

State of Vermont
Agency of Human Services

Global Commitment to Health
11-W-00194/1

Section 1115
Demonstration Year: 7
(10/1/2011 – 9/30/2012)

Quarterly Report for the period
January 1, 2012 – March 31, 2012

May 31, 2012

Background and Introduction

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

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

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

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

Implemented October 1, 2005, the Global Commitment converts the Office of Vermont Health Access (OVHA), the state's Medicaid organization, to a public Managed Care Entity (MCE). AHS will pay the MCE a lump sum premium payment for the provision of all Medicaid services in the state (with the exception of the Long-Term Care Waiver, managed separately). A Global Commitment to Health Waiver Amendment, approved October 31st 2007 by CMS, allows Vermont to implement the Catamount Health Premium Subsidy Program with the corresponding commercial Catamount Health Program (implemented by state statute October 1, 2007) up to 200 percent of the Federal Poverty Level. The Catamount Plan is a health insurance product offered in cooperation with Blue Cross Blue Shield of Vermont and MVP Health Care. It provides comprehensive, quality health coverage at a reasonable cost no matter how much an individual earns. The intent of this program is to reduce the number of uninsured citizens of Vermont. Subsidies are available to those who fall at or below 300 percent of the Federal Poverty Level (FPL). On December 23, 2009 a second amendment was approved that allowed Federal participation for subsidies up to 300 percent of the Federal Poverty Level. Additionally, this amendment also allowed for the inclusion of Vermont's supplemental pharmaceutical assistance programs in the Global Commitment to Health Waiver. Renewed January 1, 2011 the current waiver continues all of these goals.

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

One of the Terms and Conditions of the Global Commitment Waiver requires the State "to submit progress reports 60 days following the end of each quarter. ***This is the second quarterly report for waiver year seven, covering the period from January 1, 2012 through March 31, 2012.***

Enrollment Information and Counts

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

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

Enrollment counts are person counts, not member months.

Demonstration Population	Current Enrollees Last Day of Qtr 12/31/2011	Previously Reported Enrollees Last Day of Qtr 9/30/2011	Variance 06/30/11 to 09/30/11
Demonstration Population 1:	47,219	46,711	1.09%
Demonstration Population 2:	43,578	43,586	-0.02%
Demonstration Population 3:	9,502	9,770	-2.74%
Demonstration Population 4:	N/A	N/A	N/A
Demonstration Population 5:	1082	1071	1.03%
Demonstration Population 6:	3,258	3,244	0.43%
Demonstration Population 7:	34,941	35,407	-1.32%
Demonstration Population 8:	10,120	7,853	28.87%
Demonstration Population 9:	2,632	2,525	4.24%
Demonstration Population 10:	N/A	N/A	N/A
Demonstration Population 11:	11,200	11,132	0.61%

This new fiscal quarter data reflects an update in methodology. Variances, particularly in Demonstration Populations 8 and 9, reflect this methodology update. All populations are primarily identified by aid category code, which is the most accurate and up to date reflection of the Medicare and FPL status.

Demonstration population #5 has a >5% delta (-6.93%). This category represents Children with income between 225 and 300 percent of FPL who are not otherwise eligible for Medicaid or SCHIP. In both data reports (Dec 2011 and March 2012), recipients in #5 are represented by Aid Cat C3 (99%) and C9(1%) which are Dr. Dynasaur Children. 29.68% of the population that "dropped off" the March data for population #5 (23 recipients) were assigned to C3 but are pending some documentation for an aid cat assignment decision.

The remaining 52 recipients who dropped off were reassigned to these aid category codes:

Aid Cat Code	Description	Count
C0	Medicaid/Dr. Dynasaur Child	34
C2	Uninsured Expanded Dr. Dynasaur Child - 300% FPL - (Title XX1 - SCHIP)	2
C4	Medicaid/Dr. Dynasaur Child	5
C6	Uninsured Expanded Dr. Dynasaur Child - 300% FPL - (Title XX1 - SCHIP)	8
MC	Medically Needy - Over ANFC Maximum - Under PIL - Child	1
O5	Older Child - 100% FPL	1
OC	Older Child - 100% FPL	1
Y5	Younger Child at 133% FPL	1
YC	Younger Child at 133% FPL	1
	Total	52

Green Mountain Care Outreach / Innovative Activities

During the second quarter, the DVHA has not initiated new outreach strategies, but continues to maintain an up-to-date web presence to promote Green Mountain Care to uninsured individuals. We've updated annual information on premium assistance and the Vermont health care assessment in partnership with the Department of Labor (DOL). We also partnered with DOL at two lay offs to assist 35 people to access Green Mountain Care.

