- The Hub programs are now statewide and continue to see significant caseload growth; serving just under 2,400 Vermonters.
- In addition to providing methadone MAT, as they have traditionally done, Hubs now provide buprenorphine MAT to complex patients. The use of buprenorphine in these programs continues to grow, now representing 33% of the total caseload of Hubs.
- Blueprint practice facilitators are working extensively with Hub and Spoke providers on common measurement, practice-level quality improvement, and implementation of evidence-based care. In addition, the practice facilitators are working with the Hub programs on preparing to meet the NCQA Patient-Centered Specialty Practice standards. This will further align these specialty addictions programs with the patient-centered medical home primary care providers.
- Completed three learning collaboratives with the Hub programs and “Spoke” practices. These were extremely well attended (more than 17 different practices/programs) and physicians led multi-disciplinary teams in common measurement and intensive quality improvement activities.
- The Green Mountain Care Board is requiring a quarterly report on progress to increase the participation of other payers in this initiative. The CMS policy of Medicare not reimbursing for services in an Opioid Treatment Program presents as a difficulty in integrating all payers.

The Blueprint for Health (Blueprint) is Vermont’s state-led initiative charged with guiding a process that results in sustainable health care delivery reform. The Blueprint uses multi-insurer payment reforms to improve infrastructure and care provided by PCPs. It includes advanced primary care practices that are

recognized as patient-centered medical homes, multi-disciplinary core Community Health Teams (CHTs), and specialized care coordinators. The Blueprint supports the State's National Committee for Quality Assurance (NCQA) certification and performance-based payments. In 2013, the Blueprint continued to grow and strengthen the underlying model in all geographic regions, or Health Service Areas, in the state. The Blueprint for Health 2013 Annual Report to the Vermont Legislature was published online in January, 2014 and is available via:

<http://hcr.vermont.gov/sites/hcr/files/pdfs/VTBlueprintforHealthAnnualReport2013.pdf>.

As part of the Blueprint, the Hub and Spoke Initiative creates a framework for integrating treatment services for opioid addiction. This Initiative represents AHS and DVHA's efforts to collaborate with community providers to create a coordinated, systemic response to the complex issues of opioid addictions in Vermont. The Hub and Spoke Initiative is focused on beneficiaries receiving Medication-Assisted Treatment (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. The two primary medications used to treat opioid dependence are methadone and buprenorphine. Buprenorphine is typically prescribed by specially licensed physicians in a medical office setting and methadone is provided only in specialty opioid treatment programs. Both of these treatment regimens are associated with substantial service fragmentation as providers are not well integrated into the larger health care and mental health care systems.

To address this service fragmentation and better serve a patient population with high overall health care costs, Vermont has developed State Plan Amendments (SPAs) in partnership with CMS to provide Health Home services to the MAT population under section 2703 of the ACA. The SPAs supported 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.

As part of the Initiative, DVHA established five regional Hubs, which build upon the existing methadone opioid treatment programs, and provide buprenorphine treatment to a subset of clinically complex patients (Table 2). These Hubs serve as the regional consultants and subject matter experts on opioid dependence and treatment. Hubs are replacing episodic care based exclusively on addiction illness with comprehensive health care and continuity of services. Three Hubs were implemented under the first Health Home SPA, effective on July 1, 2013. Two additional regional Hubs were implemented through the second SPA beginning in January 1, 2014.

In addition to Hubs, Spoke staff is embedded directly in the prescribing practices to allow more direct access for patients to mental health and addiction services, promote continuity of care, and support the provision of multidisciplinary team care. Spoke staff provide service free of cost to patients receiving MAT. Spokes include a physician prescribing buprenorphine in office-based opioid treatment 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. Registered nurses and licensed addictions/mental health clinicians, who are part of the Blueprint CHTs, also provide support to the Spoke providers and their patients receiving MAT.

For updates from Q3 of FFY 2014, please see the above "key updates." During this quarter, Hub and Spoke Health Homes were implemented statewide and over three-fourths (83%) of the Spoke staff for the statewide program is now hired. These Spoke staff work with 60 buprenorphine providers serving 1,972 Medicaid beneficiaries receiving MAT. Spoke staffing is scaled at 1 registered nurse and 1 licensed

clinician for every 100 patients receiving MAT. The following tables present the caseloads of regional Hubs and Spoke staffing as of June, 2014.

**Table 2. Hub Caseload**

<b>Region (Counties in Vermont)</b>	<b>Start Date (Month/Year)</b>	<b>Total Number of Clients (Buprenorphine and Methadone)</b>	<b>Number of Clients Receiving Buprenorphine</b>	<b>Number of Clients Receiving Methadone</b>
Chittenden, Franklin, Grand Isle & Addison	1/2013	862	300	562
Washington, Lamoille, Orange	7/2013	251	116	135
Windsor, Windham	7/2013	547	137	410
Rutland, Bennington	11/2013	345	138	207
Essex, Orleans, Caledonia	1/2014	380	104	276
<b>Total</b>		<b>2385</b>	<b>795</b>	<b>1590</b>

**Table 3. Spoke Staffing: June 2014**

<b>Region</b>	<b>Providers</b>	<b>Staff FTE Funding</b>	<b>Staff FTE Hired</b>	<b>Medicaid Beneficiaries</b>
Bennington	6	3.5	3.5	173
St. Albans	6	5.5	2.8	262
Rutland	5	5.0	2.1	253
Chittenden	13	7.5	7.85	357
Brattleboro	6	5.0	5	230
Springfield	1	1.0	1.0	41
Windsor	2	2.0	2.0	82
Randolph	4	2.5	2.0	110
Barre	7	4.5	4.5	212
Lamoille	4	3.0	2.0	135
Newport & St Johnsbury	5	2.0	2.0	100
Addison	1	.5	0	17
<b>Total</b>	<b>60</b>	<b>42</b>	<b>34.75</b>	<b>1,972</b>

iii. Managed Substance Abuse Services

**Key updates from Q3 2014:**

- The DVHA Managed Substance Abuse Services and Mental Health Services have been consolidated into one unit to provide integrated Behavioral Health Services.
- The Behavioral Health Team adopted the McKession/Interqual tool for authorizing mental health and substance abuse services.

In March 2014, Managed Substance Abuse Services and Mental Health Services have been consolidated into one unit to provide integrated Behavioral Health Services. This collaboration will offer a more comprehensive approach for behavioral health care coordination and will utilize combined staff's expertise in substance abuse, mental health, and quality improvement services. The consolidation of the two teams will allow beneficiaries with co-occurring mental health and substance abuse conditions to receive coordinated services from DVHA, as well as provide DVHA with additional resources to work on improving access to care from achieved efficiencies. The Mental Health Team is responsible for concurrent review and authorization of inpatient psychiatric and detox services for Medicaid primary beneficiaries. The team works closely with discharge planners at inpatient facilities to ensure timely and appropriate discharge plans. The Substance Abuse Team coordinates its MAT efforts with the Hub and Spoke Initiative, the VCCI, and the Pharmacy Unit to provide beneficiary oversight and outreach. All beneficiaries receiving MAT services and who are prescribed buprenorphine will continue to have a Pharmacy Home that dispenses all of their prescriptions.

During this quarter, the Behavioral Health Team participated in the AHS Substance Abuse Treatment Coordination Workgroup. This workgroup is a coordinated effort to standardize substance abuse screening and referral processes throughout AHS. The workgroup was developing an AHS-wide training for screening. Team members also participated in monthly meetings with VDH's Alcohol and Drug Abuse Prevention Division to coordinate efforts between the two departments to provide substance abuse services to Vermont Medicaid beneficiaries.

Also during this quarter the Behavioral Health Team adopted the McKession/Interqual tool for authorizing mental health and substance abuse services. Significant research was done on the criteria as well as on the effectiveness of the tool. Implementation of the tool is planned for July, 2014.

As part of the consolidation of the two teams, the Substance Abuse Team was able to implement an electronic record system utilizing Covisint. Covisint has been utilized by the Mental Health Team for the past year, which will allow for improved coordination of services.

*Buprenorphine Program*

The Department of Vermont Health Access, in collaboration with VDH's Alcohol and Drug Abuse Programs, maintains a capitated program for 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**

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

The total payment for the Buprenorphine Program for all three quarters of FFY 2014—with the exception June, since data is not yet available—is \$123,168.32 (Table 5).

**Table 5. Buprenorphine Program Payment Summary FFY 2014**

<b>FIRST QUARTER, FFY 2014</b>	
October 2013	\$12,041.22
November 2013	\$17,688.50
December	\$19,508.14
<b>1<sup>st</sup> Quarter Total</b>	<b>\$49,237.86</b>
<b>SECOND QUARTER, FFY 2014</b>	
January 2014	\$10,988.52
February 2014	\$18,857.68
March 2014	\$11,319.48
<b>2<sup>nd</sup> Quarter Total</b>	<b>\$41,165.68</b>
<b>THIRD QUARTER, FFY 2014</b>	
April 2014	18,479.72
May 2014	\$14,285.60
June 2014	(No data at this time)
<b>3<sup>rd</sup> Quarter Total</b>	<b>\$32,764.78</b>
<b>Grand Total</b>	<b>\$123,168.32</b>

iv. 340B Drug Discount Program

**Key updates from Q3 2014:**

- The Notch Pharmacy began participating in the 340B Program this quarter.
- Vermont has realized \$202,499.62 net cost savings this quarter and year-to-date net cost savings of \$327,962.54 through Medicaid participation of a relatively small number of eligible covered entities.

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. 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 that the covered entity would have to pay

for select outpatient and over-the-counter drugs and the minimum savings that the manufacturer must provide to covered entities. The 340B ceiling price is at least as low as the price that state Medicaid agencies currently pay for select drugs. 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.

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 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).

Vermont has made substantial progress in expanding 340B availability since 2005. This expansion was aided by federal approval of the statewide 340B network infrastructure, which is operated by five federally qualified health centers (FQHCs) in Vermont. In 2010, DVHA aggressively pursued enrollment of 340B covered entities made newly eligible by the ACA and as a result of the Challenges for Change legislation passed in Vermont. As of October 2011, all but two Vermont hospitals and some of their owned practices were eligible for participation in 340B as covered entities.

DVHA expanded its 340B program to encourage enrollment of both existing and newly eligible entities within Vermont and to encourage covered entities to include Medicaid in their 340B programs. In 2012, the DVHA received federal approval for a Medicaid pricing 340B methodology. To encourage participation in the Vermont Medicaid 340B program, providers receive an incentive payment (described below). 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. DVHA continues to encourage Medicaid enrollment with the goal of enrolling all eligible and HRSA-enrolled covered entities in Vermont.

In Vermont, the following entities participate in the 340B Program. **Boldfaced** entities also participate in Medicaid’s 340B initiative (although this is not an exhaustive list of entities enrolled in Medicaid’s 340B initiative):

- Vermont Department of Health, for the AIDS Medication Assistance Program, Sexually-Transmitted Disease Drugs Programs, and Tuberculosis Program; all of these programs are specifically allowed under federal law.
- **Planned Parenthood of Northern New England’s Vermont clinics**
- **Vermont’s FQHCs**, operating 41 health center sites statewide
- **Central Vermont Medical Center**
- Copley Hospital
- **Fletcher Allen Health Care and its outpatient pharmacies**
- Gifford Hospital
- Grace Cottage Hospital

- **Indian Stream Health Center (New Hampshire)**
- North Country Hospital
- Northeastern Vermont Regional Hospital
- *Notch Pharmacy (new as of FFY Q3)*
- Porter Hospital
- Rutland Regional Medical Center
- **Springfield Hospital**

### *340B Reimbursement and Calculation of Incentive Payment*

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; and
- 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. 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 established 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.

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. Using the Global Commitment authority, the 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 rates of 340B covered entity-employed prescribers and Medicaid beneficiary participation in the program.

For the reporting period, Vermont has realized \$202,499.62 net cost savings for FFY Q3 and year-to-date net cost savings of \$327,962.54 through Medicaid participation of a relatively small number of eligible covered entities.

#### v. Utilization Management

Utilization Management is a systematic evaluation of the necessity, appropriateness, and efficiency of managed care model services. These activities are designed to influence providers’ resource utilization and clinical practice decisions in a manner consistent with established criteria or guidelines to maximize appropriate care and minimize or eliminate inappropriate care. DVHA has mechanisms in place to detect

both under/over-utilization of services and to assess the quality and appropriateness of care furnished to enrollees with special health care needs.

### *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 controls include monitoring features of our Program Integrity Unit (PIU) and the Drug Utilization Review (DUR) program, both of which are vetted through the State's Drug Utilization Review Board (DURB).

The goal of DVHA's 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. Drug Utilization Review 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 pharmaceutical care provided by the physician. The criteria, research and compilation of data, and recommended actions are reviewed and approved by consensus of the DURB.