Enrollment and legislative action:

As of the end of February there were 12,569 individuals enrolled in the premium assistance program components of Green Mountain Care (Catamount Health and Employer-Sponsored Insurance).

Act 48, a bill that authorizes Vermont's Health Benefits Exchange under the Affordable Care Act was passed by the legislature and signed into law by the Governor in May 2010. DVHA completed its first year of planning for the Exchange, and details of its work during this past year can be found on the Exchange web page at: <http://dvha.vermont.gov/administration/health-benefits-exchange>.

DVHA's application for a Level 1 Establishment grant for FFY 12 was approved at the end of November of 2011. DVHA issued an RFP for the second year of Exchange planning and development, and has executed contracts with five vendors to assist DVHA in designing and developing a wide range of Exchange functions during the 2012 contract year.

Expenditure Containment Initiatives

Vermont Chronic Care Initiative for Quarter 2 of FFY 2012

The goal of the DVHA's Vermont Chronic Care Initiative (VCCI) is to improve health outcomes of

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

The VCCI uses a holistic approach of evaluating both the physical and behavioral conditions, as well as the socioeconomic issues, that often are barriers to health improvement. The DVHA's VCCI emphasizes evidence-based, planned, integrated and collaborative care for beneficiaries who exhibit high-prevalence chronic disease states, high-expense utilization, high medication utilization, and/or high emergency room and inpatient utilization. Ultimately, the VCCI aims to improve health outcomes by supporting better self-care and lowering health care expenditures through appropriate utilization of health care services. Through targeting predicted high cost beneficiaries, resources can be allocated where there is the greatest cost savings opportunity. The VCCI focuses on helping beneficiaries understand the health risks of their conditions; engage in changing their own behavior, and by facilitating effective communication with their primary care provider. The intention ultimately is to support the person in taking charge of his or her own health care.

The VCCI supports and aligns with other State health care reform efforts. VCCI has now expanded its services to all age groups and prioritize their outreach activities to target beneficiaries with the greatest need based on urgency and ability to impact their behavior. VCCI will continue to partner with providers, hospitals, community agencies and other Agency of Human Services (AHS) departments to support a patient-focused model of care committed to enhanced self-management skills, healthcare systems improvement, and efficient coordination of services in a climate of increasingly complex health care needs and scarce resources.

In July 2010, DVHA also expanded its direct care coordination capacity in two areas of the state through the Challenges for Change initiative. The two trial areas were selected based on, among other factors, high disease prevalence and high health system utilization. The initiative adds three additional DVHA care coordination staff (two RNs and 1 Licensed Clinical Social Worker) in each of the two areas (Rutland and Franklin Counties). The staffs are co-located within doctors' offices and local hospitals, and are integrated with existing VCCI care coordination staff and lead the way for the Blueprint for Health Community Health Teams which now integrate with the VCCI efforts in these communities. In Franklin County, our VCCI team was named the 'Community Partner of the Year' at the annual meeting of Northwestern Counseling and Support Services (NCSS) a core partner serving individuals with mental health conditions, DVHA has also expanded its care coordination services which will include children's palliative care.

Health Resources and Services Administration (HRSA) and VCCI in Franklin County

HRSA designates Health Professional Shortage Areas (HPSAs), which are designated based on requests that states and others submit that demonstrate these areas meet the criteria for having too few health professionals to meet the needs of the population. Franklin County is recognized as a HPSA.

The National Health Service Corps (NHSC) is a network of primary medical, dental and behavioral health care professionals and sites that serve the most medically underserved regions of the country. To support their service, NHSC clinicians receive financial support in the form of loan repayment and scholarships, as well as educational training and networking opportunities. As a result, VCCI was able to hire a Licensed Clinical Social Worker to our workforce in Franklin County who is a participant of NHSC. This type of support is and will be instrumental in our VCCI recruiting efforts in some rural areas.

APS Contract

Since 2007, DVHA has contracted with APS Healthcare for assistance with providing disease management assessment and intervention services to Vermont Medicaid beneficiaries with chronic health conditions. DVHA currently is in the fourth year of its contract with APS and with the newest amendment has made a decision to move away from traditional disease management and instead is expanding its care coordination services provided by DVHA nurse case managers and social workers. DVHA has found this approach more effective with its highest cost/highest risk beneficiaries. As DVHA expands this approach, it requires a different kind of support than covered in the existing contract with APS. APS presented a cost neutral proposal to provide services to DVHA that are better aligned with DVHA's current needs. Specifically, APS proposed to provide an enhanced information technology and sophisticated decision-support system to assist DVHA's care coordinators target the most costly and complex beneficiaries, adjusted with new information as frequently as daily. This enhanced system builds upon the case management and tracking system DVHA staff have been using since 2007. In addition, APS will provide support to DVHA's care coordinators working within provider offices as part of the Blueprint Community Health Teams. APS has guaranteed a 2:1 return on investment by implementing these enhancements, which equates to roughly \$5 million dollars and will bear 100% of the investment for system enhancements if the agreed upon savings are not realized (i.e., full risk contract based upon agreed upon savings methodology). As a result, DVHA invoked its option to extend the contract with APS for two additional years, ending June 30, 2013.

The VCCI program now features key components of a statewide technology infrastructure to improve care coordination for Vermonters with chronic illness and high utilization of health care services, and to eliminate avoidable costs of care. This infrastructure solution is based on the following: innovative technology for care management; delivery of evidence-based interventions by Care Coordinators within the Department of Vermont Health Access (DVHA); pharmacy analysis and prescriber feedback; technical assistance/training on the use of the technology and information products; and collaborative support for provider and beneficiary interventions.

The chronic care case management system used by DVHA, APS Care Connection™, will continuously identify the highest cost/highest risk (HC/HR) beneficiaries to target for care coordination interventions. The APS Percolator™, which uses evidence-based algorithms to identify and stratify the Medicaid beneficiary population and their providers for interventions, includes indicators such as:

- Admissions for Ambulatory Care Sensitive Conditions.
- Visits to multiple physicians indicating lack of engagement in a medical home.
- Polypharmacy, low medication adherence ratios, and inappropriate prescribing.
- Emergency Department visits for non-emergent reasons, using the New York University algorithms to identify these services.
- Other visits to Emergency Departments.
- Acute admissions and readmissions.

APS will provide the technical and clinical staffing to maintain Care Connection and the Percolator. APS also will provide technical assistance, training, clinical and claims data advisory support to Care Coordinators employed by DVHA, and conduct interventions with providers delivering services to high cost, high risk beneficiaries. APS will provide extensive health informatics reporting, analysis and recommendations to DVHA.

The DVHA Care Coordinators with the support of APS will receive a list and/or receive referrals of high cost, high risk beneficiaries generated by the Percolator using data from a variety of sources (e.g., claims, pharmacy, self report, staff interactions, program goals, etc.). This listing will identify potential highest

priority cases for that day and recommend evidence-based interventions to support Care Coordinator workflow. Care Coordinators will use Care Connection to document beneficiary assessments, interventions, and other aspects of the plan of care for each beneficiary.

The care connection™ will also be enhanced by generating Patient Health Briefs for both the APS Clinical Practice Specialists and Care Coordinators to identify urgent concerns with care and both will also utilize *Patient Registries* to identify patients with chronic disease and gaps in care. These tools are in early stages of development and a work in progress. We have also utilized the patient registries for both diabetes and asthma and are now targeting heart failure. VCCI will consult with the Clinical Pharmacist and they will also identify gaps in medication adherence and issues with poly-pharmacy, as well as promote best prescribing practices.

The DVHA has also contracted with the University of Vermont (UVM) for VCCI program evaluation, and for assistance with identifying and implementing quality improvement projects. A clinical performance improvement project (PIP) was developed, focusing on heart failure which is one of the eleven high cost, high risk chronic conditions that VCCI targets. The PIP was designed and is being implemented according to the CMS PIP requirements related to quality outcomes. The PIP topic addresses the appropriate treatment of heart failure (HF), a progressive chronic condition. HF patients are managed through both APS and DVHA's VCCI. An important component of outpatient management of HF is appropriate use of evidence-based pharmaceutical treatments. The study design and analysis of the baseline data were completed and submitted for validation to the external quality review organization hired by AHS. DVHA received a validation score of 100%. Interventions are being developed and implemented for Year 2 of the PIP.