In addition, DVHA's 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.

The DUR and PIU programs continue to develop and run data-mining queries to detect improper prescribing, dispensing, and reimbursement. Findings are discussed, as deemed necessary and appropriate, with various other departments in the DVHA and agencies including, but not limited to, the Pharmacy Unit, Clinical Utilization Review Board (CURB), 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 to 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.

## *Clinical Utilization Review Board*

### **Key updates from Q3 2014:**

- The CURB held one meeting this quarter on May 21.
- A University of Vermont Professor of Psychiatry presented on one current model of co-locating psychiatric providers in Medical Homes. DVHA will explore potential for support and further deployment of this model.
- Requests for genetic testing are received for analytic validity, clinical utility, budget impact and ethical implications. DVHA determines clinical utility based on many resources including:
  - Peer-review literature
  - Technology assessments
  - Professional association opinions and guidelines
  - Direct discussion with providers
  - Other medical and commercial policies

DVHA is currently pursuing an evidence based and clinically focused tool for creating sound policy, which will enable appropriate coverage decisions.

The Clinical Utilization Review Board (CURB) was established by Act 146 Sec. C34, 33 V.S.A. Chapter 19, Subchapter 6 during the 2010 legislative session. DVHA was tasked to create the CURB to examine existing medical services, emerging technologies, and relevant evidence-based clinical practice guidelines and make recommendations regarding coverage, unit limitations, place of service, and appropriate medical necessity of services in the State's Medicaid programs.

The CURB is comprised of 10 members with diverse medical experience, appointed by the Governor upon recommendation of the DVHA Commissioner. The CURB solicits additional input as needed from individuals with expertise in areas of relevance to the CURB's deliberations. The DVHA Medical Director serves as the State's liaison to the CURB.

Additional information on these guiding principles and upcoming clinical projects considered by the CURB members are available in the CURB's 2013 annual report submitted to the Vermont Legislature in January 2014, and available via: <http://www.leg.state.vt.us/reports/2014ExternalReports/295874.pdf>.

In Q3 FFY 2014, the CURB held one meeting. Information on the CURB meetings, including agendas and minutes, is available via: <http://dvha.vermont.gov/advisory-boards>.

## *Drug Utilization Review Board*

### **Key updates from Q3 2014:**

- The DURB held two meetings this quarter on April 15 and June 3.

The DURB was authorized by Congress under Section 4401, 1927(g) of the Omnibus Reconciliation Act of 1990. This act mandated that AHS develop a drug use review program for covered outpatient drugs, effective January 1, 1993. The Act required the establishment of a DUR program to:

- 1) Review and approve drug use criteria and standards for both retrospective and prospective drug use reviews;
- 2) Apply these criteria and standards in the application of DURB activities;
- 3) Review and report the results of DUR programs; and

- 4) Recommend and evaluate educational intervention programs.

Additionally, per State statute requiring the DVHA Commissioner establish a pharmacy best practice and cost control program, the DURB was designated as the entity to provide clinical guidance on the development of a Preferred Drug List for Medicaid beneficiaries. The DURB typically includes 10-12 members, who are appointed to two-year terms. At least one-third, but not more than half, of the Board's members are licensed and actively practicing physicians, and at least one-third of its members are licensed and actively practicing pharmacists. Other interested and qualified people also may be appointed to the DURB. Board members are recommended by the DVHA Commissioner and approved by the Governor.

Meetings of the DURB occur monthly or bimonthly depending upon the number of drugs and issues to be reviewed. In Q3 FFY 2014, the DURB held two meetings. Information on the DURB and its activities in 2014 is available via: <http://dvha.vermont.gov/advisory-boards>.

vi. **Mental Health System of Care**

*State Hospital Inpatient Replacement Planning*

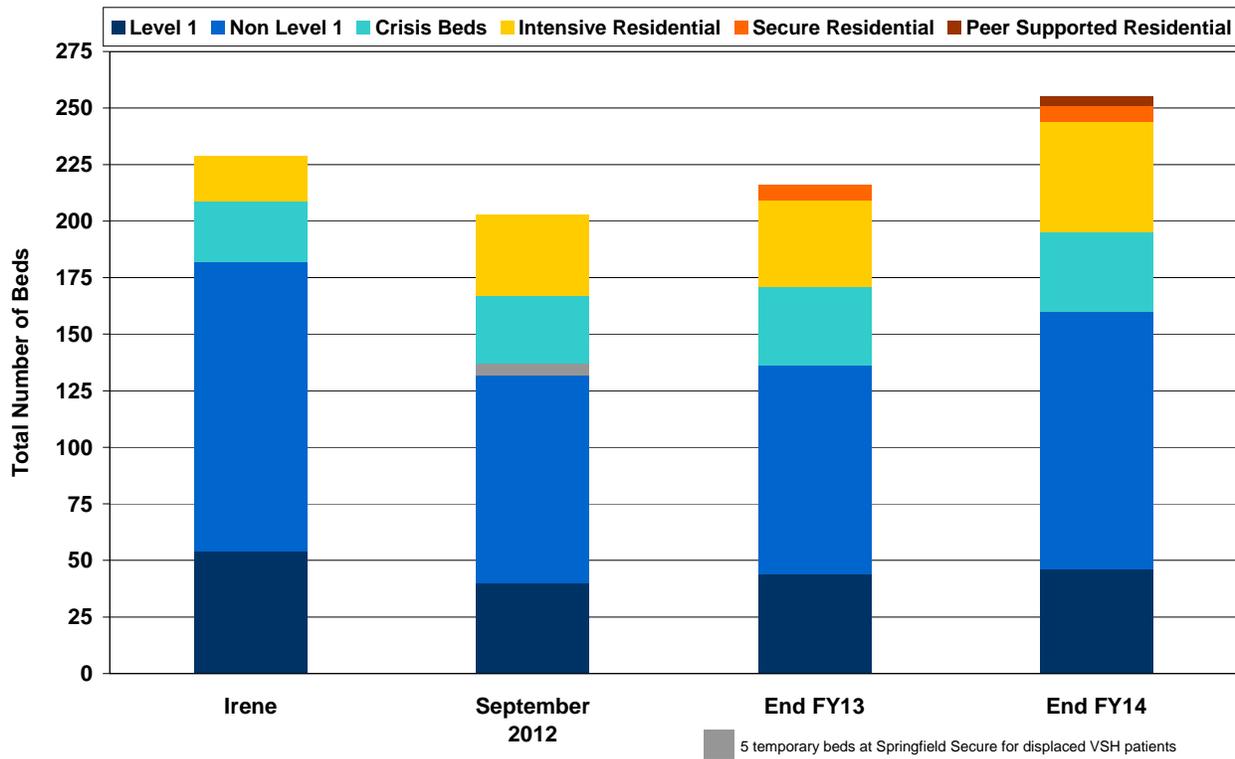
As referenced in earlier reports, an additional 28 psychiatric inpatient beds to serve Level I patients, individuals who would otherwise have been treated at the former state-run psychiatric hospital, were authorized via legislation while a new 25 bed hospital is under construction. Level I beds at the 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- VPCH) remains on target for opening on July 2nd. Key players involved in the project are focused on meeting all of the regulatory, licensing, occupancy, technology, system and program requirements for admitting patients. Delivery of furnishings, equipment and supplies is occurring. Staff training is underway in the hospital's facilities, allowing staff to be on site to become familiar with their work environment. Accomplishments during this period included:

- ◆ the Division of Fire Safety granted Full Occupancy for admission of patients in Units A through D with no violations found in the four patient units that comprise the 25-bed psychiatric hospital. All other required licenses are in hand, including from the Board of Pharmacy and the Board of Health license to operate as a hospital.

- ◆ The Department of Mental Health issued an RFP on April 17, 2014, for development of an EHR for the VPCH. As even a cursory review of the RFP will indicate, this project is complex and involves overall coordination by the project team. The RFP document is located on the BGS (Department of Buildings and General Services) website at this link: <http://bgs.vermont.gov/purchasing/bids/InformationTechnologyRFPVtPsychiatricCareHospital>

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



Development of two additional residential programs continue to move forward. The Soteria Vermont was granted an Act 250 land use permit. With a Certificate of Need (CON), local zoning and building permits already secured, the construction phase may begin. Soteria is a project of Pathways Vermont. Staff is at work on drafting policies and procedures, a necessary step for licensure as a Therapeutic Community Residence (TCR). The Vermont legislature approved a budget for FY 2015 at a level of \$500,000, allowing the program to begin operating in late winter/early spring of 2015.

Rutland Mental Health Services continues to work toward the completion of a 4-bed intensive residential recovery program (MapleWood Recovery Residence) in Rutland with room for expanding the building to eight beds without changing the building footprint. MapleWood Recovery Residence is the latest of the intensive residential programs authorized by Act 79. Work on the Rutland facility is complete, staff is hired and trained, a Certificate of Occupancy is secured, and a site visit by staff from the Division of Licensing and Protection is anticipated in the very near future. The program has the capacity to serve four individuals and will be ready to open immediately upon obtaining licensure. MapleWood is a program of the Vermont Southern Alliance for Community Care, a collaboration of Rutland Mental Health Services (RMHS) and Health Care and Rehabilitative Services of Southeastern Vermont (HCRS). An Open House on May 21<sup>st</sup> offered many people an opportunity to see the attractive new building and surroundings. MapleWood will provide a level of care for which there is an enormous need in the Rutland area. This need was exacerbated with the reduction in inpatient hospital resources following closure of Vermont State Hospital; but has also been increasing for some time as the availability of Level III Community Care Home beds in the area has decreased and the needs of individuals for 24 hour residential support in an environment with a recovery

orientation has increased. The program will serve individuals who historically have required extended lengths of stay in inpatient psychiatric settings, and those who have had their stays in these settings extended due to a lack of appropriate community resources. The focus will be on persons who are experiencing impairments in functioning primarily as a result of a mental health condition, including those with cooccurring substance use disorders, including those who are not ready for independent or transitional living and continue to require 24 hour per day supervision 7 days per week. A resident's length of stay is expected to range from three to eighteen months, depending on the individual's level of need. The program is designed to serve adults. MapleWood Recovery Residence will provide intervention services in a residential location to adults in the early stages of recovery. Individuals served will have daily access to individual, group and peer services on site that address co-occurring disorders, trauma, and resiliency. Family and vocational supports will be provided. These services specify one or more SAMHSA recovery principles as their desired outcomes, supporting the development of life skills to improve success of transition to a less restrictive setting such as their own apartments. The SAMHSA recovery principles include: Hope, Empowerment, Self-Direction, Strengths-Based, Individualized and Person-Centered, Responsibility, Holistic, Respect, Peer Support, and a Non-Linear recovery process. The MapleWood staffing ratio will be one staff for one resident during the day on Mondays through Fridays, and three staff to four residents at other times. Nursing will be available on all shifts. On call coverage for psychiatric emergencies will be provided by the RMHS Emergency Services Team and Psychiatry. Staffing will include a Director, a Residential Clinician, a Peer Recovery Coordinator, a Nurse Manager, Licensed Practical Nursing, and Residential Recovery Specialists.

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. State Fiscal Year 14 funding supported 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 was submitted to the Vermont Legislature on January 15, 2014. The report provides an overview of the significant program development areas and preliminary data collection and outcomes findings and can be found at: <http://mentalhealth.vermont.gov/sites/dmh/files/report/legislative/2014%20AFinal%202014%20Legislative%20Report%20-%20Act%2079.pdf>

### 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 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 has finished the second full state fiscal year and we have started the second pilot region in Franklin/Grand Isle counties on April 1, 2014. The initial pilot included consolidation of over 30 state and federal funding streams into one unified whole through one master grant agreement; the second pilot also includes consolidation of several state and federal funding streams. The state has created an annual aggregate spending cap for two providers in Addison and one in Franklin/Grand Isle (this provider houses the Designated Agency and Parent Child Center). This has created a seamless system of care to ensure no duplication of services for children (prenatal to 22) and families. For Addison, the aggregate annual budget for this pilot is approximately \$4M with \$3M being Global Commitment covered services, and in Franklin/Grand Isle the Global Commitment covered services are near \$5.4M. 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 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.

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.

## **VI. 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 expeditiously 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.

The FMAP SPA, to allow Vermont to draw in its expansion state FFP at 2.2% and New Adult enhancement, was not approved until May 14, 2014; accordingly, this caused a cash flow issue. AHS conducted a retroactive draw during QE0614 to receive the enhancement funds under the now approved SPA. Vermont had to postpone making the full June 1st capitation fund payment until July when additional State funds for match were available.

AHS entered into a one year contract extension with its actuarial consultant, Milliman, effective April 1,

2014, for FFY15 PMPM rate development, and worked on the rate development process throughout QE0614. The final FFY14 rate package and IGA were emailed to CMS on August 19, 2014.

AHS has worked with DVHA and CMS throughout QE0614 to ensure all the new reporting requirements per the October 2, 2013 STCs are met. The State's eligibility system has faced some difficulty with accurate beneficiary coding post-ACA implementation; AHS and DVHA are currently working through issues with the Eligibility Services unit to ensure enrollees are properly bucketed in the proper MEGs. We are working to institute a permanent automated solution.

Tracy O'Connell was hired as Monica Light's replacement as Financial Director II, effective June 2, 2014. Tracy brings a strong background in financial reporting and Federal grants management (for the Department of Public Safety) and will be managing all of the financial duties previously completed by Monica (including the CMS-64, CMS-21, CMS-37, and CMS-21B reports, and oversight of the actuarial PMPM development).

## VII. Member Month Reporting

### **Key updates from Q3 2014:**

- In Q3 FFY 2014, there were several fluctuations in enrollment, which led to an overall decrease in enrollment of -4.49%.
- Substantial decreases in enrollment were seen in Demonstration Populations 6, 7 and 11 due to coverage under VHAP and Vermont's Employer-Sponsored Insurance Premium Assistance Program (ESIA and Catamount-ESIA) ending on April 1, 2014.
- Increased enrollment was seen in Demonstration Populations 1, 2, and 5. The largest increase in enrollment (45.67%, or by 1,583 recipients) was in Demonstration Population 5, mostly due to the reclassifying of several aid category codes that target the ABD population.

Demonstration Populations are not synonymous with Medicaid Eligibility Group (MEG) reporting in Table 7. The numbers presented in the following table may represent duplicated population counts. For example, an individual in Demonstration Population 4, which is home- and community-based services, and Demonstration Population 10 may in fact be in MEG 1 or 2.

This report is run the first Monday following the close of the month for all persons eligible as of the 15th day of the preceding month. Data reported in Table 6 are not used in Budget Neutrality Calculations or Capitation Payments, as information will change at the end of the quarter. The information in this table cannot be summed across quarters. All payments are adjusted at the end of the year to reconcile expected population movement between eligibility groups.

**Table 6. Demonstration Populations, by FFY Quarter, for the last year**

Demonstration Population	Total for Quarter Ending			
	3rd Qtr FFY '14	2nd Qtr FFY '14	1st Qtr FFY '14	4th Qtr FFY '13
Demonstration Population 1:	278,325	263,544	145,498	145,446
Demonstration Population 2:	143,188	138,633	130,263	131,481
Demonstration Population 3:	34,252	40,892	28,998	29,618
Demonstration Population 4:	0	N/A	N/A	N/A
Demonstration Population 5:	5,049	3,466	2,598	2,657
Demonstration Population 6:	0	5,617	8,322	8,826
Demonstration Population 7:	12	6,143	105,494	107,354
Demonstration Population 8:	29,976	30,501	30,620	30,505
Demonstration Population 9:	7,613	7,776	7,783	7,794
Demonstration Population 10:	0	N/A	N/A	N/A
Demonstration Population 11:	6	25,264	41,962	40,093

**Table 7. Number of Recipients, by Month for FFY 2014, Q2 and Q3**

	FFY 2014 Q2			FFY 2014 Q3		
	January 31, 2014	February 28, 2014	March 31, 2014	April 30, 2014	May 31, 2014	June 30, 2014
Demonstration Population 1	86,074	87,603	89,867	95,507	92,966	89,852
Demonstration Population 3	13,485	13,627	13,780	12,280	11,466	10,506
Demonstration Population 5	1,103	1,155	1,208	1,639	1,716	1,694
Demonstration Population 6	2,175	1,857	1,585	0	0	0
Demonstration Population 7	2,379	2,021	1,743	11	1	0
Demonstration Population 11	9,759	8,327	7,178	6	0	0

Substantial decreases in enrollment were seen in several populations due to changes in coverage as programs closed. Demonstration Population 6 now has no beneficiaries currently enrolled, which is a reduction of 5,617 recipients from the last day of FFY 2014 Q2 and Demonstration Population 7 saw coverage drop of 6,131 recipient (or 99.80%). With coverage under VHAP ending on April 1, 2014 these reductions in enrollment were expected by DVHA. There was a similar decrease of 99.98% (a reduction by 25,258 recipients) in enrollment for Demonstration Population 11. This decrease also was anticipated, as coverage under Vermont's Employer-Sponsored Insurance Premium Assistance Program (ESIA and Catamount-ESIA) ended on April 1, 2014. These decreases in enrollment due to program closures and coverage changes also will be reflected in the Q4 FFY 2014 report.

Increased enrollment was seen for Demonstration Populations 1, 2, 3, and 5. The largest percent increase

in enrollment was in Demonstration Population 5, with an increase of 45.67% (or 1,583 beneficiaries) this increase is largely due to the change in the MEG rate group from 'optional' to 'underinsured,' which went into effect on January 1, 2014. The largest recipient variance was in Demonstration Population 1 with an increase of 14,781 recipients since the second quarter of FFY 2014. Most of this increase is due to the reclassifying of several aid category codes that target the Aged, Blind, and Disabled (ABD) population that occurred on January 1, 2014.

In Q3 of FFY 2014, the overall fluctuations led to a change in enrollment of -4.49%.

## VIII. 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.

## IX. Quality Improvement

### **Key updates from Q3 2014:**

- Utilizing resources from the Adult Medicaid Quality (AMQ) Grant, DVHA continued to develop staff capacity to analyze and utilize performance measure data for monitoring and improving access and the quality of care in Medicaid.
- The Breast Cancer Screening Performance Improvement Project intervention period ran from January 1, 2014 through June 30, 2014. Results will be analyzed in Q4 2014.
- Baseline data gathered and intervention chosen for the Follow-up After Hospitalization for Mental Illness performance improvement project.

The DVHA Quality Improvement and Clinical Integrity Unit monitors, evaluates and improves the quality of care to Vermont Medicaid beneficiaries by improving internal processes, identifying performance improvement projects and performing utilization management. Efforts are aligned across the Agency of Human Services as well as with community providers. The Unit is responsible for instilling the principles of quality throughout DVHA; helping everyone in the organization to achieve excellence. The Unit's goal is to develop a culture of continuous quality improvement throughout DVHA.

### *Quality Committee Updates*

DVHA's Medical Director and Quality Improvement (QI) Administrator continue to coordinate the monthly Quality Committee (DQC) meetings. In Q3, the DQC focused on a review of Intra-Governmental Agreement (IGA) partners' quality management plans. The DQC is collaborating with its IGA Partners' Commissioners to solidify their Departments' representation on the DQC, as well as to re-establish performance measures that they will routinely report on for the Medicaid population(s) they serve.

The DQC also tasked a joint AHS-DVHA work group with an in-depth analysis of the current *Global Commitment for Health* investment expenditures. The review is expected to determine whether the investment expenditures are realizing optimal outcomes, as well as identify whether existing investments could become programmatic or administrative claims instead.

### *Formal (Validated) Performance Improvement Project*

DVHA's QI Administrator continues to lead an AHS-wide Performance Improvement Project (PIP) on Follow-up After Hospitalization (FUH) for Mental Illness, the study indicator for which is the Healthcare Effectiveness Data and Information Set (HEDIS) measure of the same name (FUH HEDIS). During Q3, the FUH PIP Implementation Team solidified our final baseline data, performed deeper demographic data analysis, conducted a cause and effect exercise, prioritized, and chose a study intervention.

Implementation of the study intervention is planned for the end of June, 2014. The intervention includes educating local designated hospitals (the hospitals in Vermont with inpatient psychiatric floors and accept involuntary admissions) on Medicaid's discharge planning and discharge policies and procedures. The intervention will include face-to-face meeting time between the hospital staff and PIP team members, distribution of updated materials, and regular performance reports from DVHA to the designated hospitals.

### *Consumer Assessment of Healthcare Providers and Systems Survey*

The DVHA Quality Unit's QI Administrator continued to coordinate the Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys during this quarter. DVHA's contracted vendor, WBA Research, distributed and collated both the Adult and Children's Medicaid CAHPS 5.0H surveys.

Also during this quarter, the QI Administrator registered Vermont Medicaid with the CAHPS data warehouse for the first time. This will allow DVHA access to national comparative reports in the future.

### *AHS Performance Accountability Committee*

DVHA's Quality Unit Director and QI Administrator continued to represent Vermont Medicaid's *Global Commitment for Health* activities at the monthly AHS-lead Performance Accountability Committee (PAC) meetings. Quality representatives from the other AHS Departments (Department of Health, Department of Mental Health, Department of Corrections, Department of Aging and Independent Living and the Department of Children and Families), as well as other AHS operations managers make up this committee. DVHA reported out to the PAC on FUH PIP progress and added input to a revision of the Vermont Quality Strategy document.

Additionally, S.293 "The Outcomes Bill" was signed into Vermont law during Q2 FFY 2014. Members of the PAC, including DVHA staff, will be working in the months to come on the requirements of this new

legislation. In particular, performance accountability liaisons (PALs) have been appointed from each AHS Department to work with the State legislature. DVHA has also already named our Quality Improvement Administrator as the owner of a results-based scorecard that will become available for initial development starting in Q4 FFY 2014.

#### *Adult Quality Measures Grant*

In Q3 FFY 2014, DVHA staff engaged in six hours of training through the Adult Quality Measures (AQM) Grant.

- The Lewin Group is providing a seven hour series of trainings on how to complete Performance Improvement Projects per CMS protocols. Staff completed trainings three and four this quarter on Creating a Sampling Plan and Developing a PIP Data Management/Analysis Plan.
- The Lewin Group also provided two hours of training on performance measurement to the Managed Care Medical Committee (MCMC). The module introduced the process of performance measurement and explored its applications within the health care field and beyond.
- One element of the AQM grant is for DVHA staff to develop the capacity to complete chart reviews in order to report on hybrid HEDIS measures. In June of 2014, the Vermont Child Health Improvement Program (VCHIP) provided a committee of DVHA staff with two hours of training on best practices in developing a chart review process. In Q4 2014, the committee will draft internal policy and procedures on completing hybrid measure chart reviews, and then will train selected DVHA staff on the new policy and procedures.

#### AHS Monitoring Activity

##### *AHS Performance Accountability Committee*

During this quarter, the AHS Performance Accountability Committee (PAC) met to review/discuss the following items: Global Commitment Quality Strategy, AHS Results Framework, Global Commitment Performance Measures, Vermont S.293, AHS Newsletter, Improvement Projects, and the AHS Scorecard. Members of the PAC provided feedback re: the GC Quality Strategy. With the pending waiver consolidation, the document will need to be further modified to account for those Medicaid beneficiaries receiving long-term services and supports. Also, the group reviewed a proposed quality management system (Results Framework) during this quarter. This framework will guide the quality assessment and improvement activities of the Medicaid program and be consistent with the GC Quality Strategy. During this quarter, the group also reviewed 3 quality improvement projects. Projects were conducted using the Agency Improvement Model, Results Based Accountability, or the CMS PIP methodology. In addition, the group began to strategize how the AHS Scorecard can be used to assist in monitoring the performance of the Managed Care Entity as well as the Agency. Finally, the group reviewed and provided feedback on the new AHS Newsletter. The group will continue to discuss how the newsletter can support their efforts.

DVHA's Quality Unit Director and QI Administrator continued to represent Vermont Medicaid's *Global Commitment for Health* activities at the monthly AHS-lead Performance Accountability Committee (PAC) meetings. Quality representatives from the other AHS Departments (Department of Health, Department of Mental Health, Department of Corrections, Department of Aging and Independent Living and the Department of Children and Families), as well as other AHS operations managers make up this committee.

DVHA reported out to the PAC on FUH PIP progress and added input to a revision of the Vermont Quality Strategy document.

Additionally, S.293 “The Outcomes Bill” was signed into Vermont law during Q2 FFY 2014. Members of the PAC, including DVHA staff, will be working in the months to come on the requirements of this new legislation. In particular, performance accountability liaisons (PALs) have been appointed from each AHS Department to work with the State legislature. DVHA has also already named our Quality Improvement Administrator as the owner of a results-based scorecard that will become available for initial development starting in Q4 FFY 2014.