Highlights of the Vermont Chronic Care Initiative (Quarter 2 of FFY 2012)

- All analysis from UVM's VCCI evaluation has been completed on the clinical performance improvement project (PIP) on Heart Failure. The PIP will be implemented during the 1st quarter of FFY 2011. Interventions are being developed and implemented for year 2 of the PIP
- DVHA is transitioning away from traditional disease management and expanding its care coordination services provided by DVHA Nurse Case Managers and Medical Social Workers, Licensed Clinical Social Worker and Licensed Drug and Alcohol Counselor.
- DVHA has an enhanced information technology and sophisticated decision-support system through its contract with APS which targets the most costly and complex beneficiaries, adjusted with new information as frequently as daily.
- DVHA has enhanced its specialty services by adding a Licensed Clinical Social Worker and a Licensed Alcohol and Drug Counselor to the VCCI team; and has received NHSC recognition in Franklin County.
- DVHA care coordinators expanded meetings and electronic data exchange systems with hospital emergency departments (EDs) for increased collaboration regarding emergency room utilization among VCCI beneficiaries.
- DVHA care coordinators in the Challenges for Change Pilot for both Rutland and St. Albans have established high penetration in EDs and in various Primary Care Physician co-location sites in those counties.
- DVHA is expanding its VCCI scope to now include Palliative Care.

- The data indicates that from January 1, 2012 through March 31, 2012 VCCI maintained an average monthly caseload of 734 beneficiaries and 943 unique members were served. Unique members are beneficiaries who have been assigned to VCCI staff and have had a Social Needs, Behavioral Risk or Transitions of Care Assessment completed.

Buprenorphine Program

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

(Figure 1)

Complexity Level	Complexity Assessment	Rated Capitation Payment	+ <u>BONUS</u> = 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 Buprenorphine Practice guidelines are reviewed and updated every two years and DVHA is in the process of revising them.

The total for the both quarters (October 2011- March, 2011) is \$84,106.76 (Figure 2).

(Figure 2)

Buprenorphine Program Payment Summary FFY 2012	
FIRST QUARTER	
Oct-11	\$14,415.76
Nov-11	\$ 15,136.66
Dec-11	\$ 15,255.38
1st Quarter Total	\$44,807.80
SECOND QUARTER	
Jan – 2012	\$11,626.56
Feb – 2012	\$16,199.22
March- 2012	\$11,473.18
2nd Quarter Total	\$39,298.96
Grand Total	\$84,106.76

340B DRUG DISCOUNT PROGRAM

Background

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

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

Covered entities include:

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

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

340B PROGRAM IN VERMONT

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

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

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

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

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

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

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

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

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

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

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

Safeguards for Overprescribing

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

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

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

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

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

340B Reimbursement and Calculation of Incentive Payment

Determination of Dispensing Fee and Savings Sharing Amounts

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

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

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

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

Summary

Because of federal laws prohibiting "duplicate discounts" on Medicaid drug pricing related to the interaction of 340B and manufacturer rebate programs, Medicaid participation in 340B has been limited both in Vermont and nationally. Vermont has put in place an innovative, first in the nation methodology to maximize Medicaid participation in 340B pricing for Medicaid beneficiaries served by eligible prescribers at 340B enrolled covered entities. This methodology can enable substantial expansion participation in 340B. Using the Global Commitment authority, DVHA provides incentive payments to providers for their 340B participation that recognizes the additional administrative burden of the program. Because of the beneficial 340B pricing, both Vermont and CMS benefit from higher 340B covered entity-employed prescriber and Medicaid beneficiary participation in the program. **CY 2011, Vermont has realized**

approximately \$600,000 in savings through Medicaid participation of a relatively small number of eligible covered entities. DVHA is focused on outreach and education of all Vermont covered entities to encourage enrollment in the 340B discount program.

Mental Health – Vermont Futures Planning

Vermont State Hospital – Replacement Planning

A significant focus of the Vermont 2012 Legislative Session was the State's Mental Health System of Care and replacement planning for the Vermont State Hospital that was closed due to flooding from Tropical Storm Irene. The Department of Mental Health, consistent with the plan advanced by Governor Peter Shumlin in early January proposed a more person-centered, flexible and community based system with all the elements for a comprehensive and integrated system of care.

The Mental Health Bill, H. 630 as it has become known, was passed by the House in January and the Senate in March and approved by both Houses at the end of this quarter. The legislation, awaiting signature by the Governor, proposes sweeping changes to the state's public mental health system and proposes up to 25 acute hospital beds at a new state-run hospital to be built in Central Vermont.

The current legislation would authorize an additional 20 inpatient beds to serve individuals who would otherwise have been treated at the former Vermont State Hospital. This plan continues to anticipate long term agreements with two hospitals to provide nearly half of these beds: the Brattleboro Retreat (14 beds) and Rutland Regional Medical Center (6 beds). During this period of renovations necessary at Rutland Regional Medical Center and the Brattleboro Retreat to accommodate this population, Fletcher Allen Health Care will continue to offer acute in-patient care beds within its existing capacity until a new state hospital is built.