### *Quality Strategy*

The AHS Quality Improvement Manager continued to work with the members of the AHS Performance Accountability Committee (PAC) to update the current GC Quality Strategy. Rather than seeking public comment – and finalizing an updated version – it was decided to modify the existing document to accommodate the quality assessment and improvement activities associated with the Choices for Care 1115 Waiver. This waiver is expected to be consolidated with the GC Waiver in October of this year. An updated version of the strategy will still need to be reviewed by the AHS Integrated Operations and Planning Team (IOPT) and AHS Executive Committee, and made available for public comment. After incorporating public comments, the final document will be forwarded to CMS for review/approval. In addition to including the aforementioned elements, the updated version of the strategy will follow the formatting requirements as set forth in Section 508 of the Rehabilitation Act (29 U.S.C. §794d). Going forward, the AHS Performance Accountability Committee will be responsible for conducting periodic reviews of the quality strategy to evaluate its effectiveness.

### *External Quality Review Organization (EQRO)*

During this quarter, review documents were sent by the EQRO to DVHA for all three EQRO required activities: Performance Improvement Project (PIP) Validation; Review of Compliance with Standards; and Validation of Performance Measures. The AHS Quality Improvement Manager (QIM) participated in a technical assistance call with the EQRO and face-to-face meetings with DVHA to clarify elements contained in the PIP data collection tool. The PIP validation tool was completed by DVHA and submitted to the EQRO at the end of this quarter. Feedback and scoring is expected to take place during next quarter. Also during this quarter, the AHS QIM participated in technical assistance calls with the EQRO and DVHA to prepare for the Performance Measure Validation on-site review. During these calls, it was decided that administrative only measures would be validated by the EQRO this year. The scope of the review was finalized and initial rates were sent to the EQRO along with requested documentation. The on-site review is scheduled for early next quarter. Finally, the AHS QIM participated in a number of calls/meetings to clarify the requirements for this year’s compliance on-site review. During the quarter, all review documents were posted by the EQRO and completed/reposted by DVHA. The on-site review is scheduled for early next quarter.

## **X. Compliance**

### **Key updates from Q3 2014:**

- Updated Inter-Governmental Agreements (IGAs) are now in circulation with management at partnering AHS departments.
- In June, DVHA and AHS completed the annual External Quality Review Organization (EQRO) audit.

The Managed Care Compliance program is responsible for ensuring that managed care operations are in compliance with all governing policies, regulations, agreements and statutes. This is accomplished through audits and corrective actions coordinated by the Managed Care Compliance Committee. This work is coordinated across AHS through Inter-Governmental Agreements (IGAs) with the departments involved in managed care programs.

Our updated IGAs are now in circulation with management at partnering AHS departments. These new IGAs further clarify roles and responsibilities related to managed care activities as described in the Global Commitment waiver. After implementation of these new agreements, DVHA and IGA partners will establish two new committees: a Managed Care Compliance Committee and a Global Commitment to Health Leadership Committee. The Managed Care Compliance Committee will include members from each IGA department, which will provide a wider range of expertise and experience when managing compliance concerns and projects. The Global Commitment to Health Leadership Committee will comprise of Commissioners from each of the IGA departments (as well as an AHS Central Office representative). This committee will be responsible for executive-level leadership of managed care responsibilities.

In June, DVHA and AHS completed the annual External Quality Review Organization (EQRO) audit. The EQRO audits are designed to cover different topics each year, with a complete cycle repeating every three years. This year, the EQRO audit evaluated the following standards:

- 1) Provider Selection
- 2) Provider Credentialing/Re-Credentialing
- 3) Member Information and Communication
- 4) Member Rights
- 5) Confidentiality
- 6) Member Grievances, Appeals and Fair Hearings
- 7) Subcontracts and Delegations

During the audit closing session, the auditors provided a few suggestions for improving some processes. DVHA expects to see a few audit findings, but the feedback we received from the auditors was very good overall. The auditors made several remarks that positively compared DVHA to Managed Care Organizations/Entities across the country and stated that Vermont continues to lead the way by setting and meeting very high standards for the delivery of services to Medicaid members. The final audit report will be available next quarter, and another report with specific information about findings and corrective actions will be provided.

## **XI. Demonstration Evaluation**

As a member of the AHS Institutional Review Board (IRB), the AHS QIM participated in a review of

Research Triangle Institute's (RTI) external SIM evaluation plan. Conditional approval was granted for the project. Final approval will be granted upon receipt of pending documentation. Also during this quarter, the AHS QIM continued to work with members of Vermont's System Innovation Model (SIM) grant to develop its internal evaluation plan. While Medicaid is only one of the participating payers, it was thought that there might be some efficiencies realized by leveraging the Global Commitment waiver evaluation efforts with those of the internal evaluation of the SIM grant. As the requirements/details of the internal SIM grant evaluation plan become clearer, so will the opportunities for coordination/integration. Finally, the AHS QIM continued to review evaluation documents associated with Long Term Care (LTC) program – specifically those linked to Vermont's current Choices for Care waiver. As the state plans to consolidate their existing Medicaid 1115 waivers – more attention needs to be given to how this change might impact the current Global Commitment evaluation plan. The AHS QIM will continue to work with staff at the Pacific Health Policy Group (PHPG) to follow these developments and modify the plan as needed.

## **XII. 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.

## **XIII. Enclosures/Attachments**

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

Attachment 1: Budget Neutrality Workbook

Attachment 2: Enrollment and Expenditures Report

Attachment 3: Complaints Received by Health Access Member Services

Attachment 4: Medicaid Managed Care Entity Grievance and Appeal Reports

Attachment 5: Office of the Health Care Advocate Report

Attachment 6: State Fiscal Year 2013 Managed Care Entity Investments

#### **XIV. 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) <a href="mailto:jim.giffin@state.vt.us">jim.giffin@state.vt.us</a>
Policy/Program:	Monica Light, Director AHS Health Care Operations, Compliance, and Improvement VT Agency of Human Services 208 Hurricane Lane Williston, VT 05495	802-871-3254 (P) 802-871-3001 (F) <a href="mailto:monica.light@state.vt.us">monica.light@state.vt.us</a>
Managed Care Entity:	Mark Larson, Commissioner Department of VT Health Access 312 Hurricane Lane, Suite 201 Williston, VT 05495	802-879-5901 (P) 802-879-5952 (F) <a href="mailto:mark.larson@state.vt.us">mark.larson@state.vt.us</a>

**Date Submitted to CMS: August 28, 2014**

## **ATTACHMENTS**

Global Commitment Expenditure Tracking

QE	Quarterly Expenditures	PQA: WY1	PQA: WY2	PQA: WY3	PQA: WY4	PQA: WY5	PQA: WY6	PQA: WY7	PQA: WY8	PQA: WY9a	PQA: WY9b	PQA: WY10	PQA: WY11	Net Program PQA	Net Program Expenditures as reported on 64	Excess New Adult Expenditures as reported on 64 per STC 55e	non-MCO Admin Expenses	Total columns J:K for Budget Neutrality calculation - Includes New Adult	Cumulative Waiver Cap - Excluding New Adult per 10/2/13 STCs	Variance to Cap under/(over)
1205	\$ 178,493,793														\$ 178,493,793					
0306	\$ 189,414,365	\$ 14,472,838												\$ 14,472,838	\$ 203,887,203					
0606	\$ 209,647,618	\$ (14,172,165)												\$ (14,172,165)	\$ 195,475,453					
0906	\$ 194,437,742	\$ 133,350												\$ 133,350	\$ 194,571,092					
WY1 SUM	\$ 771,993,518	\$ 434,023												\$ 434,023	\$ 782,159,845		\$ 4,620,302	\$ 786,780,147	\$ 841,266,663	\$ 54,486,516
1206	\$ 203,444,640	\$ 8,903												\$ 8,903	\$ 203,453,543					
0307	\$ 203,804,330	\$ 8,894,097												\$ 8,894,097	\$ 212,698,427					
0607	\$ 186,458,403	\$ 814,587	\$ (68,408)											\$ 746,179	\$ 187,204,582					
0907	\$ 225,219,267	\$ -	\$ -											\$ -	\$ 225,219,267					
WY2 SUM	\$ 818,926,640	\$ 9,717,587	\$ (68,408)											\$ 9,649,179	\$ 802,884,359		\$ 6,464,439	\$ 809,348,797	\$ 1,684,861,317	\$ 88,732,372
Cumulative																				
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	\$ 1,199,549,732		\$ 6,260,794	\$ 1,205,810,526	\$ 8,450,684,486	\$ 609,071,343
Cumulative																				
1213	\$ 319,939,651	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 3,652,767						\$ 3,652,767	\$ 323,592,418					
WY9a SUM	\$ 319,939,651	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 3,652,767					\$ 3,652,767	\$ 319,939,651		\$ 1,214,631	\$ 321,154,282	\$ 8,955,886,798	\$ 793,119,374
Cumulative																				
0314	\$ 288,542,475	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 2,159,834						\$ 2,159,834	\$ 290,702,309					
0614	\$ 288,845,927	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -						\$ -	\$ 288,845,927					
0914	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -						\$ -	\$ -					
1214	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -						\$ -	\$ -					
WY9b SUM	\$ 577,388,402	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 2,159,834	\$ -	\$ -			\$ 2,159,834	\$ 577,388,402	\$ 2,827,820	\$ 2,617,527	\$ 582,833,749	\$ 10,290,338,883	\$ 1,544,737,710
Cumulative																				
0315	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -						\$ -	\$ -					
0615	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -						\$ -	\$ -					
0915	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -						\$ -	\$ -					
1215	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -						\$ -	\$ -					
WY10 SUM	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Cumulative																				
0316	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -						\$ -	\$ -					
0616	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -						\$ -	\$ -					
0916	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -						\$ -	\$ -					
1216	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -						\$ -	\$ -					
WY11 SUM	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Cumulative																				
	\$ 8,496,508,069	\$ 10,166,327	\$ (16,042,281)	\$ 79,876,130	\$ 41,153,315	\$ 19,453,990	\$ 4,878,725	\$ 48,036,100	\$ 7,849,694	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 8,691,880,069	\$ 2,827,820	\$ 50,893,285	\$ 8,745,601,173	\$ 13,209,265,211	\$ 4,463,664,038

## 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

**New Adult** - Adults who are at or below 138% of the FPL

**Exchange Vermont Premium Assistance** - Individuals enrolled in qualified health plans (QHP) with incomes between 133-300% FPL

**Exchange Vermont Cost Sharing** - Individuals enrolled in qualified health plans (QHP) with incomes between 200-300% FPL

**Underinsured Child** – Beneficiaries age 18 or under with household income 225-300% (as of 1/1/14, 237-312%) 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, and/or enhanced residential care (ERC)



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**The Department of Vermont Health Access**  
**Caseload and Expenditure Report ~ All AHS Medicaid Spend**  
**All AHS YTD '14**  
 Thursday, July 31, 2014

	SFY '14 Budget Adjustment			SFY '14 Actuals thru June 30, 2014			% of Approp. Spent to Date
	Caseload	Expenses	PMPM	Caseload	Expenses	PMPM	
ABD Adult	14,660	\$ 185,030,520	\$ 1,051.77	15,447	\$ 188,835,438	\$ 1,018.76	102.06%
ABD Dual	17,351	\$ 200,918,225	\$ 964.95	17,382	\$ 201,968,814	\$ 968.30	100.52%
General Adult	11,550	\$ 84,215,797	\$ 607.60	12,840	\$ 84,532,839	\$ 548.62	100.38%
VHAP *	37,921	\$ 100,020,181	\$ 386.93	36,617	\$ 105,278,087	\$ 421.28	105.26%
VHAP ESI *	764	\$ 462,511	\$ 99.99	721	\$ 851,137	\$ 147.61	184.03%
Catamount *	13,208	\$ 35,764,708	\$ 459.64	13,326	\$ 48,356,058	\$ 450.96	135.21%
ESIA *	772	\$ 497,443	\$ 108.33	687	\$ 638,510	\$ 98.07	128.36%
New Adult **	34,834	\$ 92,812,770	\$ 444.07	44,197	\$ 80,536,031	\$ 350.28	86.77%
Exchange Premium Assistance ** #	40,748	\$ 6,586,587	\$ 26.94	14,013	\$ 2,565,588	\$ 36.82	38.95%
Exchange Cost Sharing ** #	15,094	\$ 1,484,460	\$ 16.39	4,452	\$ 332,623	\$ 19.52	22.41%
ABD Child	3,712	\$ 92,534,006	\$ 2,077.42	3,564	\$ 91,503,344	\$ 2,139.73	98.89%
General Child	55,646	\$ 240,214,462	\$ 359.74	55,931	\$ 236,587,894	\$ 352.50	98.49%
Underinsured Child	874	\$ 2,154,907	\$ 205.44	1,196	\$ 2,521,774	\$ 175.67	117.02%
CHIP	4,174	\$ 10,431,858	\$ 208.26	3,804	\$ 10,218,851	\$ 223.89	97.96%
Pharmacy Only	12,510	\$ 5,393,070	\$ 35.93	12,663	\$ 4,485,706	\$ 29.52	83.18%
Choices for Care	3,884	\$ 206,699,425	\$ 4,434.86	4,029	\$ 202,593,610	\$ 4,190.32	98.01%
<b>Total Medicaid</b>	<b>177,027</b>	<b>\$ 1,265,220,931</b>	<b>\$ 595.59</b>	<b>178,206</b>	<b>\$ 1,261,806,304</b>	<b>\$ 590.05</b>	<b>99.73%</b>

\* Caseload for sunseting programs are point-in-time values for the BAA, and point-in-time for Actuals (December 2013)  
 Actual PMPM for sunseting programs are Total Expenses per Total enrolled

\*\* Caseload for new programs are point in time values for the BAA and are not included in total Medicaid caseload count due to the expected transition from sunseting programs to new programs  
 Caseload for new programs are point in time values for Actuals (June 2013) and are not included in total Medicaid caseload count due to the expected transition from sunseting programs to new programs  
 Actual PMPM for new programs are Total Expenses per Total enrolled

# Exchange Premium Assistance and Cost Sharing PMPMs were budgeted based on member count. Actual PMPM is based on subscriber count, which may include more than one member per plan



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

	SFY '14 Budget Adjustment			SFY '14 Actuals thru June 30, 2014			% of Approp. Spent to Date
	Caseload	Expenses	PMPM	Caseload	Expenses	PMPM	
ABD Adult	14,660	\$ 111,814,690	\$ 635.59	15,447	\$ 108,329,783	\$ 584.43	96.88%
ABD Dual	17,351	\$ 50,384,851	\$ 241.98	17,382	\$ 49,143,760	\$ 235.61	97.54%
General Adult	11,550	\$ 76,593,458	\$ 552.61	12,840	\$ 76,094,174	\$ 493.86	99.35%
VHAP *	37,921	\$ 96,400,670	\$ 372.92	36,617	\$ 97,932,892	\$ 391.89	101.59%
VHAP ESI *	764	\$ 462,511	\$ 99.99	721	\$ 849,213	\$ 147.28	183.61%
Catamount *	13,208	\$ 35,764,708	\$ 459.64	13,326	\$ 48,356,058	\$ 450.96	135.21%
ESIA *	772	\$ 497,443	\$ 108.33	687	\$ 638,510	\$ 98.07	128.36%
New Adult **	34,834	\$ 90,067,832	\$ 432.05	44,197	\$ 72,982,243	\$ 317.42	81.03%
Exchange Premium Assistance ** #	40,748	\$ 6,586,587	\$ 26.94	14,013	\$ 2,571,477	\$ 36.91	39.04%
Exchange Cost Sharing ** #	15,094	\$ 1,484,460	\$ 16.39	4,452	\$ 332,623	\$ 19.52	22.41%
ABD Child	3,712	\$ 33,110,973	\$ 743.35	3,564	\$ 36,486,052	\$ 853.20	110.19%
General Child	55,646	\$ 131,835,785	\$ 197.43	55,931	\$ 130,940,851	\$ 195.09	99.32%
Underinsured Child	874	\$ 708,670	\$ 67.56	1,196	\$ 1,072,657	\$ 74.72	151.36%
CHIP	4,174	\$ 7,601,478	\$ 151.75	3,804	\$ 7,465,861	\$ 163.57	98.22%
Pharmacy Only	12,510	\$ 5,393,070	\$ 35.93	12,663	\$ 4,485,706	\$ 29.52	83.18%
Choices for Care	3,884	\$ 206,699,425	\$ 4,434.86	4,029	\$ 202,593,610	\$ 4,190.32	98.01%
<b>Total Medicaid</b>	<b>177,027</b>	<b>\$ 855,406,614</b>	<b>\$ 402.67</b>	<b>178,206</b>	<b>\$ 840,275,469</b>	<b>\$ 392.93</b>	<b>98.23%</b>

\* Caseload for sunseting programs are point-in-time values for the BAA, and point-in-time for Actuals (December 2013)  
 Actual PMPM for sunseting programs are Total Expenses per Total enrolled

\*\* Caseload for new programs are point in time values for the BAA and are not included in total Medicaid caseload count due to the expected transition from sunseting programs to new programs  
 Caseload for new programs are point in time values for Actuals (June 2013) and are not included in total Medicaid caseload count due to the expected transition from sunseting programs to new programs  
 Actual PMPM for new programs are Total Expenses per Total enrolled

# Exchange Premium Assistance and Cost Sharing PMPMs were budgeted based on member count. Actual PMPM is based on subscriber count, which may include more than one member per plan

**Questions, Complaints and Concerns Received by Health Access Member Services**  
**March 30, 2014 – June 28, 2014**

**March 30 – April 5:**

- Dr. Dynasaur premiums generated in both the CRM and ACCESS when bill had been paid: CSR's advised to follow through with VHC invoices and disregard GMC Dr. Dynasaur bills.
- Payment confirmation: CSR's verified status of premium and advised accordingly.
- Overlapping coverage: CSR's escalated the call to level 3 SR and supervisors sent to COPS.

**April 7 – April 12:**

- Reviews: CSR's took application if caller needed to apply through VHC, or advised them which application to complete.
- Payment confirmation: CSR's verified status of premium and advised accordingly.
- Overlapping coverage: CSR's escalated the call to level 3 SR and supervisors sent to COPS.

**April 14 – April 19:**

- Payments: CSR's reviewed account and advised the caller accordingly.
- Covered services: CSR's reviewed the KB for requested information.

**April 21 – April 24:**

- The CSC experienced a large unexpected spike in calls this week as the result of consumer confusion about closure notices triggered by the ACCESS system. Many of these consumers had already applied through VHC and the CSC reassured them that they were not losing their coverage.
- Payments: CSR's reviewed account and advised the caller accordingly.
- Overlapping coverage: CSR's escalated the call to level 3 SR and supervisors sent to COPS.
- Reviews from clients transitioning from GMC to VHC, but are still set to close on 4/30 in ACCESS: CSR's confirmed that caller had applied through VHC and advised accordingly.
- Clients found eligible in CRM for Medicaid, but unable to access benefits because coverage was not transferring to ACCESS: CSR's escalated the call to HAEU.



### **April 28 – May 3:**

- Reviews: CSR's confirmed if further information was needed and advised accordingly.
- Inability to pick up prescriptions: CSR's reviewed RxClaims and noted issue in the system.

### **May 5 – May 10:**

- Reviews: CSR's confirmed if further information was needed and advised accordingly.
- Inability to pick up prescriptions: CSR's reviewed RxClaims and noted issue in the system.
- Overlapping coverage: CSR's escalated the call to level 3 SR and supervisors sent to COPS.

### **May 12 – May 17:**

- RX Review extension letters including RX review application: CSR's reviewed account and advised if an application needed.
- Dr. Dynasaur customers receiving refunds from GMC after applying through VHC: CSRs review both systems, advised caller if the refund is correct and if premium is due for VHC.

### **May 19 – May 24:**

- Inaccurate Review Closure notices: CSR's informed callers of the error and advised accordingly.

### **May 26 – May 31:**

- Applications for clients previously on CHAP: CSR's assisted callers complete the application process as their SEP was ending.
- Urgent RX and medical needs: CSR's reviewed the case and escalated appropriately; calls were escalated to HAEU if client was not showing active in ACCESS, to COPS if there were overlapping segments, or to SSU if waiting for a COC request to be processed.

### **June 2 – June 7:**

- Change of Circumstance confirmations: CSR's advised that changes are being addressed, and escalated to HAEU when necessary.
- Overlapping coverage: CSR's escalated the call to level 3 SR and supervisors sent to COPS.

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**June 9 – June 14:**

- VPharm reviews: CSR's advised callers that cover has been extended to 2015.
- LIS applications: CSR's updated ACCESS or referred to COA/AOC for assistance.

**June 16 – June 21:**

- LIS applications: CSR's updated ACCESS or referred to COA/AOC for assistance.
- PC Plus Enrollment: CSR's assisted callers with enrolling in their PCP of choice.

**June 23 – June 28:**

- Review notices: CSR's advised that application was received and to disregard, or assisted caller complete application as needed; if there was an access to care issue calls were escalated to HAEU.
- Premium closures: CSR's advised if payment had been received, and if not advised where to send payment.



**Grievance and Appeal Quarterly Report  
Medicaid MCE All Departments Combined Data  
April 1, 2014 – June 30, 2014**

The MCE is composed of various administrative areas within the Agency of Human Services (AHS). These include: the Department of Vermont Health Access (DVHA), the Department for Children and Families (DCF), the Department of Mental Health (DMH), the Department of Disabilities, Aging and Independent Living (DAIL), and the Department of Health (VDH). Also included in the MCE are the Designated Agencies (DA) and Specialized Service Agencies (SSA) that provide service authorizations for DMH and DAIL. Each entity should have at least one assigned grievance and appeal coordinator who enters data into the MCE database. This report is based on data compiled on July 1, 2014, from the centralized database for grievances and appeals that were filed from April 1, 2014 through June 30, 2014.

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 20 grievances filed with the MCE; with three 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 four days. Of the grievances filed, 75% were filed by beneficiaries, and 25% were filed by a representative of the beneficiary. Of the 20 grievances filed, DMH had 70%, DAIL had 5%, DVHA had 5%, and VDH had 20%.

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.

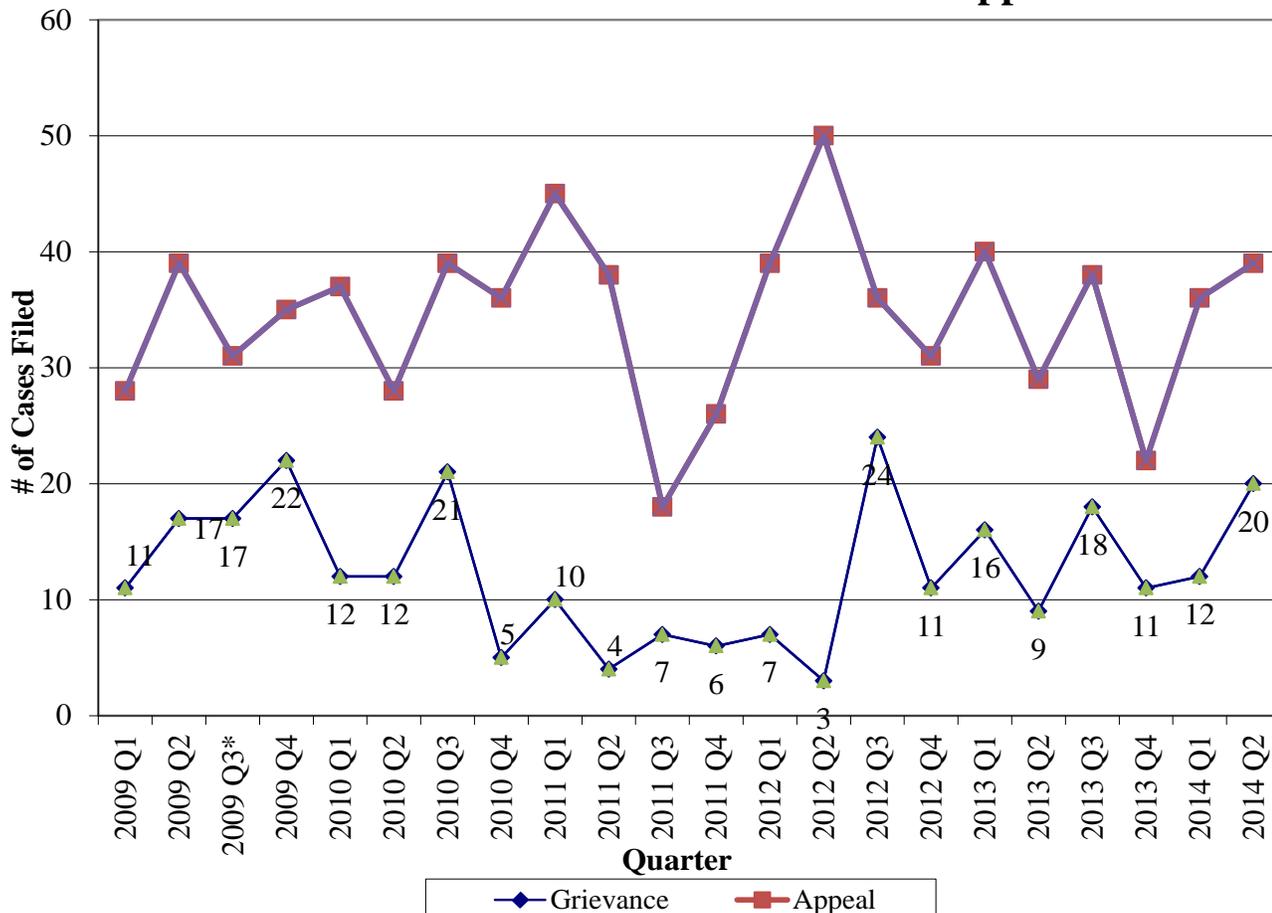
During this quarter, there were 39 appeals filed with the MCE; 5 requested an expedited decision, with five of them meeting the criteria. Of these 39 appeals, 25 were resolved (64% of filed appeals), 11 were still pending (28%), 2 were withdrawn (5%), and one was filed to late (3%). In thirteen cases (52% of those resolved), the original decision was upheld by the person hearing the appeal, 2 cases (8% of those resolved) were approved by the applicable department/DA/SSA before the appeal meeting, in ten cases (40%) the original decision was reversed.

Of the 25 appeals that were resolved this quarter, 88% were resolved within the statutory time frame of 45 days; 65% were resolved within 30 days. The average number of days it took to resolve these cases was 30 days. Acknowledgement letters of the receipt of an appeal must be sent within five days; the average was three days, with four of them being late.

Of the 39 appeals filed, 16 were filed by beneficiaries (41%), 22 were filed by a representative of the beneficiary (56%), and 1 (3%) was filed by the provider. Of the 39 appeals filed, DVHA had 44%, DAIL had 54%, and DMH had 2%.

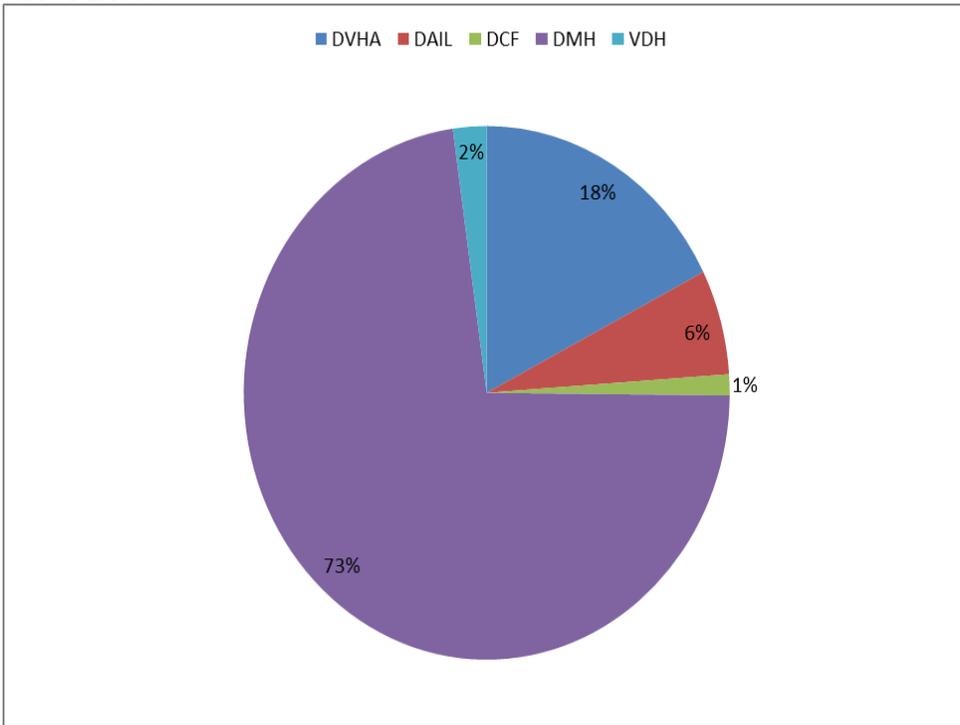
Beneficiaries can file an appeal and a fair hearing at the same time, and they can file a fair hearing if their appeal is not decided in their favor. There were seven fair hearing filed this quarter.

### Medicaid MCE Grievances & Appeals

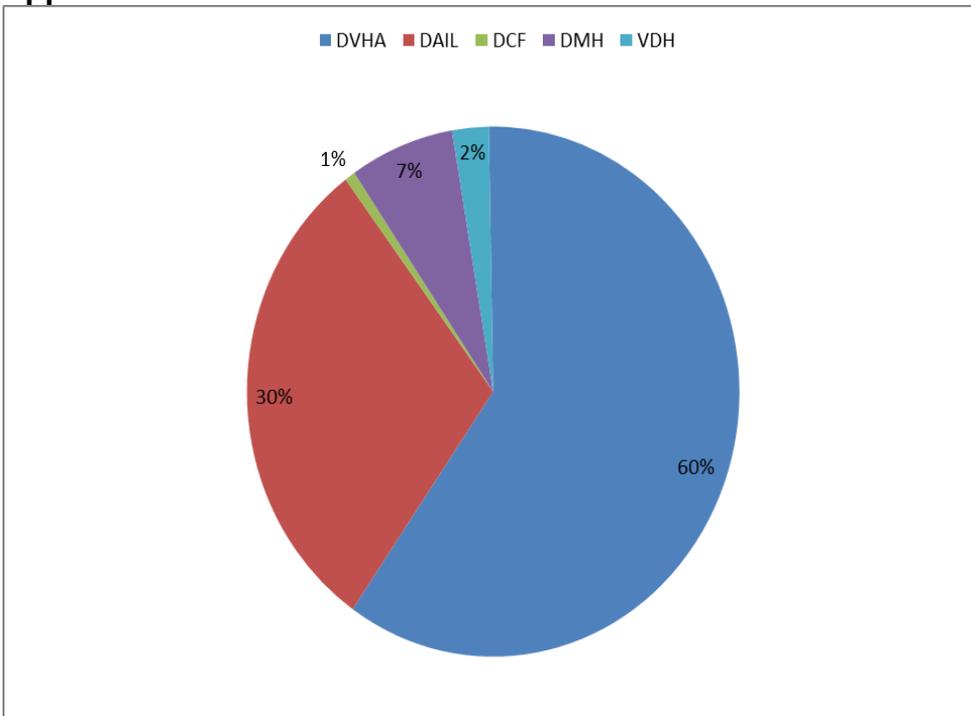


### MCE Grievance & Appeals by Department From January 1, 2009 through June 1, 2014

#### Grievances



#### Appeals



# VERMONT LEGAL AID, INC.

## OFFICE OF THE HEALTH CARE ADVOCATE

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MONTPELIER  
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## QUARTERLY REPORT

April 1, 2014 – June 30, 2014

to the

Agency of Administration

submitted by

Trinka Kerr, Chief Health Care Advocate

July 18, 2014

## I. Introduction

The Office of the Health Care Advocate (HCA) provides consumer assistance to individual 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 Green Mountain Care Board, 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 and Education**
- Six data reports
  - **All calls/all coverages:** 1,022 calls
  - **DVHA beneficiaries:** 413 calls or **40%** of total calls
  - **Commercial plan beneficiaries:** 209 calls or **20%**
  - **Uninsured Vermonters:** 136 calls or **13%**
  - **Vermont Health Connect:** 419 calls or **41%** (this data report draws from the All Calls data set above)
  - **Reportable Activities (Summary & Detail):** 149 activities, 52 documents

## II. Individual Consumer Assistance

The HCA provides assistance to consumers mainly through our statewide hotline (**1-800-917-7787**) and through our Online Help Request feature on our website, [www.vtlawhelp.org/health](http://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.

The HCA received 1,022 calls this quarter. We divided these calls into five issue categories. The figures below are based on the All Calls data. The percentage and number of calls in each issue category based on the caller's primary issue was as follows:

- **21.72%** (222) of our total calls were regarding **Access to Care**;
- **16.73%** (171) were regarding **Billing/Coverage**;
- **1.76%** (18) were questions regarding **Buying Insurance**;
- **8.51%** (87) primarily involved **Consumer Education**;
- **27.59%** (282) were regarding **Eligibility** for VHC programs and Medicare; and
- **23.68%** (242) 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.

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 282 cases had Eligibility for state health care programs as the primary issue, there were actually a total of 862 calls in which we spent a significant amount of time assisting consumers regarding eligibility for health insurance. In each section of this narrative we indicate 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 Vermont Health Connect and Medicaid programs fell into all three insurance status categories.

See our recommendations to the state at the end of this section, beginning on page 10.

#### **A. The HCA's call volume continued to set record high levels primarily due to problems with Vermont Health Connect.**

The HCA's call volume was about 42% higher than in the same quarter last year, although calls decreased 13.6% from last quarter. The state launched its health benefit exchange, Vermont Health Connect (VHC), on October 1, 2013, as required by the federal Affordable Care Act (ACA). The rollout was rocky, and VHC continues to be plagued by operational problems. As a result, our call volume has hit record levels month after month since December 2013.

We received 1,022 calls this quarter, compared to 1,184 last quarter. This compares to 721 calls in the second quarter of calendar year 2013. Thus, our SFY 2014 Q 4 call volume was 41.7% higher than SFY 2013 Q 4. Because about 41% of our calls this quarter were related to VHC, it seems safe to assume that this big increase was directly attributable to problems with the exchange.

In each month this quarter we saw a record number of calls for that particular month. April's call volume was 354, compared to 253 last year; May's was 324 compared to 228; and June's was 344 compared to 240.

**B. Vermont Health Connect still does not have Change of Circumstance functionality and the number of cases needing these changes has continued to grow.**

By the end of this quarter, VHC did not yet have the ability to make changes to applications or accounts except through a difficult manual method. Many consumers have been waiting months to get their changes processed. The HCA had 62 VHC cases involving Change of Circumstance (COC) this quarter, or 16% of the total VHC calls. Many have put off health care while waiting in limbo for their insurance status to be fixed. At a certain point people cannot wait longer because they need care or prescriptions, and the situation becomes urgent. Thirteen of our VHC COC cases involved access to care issues. These cases are often complex and time-consuming for the HCA, difficult for the State to resolve, and extremely distressing for the consumers.

Even after the COC functionality is deployed, which we hope will be soon, it will only work prospectively. This means that all the COCs in the pipeline must be manually processed. Our understanding is that there were something like 12,000 COCs waiting to be processed at the end of the quarter. The State has hired a new vendor, Optum, to do this work. Meanwhile, new COC requests are added every day that the functionality is not in place.

**C. Problems with the Vermont Health Connect invoice and payment system continue to exasperate consumers.**

Many consumers who purchased Qualified Health Plans from VHC are having problems getting what they bought. The problems include non-receipt of invoices, delays in processing, and sometimes longer delays in actually getting coverage. Some people reported that they had made payments for months which did not seem to be recorded anywhere. Frequently these problems resulted in individuals not having coverage for months. Needless to say, by the time many of these callers got to the HCA, they were irate. In many cases they were deferring or going without care or medications because their insurance had not been activated.

#### **D. Vermont Health Connect is still not sending out Notices of Decision.**

Our call volume probably would have been even higher but for the fact that VHC has not yet started sending out written Notices of Decision (NODs) to applicants, which is a legal requirement. The HCA phone number is on DVHA NODs and is one of the main ways that consumers find out about our services. We started complaining about the lack of notices right after VHC launched. We know the State is working on this functionality, but at this point, eight months after the launch of VHC, it is unacceptable that NODs are still not going out.

#### **E. The Medicaid renewal process has created difficulties for thousands of consumers.**

VHC began processing previously deferred Medicaid renewals at the beginning of this quarter. For most Medicaid beneficiaries these reviews mean that they have to apply through VHC for the first time to have their eligibility determined under the new rules. This process has not gone well, and the reasons for that are not completely clear.

The Medicaid renewal process has generated calls to the HCA from consumers who thought they had completed the VHC application process to renew their Medicaid coverage, only to find out that their coverage was not active when they went to pick up medications at the pharmacy. Some consumers have not clearly understood that their Medicaid coverage would close if they did not proactively apply through VHC, and some were unsure how to actually apply through VHC. Furthermore, it is our understanding that thousands of Medicaid beneficiaries have not even started the VHC application process as required.

As of the writing of this report, VHC has told the HCA that it is acutely aware of the problems with Medicaid renewals and is working hard to resolve them. It is in the process of halting current and future reviews and reinstating individuals whose benefits were closed. It has been in close contact with the HCA on its efforts, which we greatly appreciate.

#### **F. The HCA, Vermont Health Connect and the insurance carriers continue to work collaboratively to ensure consumers get the coverage they need.**

Although there are many problems with VHC, there are also many people who are working extremely hard to help individuals and improve the system. We are grateful for everyone's efforts.

#### **G. The top issues generating calls**

This section includes both primary and secondary issues. The most common issues raised by callers were complaints about VHC, requests for information about VHC and applying for VHC and Medicaid programs, complaints about providers, access to prescription drugs, Medicaid eligibility, complaints about the VHC website, and premium billing problems.

**All Calls (1,022, compared to 1,184 last quarter)**

1. VHC complaints 190 (compared to 230 last quarter)
2. Information about VHC 138 (231)
3. Complaints about Providers 132 (118)
4. Access to Prescription Drugs 116 (112)
5. Information about DVHA programs 116 (139)
6. Medicaid (non-MAGI) eligibility 110 (104)
7. VHC website/technology problem 109 (108)
8. MAGI Medicaid eligibility 102 (131)
9. Premium Billing 70 (80)
10. Communication Problems with DCF/ESD/HAEU 67 (138)
11. Change of Circumstance 63 (41)
12. Affordability-access problem 60 (102)
13. Buying QHPs through VHC 54 (111)
14. VHC Invoice Problem 54 (38)
15. Premium Tax Credit Eligibility 53 (79)

**DVHA Beneficiary Calls (413, compared to 469 last quarter)**

1. Complaints about Providers 67 (73 last quarter)
2. Access to Prescription Drugs 63 (60)
3. Information about DVHA programs 59 (60)
4. Medicaid (non-MAGI) eligibility 54 (46)
5. MAGI Medicaid eligibility 42 (50)
6. VHC complaints 41 (37)
7. Medicaid Billing 36 (24)
8. VHC website/technology problem 31 (17)
9. Affordability-access problem 31 (40)
10. Information about VHC 28 (54)

**Commercial Plan Beneficiary Calls (209, compared to 271 last quarter)**

1. VHC complaints 80 (152 last quarter)
2. Information about VHC 54 (87)
3. Premium billing 37 (43)
4. VHC invoice problem 32 (29)
5. VHC website/technology problem 29 (53)
6. Change of Circumstance 25 (25)
7. Access to Prescription Drugs 21 (15)
8. Copayments-access problem 19 (11)
9. MAGI Medicaid 18 (19)
10. Buying QHPs through VHC 18 (53)
11. Affordability-access problem 15 (27)

## **Vermont Health Connect Calls (419, compared to 541 last quarter)**

1. VHC complaints 190 (230 last quarter)
2. Information about VHC 138 (228)
3. VHC website/technology problem 109 (108)
4. MAGI Medicaid eligibility 97 (127)
5. Medicaid eligibility 63 (63)
6. Change of Circumstance 62 (41)
7. Information about applying for DVHA programs 55 (72)
8. Premium billing problem 55 (60)
9. Buying QHPs through VHC 54 (110)
10. VHC Invoice problem 54 (38)
11. Premium Tax Credit eligibility 53 (79)
12. Access to Prescription Drugs 52 (48)

## **H. Hotline call volume by type of insurance:**

The HCA received 1,022 total calls this quarter. Callers had the following insurance status:

- **DVHA programs** (Medicaid, VHAP<sup>1</sup>, VPharm, or both Medicaid and Medicare aka “dual eligibles”) insured **40%** (413 calls), compared to 40% (472) last quarter;
- **Medicare**<sup>2</sup> (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 **21%** (210), compared to 23% (269) last quarter;
- **Commercial plans** (employer sponsored insurance, individual or small group plans, and Catamount Health<sup>3</sup> plans) insured **20%** (209), compared to 23% (270) last quarter; and
- **Uninsured** callers made up **13%** (136) of the calls, compared to 14% (165) last quarter.
- In the remainder of calls the insurance status was either unknown or not relevant.

## **I. Dispositions of closed cases**

### **All Calls**

We closed 1,021 cases this quarter, compared to 1,114 last quarter.

- 27% (276 cases) were resolved by brief analysis and advice;
- 25% (259) were resolved by brief analysis and referral;

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<sup>1</sup> Although the VHAP program ended on March 31, 2014, three cases were coded as VHAP because their problems related to VHAP billing issues.

<sup>2</sup> Since Medicare beneficiaries can also have commercial or DVHA coverage, these Medicare numbers overlap with those figures.

<sup>3</sup> Although the Catamount Health program ended on March 31, 2014, one case was coded as Catamount because the consumer’s problem involved a Catamount billing issue.

- 23% (234) of the cases were complex interventions involving complex analysis, usually direct intervention, and more than two hours of an advocate's time;
- 20% (208) were resolved by direct intervention, including calling an insurance company, calling providers, writing letters, gathering supporting medical documentation, etc.;
- <1% (4) 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: 18 cases involved help with appeals: 4 commercial plan appeals, 11 Fair Hearings, 2 DVHA internal MCO appeals and 1 Medicare appeal. With all the problems VHC was having, we expected a sharp increase in appeals. However, because VHC was aware of the high number of problems in processing eligibility, it resolved most of our clients' complaints outside of the appeal system.

### **DVHA Beneficiary Calls**

We closed 401 DVHA cases this quarter, compared to 455 last quarter.

- 29% (115 cases) were resolved by brief analysis and advice;
- 25% (99) were resolved by brief analysis and referral;
- 23% (91) were considered complex intervention, which involves complex analysis, usually direct intervention, and more than two hours of an advocate's time;
- 21% (86) were resolved by direct intervention on the caller's behalf, including advocacy with DVHA and providers, writing letters, and gathering medical information;
- Just 3 DVHA beneficiary calls were resolved in the initial call.
- In the remaining cases, clients withdrew, resolved the issue on their own, or had some other outcome.
- Appeals: 13 cases involved appeals: 11 Fair Hearings and 2 internal MCO appeals.

### **Commercial Plan Beneficiary Calls**

We closed 222 cases involving individuals on commercial plans,, compared to 239 last quarter.

- 31% (68 cases) were resolved by brief analysis and advice;
- 15% (34) were resolved by brief analysis and referral;
- 28% (63) were considered complex intervention, which involves complex analysis, usually direct intervention, and more than two hours of an advocate's time (this measure increased by 20% over last quarter);
- 23% (52) were resolved by direct intervention on the caller's behalf, including advocacy with the carrier and providers, writing letters, and gathering medical information;
- Just 1 call from a commercial plan beneficiary was resolved in the initial call.
- In the remaining cases clients withdrew, resolved the issue on their own, or had some other outcome.
- Appeals: 4 cases involved appeals.

## J. Case outcomes

### All Calls

The HCA helped 137 people get enrolled in insurance plans and prevented 17 insurance terminations or reductions. We obtained coverage for services for 52 people. We got 36 claims paid, written off or reimbursed. We assisted 11 people with completing applications and estimated VHC insurance program eligibility for 34 more. We provided other billing assistance to 31 individuals. We obtained hospital patient assistance for 3 people. We provided 491 individuals with advice and education. We obtained other access or eligibility outcomes for 64 more people, many of whom we expected to 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 after our assessment and advice.

In total, this quarter the **HCA saved individual consumers \$127,348.41** in cases opened this quarter. The amount of individual savings for State Fiscal Year 2014 was **\$313,265.50**.

## K. Case examples

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

1. Lack of Change of Circumstance functionality delayed Medicaid coverage for Ms. A. Ms. A lost her job and could no longer afford her health insurance premiums for her Qualified Health Plan (QHP). She reported the job loss and the resulting decrease in income to VHC at the end of March. Her income had dropped so low that she became eligible for Medicaid. However, because VHC's Change of Circumstance (COC) functionality was still not working, VHC could not easily transfer Ms. A from her QHP to Medicaid. Ms. A was stuck on the QHP and required to pay premiums to maintain coverage. She stopped paying those premiums because she did not have the money. When she was about to run out of her diabetes medications, she called the HCA for help. In the two and a half months since she reported her change in income, VHC had not moved her to Medicaid. Ms. A's HCA advocate contacted VHC and requested that her COC be rushed because of the high medical need for her medications. Within two days, Ms. A was put on Medicaid so she could pick up her medications.
2. VHC's failure to promptly apply Ms. B's payment to her account caused her to delay medical treatments.

Ms. B signed up on VHC to start her health care coverage on May 1, 2014. She paid the first payment on time with her debit card in the third week of April. The money was taken from her bank account that same day. By mid-May, however, VHC still had not applied the payment to her account. This meant that Ms. B's QHP coverage was not activated. Ms. B called VHC during the first week of May and was told that the issue would be investigated and someone would call her back. No one called her back. Ms. B finally called the HCA because she had been delaying medical appointments due to lack of insurance coverage. The HCA advocate asked VHC to apply the payment to her account immediately. VHC confirmed that Ms. B had made the payment, and explained that a computer glitch had prevented the application of the payment to her account. More than three weeks after the initial payment, and several weeks after the promised start date for her QHP, Ms. B's coverage was made active.

3. Ms. C called the HCA because her COBRA coverage had ended and she was unable to get new coverage through VHC.

When Ms. C called VHC to apply for new coverage, she was told that because she was outside the open enrollment period she would have to wait until the next open enrollment period to apply for coverage, which could not start until January 2015. Furthermore, she was told that she did not qualify for a "special enrollment period" (SEP). Desperate, she called the HCA. Her HCA advocate knew that CMS had recently authorized a temporary SEP specifically for loss of COBRA coverage, and that Ms. C qualified for that SEP. The advocate contacted the State, and argued that it had incorrectly denied the SEP for Ms. C. VHC agreed and reversed its decision. Ms. C was able to select and enroll in a QHP and now has coverage.

4. Mr. D called the HCA because Medicaid had denied coverage of a life-changing medication.

Mr. D had a life threatening illness. His doctor prescribed a very expensive new medication for him, which has the potential to cure rather than simply treat the disease. Mr. D's provider submitted two prior authorizations to Medicaid which were each denied. Mr. D requested an internal appeal and asked the HCA to help him prepare for the hearing. His HCA advocate reviewed the reasons for the denial and the criteria for coverage, talked to the provider, researched background on the new medication, and helped develop Mr. D's argument and strategy for the hearing. Mr. D prevailed at the hearing and DVHA reversed its decision. He was thus able to pick up the medication and begin his course of treatment.

## L. Table of all calls by month and year

	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
January	252	178	313	280	309	240	218	329	282	289	428
February	188	160	209	172	232	255	228	246	233	283	304
March	257	188	192	219	229	256	250	281	262	263	451
April	203	173	192	190	235	213	222	249	252	253	354
May	210	200	235	195	207	213	205	253	242	228	324
June	176	191	236	254	245	276	250	286	223	240	344
July	208	190	183	211	205	225	271	239	255	271	
August	236	214	216	250	152	173	234	276	263	224	
September	191	172	181	167	147	218	310	323	251	256	
October	172	191	225	229	237	216	300	254	341	327	
November	146	168	216	195	192	170	300	251	274	283	
December	170	175	185	198	214	161	289	222	227	340	
<b>Total</b>	<b>2409</b>	<b>2200</b>	<b>2583</b>	<b>2560</b>	<b>2604</b>	<b>2616</b>	<b>3077</b>	<b>3209</b>	<b>3105</b>	<b>3257</b>	<b>2205</b>

## M. Recommendations

1. *The Change of Circumstance functionality must be made operational as soon as possible.*

This is still the biggest problem we see. We know VHC is well aware of this issue and working on it, but it remains a huge problem affecting thousands of people. No firm date has been given for the deployment of the COC functionality.

2. *The backlog of Change of Circumstances must be eliminated before open enrollment begins.*

The State's new vendor, Optum, has just begun to work through the backlog of thousands of COCs. This is a big undertaking but we are hopeful that by the end of the summer the backlog will be gone, although that could be overly optimistic considering the complexity of the problems. All 2014 COCs need to be processed before open enrollment begins on November 15<sup>th</sup>. If they are not, there will be massive confusion and problems with renewals.

3. *The invoice and payment system must be fixed or redesigned.*

We continue to hear from consumers who say they are not getting invoices, are not getting correct invoices, or whose premium payments are not being processed in a timely manner or sometimes even recorded. It is very difficult for the HCA to pinpoint what the exact problems are, because these problems are not happening to everyone. It might make more sense to have consumers pay the carriers directly, rather than send their payments to VHC. There are too many steps in the payment process which result in opportunities at each step for something to go wrong.

4. *The functionality to send Notices of Decision to all VHC applicants must be fixed before open enrollment.*

The 2014 coverage NODs must go out before the 2015 NODs. With the next open enrollment only about four months away, VHC needs to address how it is going to handle the NODs for 2014 coverage if they haven't gone out well before November 15<sup>th</sup>. It will be very confusing to consumers when open enrollment starts if they still haven't gotten notices regarding eligibility for their 2014 coverage. Sending NODs for both 2014 and 2015 coverage around the same time will be a recipe for disaster. If the 2014 NODs can't go out before Vermonters start hearing about open enrollment for 2015, they probably shouldn't go out at all. The State is legally required to send these notices, so this functionality must be fixed.

5. *Maximus and the Health Access Eligibility Unit staff need to continue to work on training, resource materials and supervision.*

We continued to hear incorrect information from some Maximus customer service representatives and HAEU staff. We also heard the same thing from consumers and navigators. These errors cause confusion and serious problems for consumers. We report these errors in individual cases to VHC and AOPS frequently, and we assume that they report the types of problems we see to each other and to HAEU. We appreciate the difficulties in running large call centers which must handle complex information, but because the mistakes can be so harmful, there should be an ongoing effort to improve training, resource materials and quality control. This quarter we encountered 30 instances of HAEU errors and 9 instances of Maximus errors.

6. *VHC needs to continue to work on its process for resolving consumer issues and providing improved customer service.*

We continue to hear from consumers who have spent many hours on the phone with VHC trying to resolve problems. By the time they reach the HCA for assistance, they have talked to multiple people and frequently heard multiple explanations of the problem, and have been given multiple assurances that the situation was being worked on. Problems cannot be fixed quickly in many cases and consumers understandably get extremely frustrated. VHC needs to work on providing consistent customer service, focusing particularly on timeliness and accuracy. Consumers should not be told that they will get a return call when no one actually makes those call backs. Consumers should also be given accurate and realistic estimates of how long it will take to resolve an issue.

### **III. Consumer protection activities**

#### **A. Rate review work**

Insurance carriers filed four new rate cases with the Green Mountain Care Board (GMCB) in this calendar quarter. The HCA filed Notices of Appearance in all of these new filings. We also filed

memoranda in eight rate cases filed in this quarter and the prior quarter. No contested hearings were held during this quarter.

The most significant new filings were the two filings for Vermont Health Connect filed by Blue Cross Blue Shield of Vermont and MVP on June 2, 2014. The HCA has worked with its independent actuary to review these filings and prepare suggested questions for the Board to pose to the carriers. Four pre-hearing conferences for these filings were held during the quarter.

The HCA participated in a panel at a forum about rate review held by the Green Mountain Care Board in Burlington in May.

The HCA continued to work to amend the GMCB's policy regarding the treatment of confidential materials in rate review cases. We have requested that we be allowed to keep a record of some hearing materials which contain confidential information after the time for appeal has ended. The negotiation regarding this request continued during the quarter.

A summer intern from the George Washington University Law School worked with HCA staff on policy issues before the Green Mountain Care Board during the quarter. He has helped to review and analyze the VHC rate filings and is researching topics including the effect of cost sharing in plan benefit design on different populations.

## **B. Other Green Mountain Care Board activities**

Pursuant to Act 48 of 2011 and Act 171 of 2012, the GMCB is required to consult with the HCA about various health care reform issues. The HCA is directed in Act 79 of 2013 to "suggest policies, procedures, or rules to the GMCB in order to protect patients' and consumers' interests." This quarter we:

- Attended 11 GMCB public meetings
- Attended one meeting of the GMCB Advisory Committee
- Met twice with GMCB staff
- Met once with the Chair of the GMCB
- Continued to monitor new and pending Certificate of Need (CON) letters of intent, requests for jurisdictional determination and applications.
- Filed a Notice of Intervention as an Interested Party in one CON, the Fletcher Allen Health Care, Burlington Property Acquisition, GMCB-015-14con in June.

## **C. Vermont Health Care Innovation Project**

We continue to participate in the State's Vermont Health Care Innovation Project (VHCIP) aka the SIM grant. This quarter we:

- Participated in two meetings as a member of the VHCIP Steering Committee
- Participated, along with representatives from other projects of Vermont Legal Aid, as “active members” in six of the seven VHCIP work groups: the Payment Models Work Group, the Quality and Performance Measures Work Group, the Disability and Long Term Services and Supports Work Group (formerly the Duals Demonstration Work Group), the Population Health Work Group, the Care Models and Care Management Work Group, and the Health Information Exchange/Health Information Technology Work Group
- Attended three meetings of the Core Team
- Submitted comments to the Quality and Performance Measures Work Group recommending changes to the criteria to be used to select measures for the second year of the Accountable Care Organization (ACO) Medicaid and Commercial Shared Savings Programs
- Submitted six sets of comments to DVHA and the Medicaid Shared Savings Program ACOs on their patient notices, opt out forms, change of preference forms, call center scripts, and consumer advisory group recruitment materials.

## **D. Other Activities**

### **Plain Language Materials**

One of the HCA’s priorities this quarter has been to advocate for the use of plain language in materials written for health care consumers.

We have found that many agencies draft materials in language too complex or high-level for the average consumer to read and understand. This quarter, we worked extensively with DVHA and the two Medicaid Shared Savings Program ACOs (OneCare Vermont and Community Health Accountable Care) to improve the readability of their consumer materials. These materials included patient notices, opt out and change of preference forms, phone scripts for call center staff who will be answering consumer questions, and consumer advisory group recruitment materials. We also continued to work with Vermont Information Technology Leaders, Inc. (VITL) on their patient consent materials, which we discuss further below. Additionally, we brought the issue of plain language materials to the Green Mountain Care Board at one of our monthly meetings with board staff, and subsequently created a summary of widely used guidelines for writing in plain language. We have shared the summary with GMCB and DVHA staff.

In February 2014 and at the HCA’s request, the Green Mountain Care Board ordered VITL to work with the HCA to develop a plain language consent form, revocation form, and informational brochure for the Vermont Health Information Exchange (HIE). The HCA collaborated with VITL on this project for several months and agreed on the final drafts in June 2014. While VITL’s materials began at a grade level of 18, which is equivalent to two years of

graduate-level education, the HCA negotiated the language for the brochure, consent form, and revocation form down to 7<sup>th</sup>, 8<sup>th</sup>, and 9<sup>th</sup> grade reading levels, respectively. Our understanding is that all providers participating in the Vermont Health Information Exchange will use these materials. The HCA's work with VITL will help Vermont patients to understand the Vermont Health Information Exchange and what it will mean if the individual gives or withholds consent for his or her information to be accessed on the HIE.

### **Policy Paper on Emerging Privacy Issues**

The HCA receives a significant number of phone calls regarding consumer concerns about health information privacy. In addition, there are emerging privacy issues related to electronic health records and electronic health exchanges. In order to keep abreast of these issues, the HCA developed a white paper on federal and state privacy rules related to health records.

The paper was posted to the HCA's website in June:

[Protected Health Information: What Vermonters Should Know](#)

This document concentrates on HIPAA (Health Information Portability and Accountability Act) rules, including recent changes to the Act that address electronic health records and health information exchanges, as well as Vermont laws that provide patients with additional rights and protections. Specific topics include information on how patients can obtain a copy of their health records, when providers must obtain consent before sharing a patient's protected health information, and what patients can do if they would like a provider to amend their health information.

### **Health Benefit Eligibility and Enrollment regulations**

For more than a year the Agency of Human Services has been working on its regulations for implementing the new health insurance programs required by the Affordable Care Act. These proposed and emergency rules not only set out the requirements for Vermont's expanded Medicaid program and the purchase of commercial plans through VHC, but also integrated some of the previous Medicaid program rules into one set of rules.

The HCA, in collaboration with other projects at Vermont Legal Aid, has been extensively involved in this process. In this past quarter we submitted 40 pages of formal comments on the HBEE final proposed regulations. We also had numerous conversations with AHS staff about the rules.

On June 26, 2014, we testified before the Legislative Committee on Administrative Rules (LCAR) about the HBEE regulations. Although we had resolved many of our concerns with AHS, we opposed portions of the rules at that LCAR meeting. We believed certain provisions changed the Choices for Care program and might harm a small group of Vermonters. As a result, LCAR delayed its decision on the rules until its next scheduled meeting, on July 10, 2014. By that time the HCA and VLA had reached a resolution with AHS. We withdrew our opposition to the rules

and AHS agreed to continue to work with us to improve the regulations, including the provision related to the Choices for Care program. LCAR approved the rules with a number of amendments that AHS had negotiated with various stakeholders, including the HCA.

### **Other Activities**

In addition, the HCA engaged in the following systemic activities:

- Participated in:
  - Three Medicaid and Exchange Advisory Board (MEAB) meetings
  - Two Governor’s Consumer Advisory Council meetings
  - Two Improving Access Work Group meetings (a subgroup of the MEAB to improve access to Medicaid services, which the Chief Health Care Advocate chairs)
  - Two VHC Consumer Experience Work Group meetings
  - Two VHC Customer Support meetings with Maximus, VHC, DVHA and HAEU
- Commented on VHC notices at least 12 times.
- Participated in at least 34 legislative activities, testified two times, and submitted one document
- Participated with other stakeholders in a work group to improve the VHC application
- Submitted at least two sets of complaints and suggestions to VHC
- Participated in two national e-mail forums organized by Consumers Union, The Health Cost Forum and a Rate Review Group
- Participated in the following staff training activities:
  - One webinar on Designing Silver Health Insurance Plans with Affordable Out-of-Pocket Costs for lower and moderate income individuals
  - Two webinars on rate review hosted by Consumers Union
  - One webinar on meaningful Consumer Engagement, hosted by CMS in collaboration with The Lewin Group and Community Catalyst
  - One webinar on Community Health Needs Assessments and Health Equity, hosted by the Association of State and Territorial Health Officials (ASTHO)

### **E. Collaboration with other organizations**

The HCA worked with the following organizations this quarter:

- American Civil Liberties Union (ACLU)
- Bi-State Primary Care
- Families USA
- Community of Vermont Elders (COVE)
- Disability Rights Vermont
- Planned Parenthood of Northern New England
- Vermont Campaign for Health Care Security
- Vermont CARES
- Vermont Family Network

- Vermont Public Interest Research Group (VPIRG)
- Voices for Vermont's Children

## IV. Outreach and education

### A. Website

Vermont Law Help is a statewide website that is maintained by Vermont Legal Aid and Law Line of Vermont. The site includes a substantial Health section, [www.vtlawhelp.org/health](http://www.vtlawhelp.org/health), with more than 150 pages of consumer-focused information that is maintained by the HCA. Since the launch of Vermont Health Connect, we have worked diligently to keep the site updated in order to provide the latest and most accurate information to Vermont consumers.

The end of this quarter marks a year and a half since we began to expand and enhance the presentation of the health contents on the Vermont Law Help website. While we regularly update, add to and otherwise improve the site, it is unrealistic to continue to expect the dramatic double- and triple-digit increases in site performance statistics we have experienced over the past year.

When comparing this quarter's statistics with the same quarter last year, however, the number of pages visited by Vermonters seeking information about and assistance with health care is still increasing:

- Pageviews of the Health Home Page **increased by 75.93%** (519 vs. 295)
- Pageviews of All Health Pages **increased slightly** (1,109 vs. 1,101)

The bounce rate (percentage of people who left the site from the page they entered on without interacting with the page) **decreased by 38.76%** (51.44% vs. 84%). A decrease in the bounce rate is a positive sign that users are finding information they're looking for and are clicking links to get even more information.

### **Vermonters Continue to Seek Information Related to Vermont Health Connect and Health Care Reform**

More than half (29) of the 50 most-visited pages in the Health section provide information related to **health insurance topics**:

- 24 of these 29 pages explain aspects of Vermont Health Connect, health care reform (including rate reviews), and Vermont's sunseting health care programs
  - Four of the top-visited pages within this category were:
    - How to Be Involved in Vermont Health Care Reform (policy) (58 visits)
    - Health Insurance Rate Reviews (55 visits)
    - How the Public Can Participate (rate reviews) (44 visits)
    - News: Public Invited to Comment on 2015 Vermont Health Connect Plan Rates (21 visits)
- The other five pages provide general information about insurance, employer-sponsored health insurance and regulation.

## **Health Care Policy Page**

The new Health Care Policy section that was launched last quarter continues to gain traction. We post policy papers, comments and other work the HCA Policy Team produces to represent consumers before the Green Mountain Care Board; the legislature; and state agencies, committees, boards and task forces as well as white papers on important and emerging health care issues.

**How to Be Involved in Vermont Health Care Reform** was the most visited page in the Health section after the home page. Visitors spent an average of four minutes, nearly three times the Health site average, interacting with this page.

## **Privacy**

Consumers also sought out information about the privacy of their health information. Eight different web pages in the Health section that relate information about personal health records, privacy and HIPAA, including the recently added policy paper **Protected Health Information: What Vermonters Should Know**, were among the 50 most-visited pages in the Health section.

## **B. Education**

In April the HCA presented a workshop on Vermont Health Connect at Vermont Family Network's annual meeting. The presentation was an overview of eligibility requirements for Vermont's Medicaid expansion, the income rules for this new adult program, and premium tax credits and cost sharing reduction subsidies for Qualified Health Plans.

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.

## SFY14 Final MCO Investments

8/27/14

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	FOHC 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
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	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	DCF	Children's Integrated Services Early Intervention
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