The Department has been actively exploring development of an 8-bed interim hospital while long-term options are finalized. DMH is actively working to lease and renovate two wings of a former nursing home facility that currently serve as administrative office and program space for a local mental health agency in Morrisville, Vermont. Such a geographic distribution of acute inpatient services will provide individuals with in-patient options closer to home which can be very important to their recovery and discharge planning needs. In tandem with these efforts, the Department is also moving forward with preliminary planning for a new state hospital. Two sites are actively being explored in Berlin, Vermont and site applications were submitted late this quarter. Berlin is centrally located in the state and each site is in close proximity to a primary care hospital, Central Vermont Medical Center. Ongoing meetings with town officials and interested stakeholders in both communities are planned in the upcoming quarter as efforts unfold.

Necessary facility renovations at the Brattleboro Retreat, Rutland Regional Medical Center, and the Morrisville interim hospital will require Emergency Certificate of Need (CON) applications with the State as the applicant and its hospital partners as co-applicants. Work on the components of the applications is underway and should be submitted to the Department of Financial Regulation (formerly Banking, Insurance, Securities and Health Care Administration) during the next quarter.

Community System Development

H. 630 proposes significant investments in a more robust publicly funded mental health services system for Vermont as outlined in the previous quarter report. Once approved, Fiscal Year 13 funding will allow full

implementation of service expansion in:

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

An upward Departmental budget adjustment during FY 12 will also allow some partial year funding for start-up work in these target areas as well. DMH is proactively working with the designated agencies and community partner organizations to develop service enhancement plans for FY 13 that will outline the new activities and outcomes to be realized from additional resources. In late December, partial year funding was deployed for emergency service enhancement plans developed by local mental health agencies and peer support organizations that addressed reduction in emergency room utilization, promoted more mobile crisis capacity, and increased collaborations with law enforcement, hospitals, and peer support services. Outcomes and cost-savings to the service system will be reported back to the legislature under pending language of the current bill working its way to the Governor.

Financial/Budget Neutrality Development/Issues

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

AHS began utilizing the FFY12 rates in calculating the monthly PMPM payments on October 1, 2012. AHS posted an actuarial consultant RFP in July, 2011, in accordance with State contracting guidelines that required this contract to be rebid. The agreement with Aon expired on March 31, 2012. AHS selected Milliman, Inc. as its new actuarial services vendor for the FFY13 and FFY14 periods, and entered into a contractual arrangement with Milliman effective April 1, 2012. Milliman previously had a successful relationship with AHS, having provided the actuarially certified PMPM rate ranges for Global Commitment for the FFY06, FFY07, and FFY08 periods. AHS has begun to work with Milliman on development of the FFY13 rates, having completed a project kickoff meeting on April 10, 2012; the project is on schedule and AHS anticipates no delays or issues at this time.

Member Month Reporting

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

This report is run the first Monday following the close of month for all persons eligible as of the 15th of the preceding month.

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

Demonstration Population (DP)	Month 1	Month 2	Month 3	Total for Quarter Ending 2nd Qtr FFY '12	Total for Quarter Ending 1st Qtr FFY '12	Total for Quarter Ending 4th Qtr FFY '11	Total for Quarter Ending 3rd Qtr FFY '11	Total for Quarter Ending 2nd Qtr FFY '11	Total for Quarter Ending 1st Qtr FFY '11	Total for Quarter Ending 4th Qtr FFY '10	Total for Quarter Ending 3rd Qtr FFY '10	Total for Quarter Ending 2nd Qtr FFY '10	Total for Quarter Ending 1st Qtr FFY '10	Total for Quarter Ending 4th Qtr FFY '09	Total for Quarter Ending 3rd Qtr FFY '09	Total for Quarter Ending 1st Qtr FFY '09	Total for Quarter Ending 4th Qtr FFY '08	Total for Quarter Ending 3rd Qtr FFY '08	Total for Quarter Ending 2nd Qtr FFY '08	Total for Quarter Ending 1st Qtr FFY '08
	1/31/2012	2/28/2012	3/31/2012																	
DP 1:	47,535	47,427	47,403	142,365	141,300	139,591	138,493	137,968	136,144	134,256	132,168	131,930	131,513	129,656	128,203	125,825	123,997	122,281	121,928	120,113
DP 2:	43,014	44,329	44,042	132,285	132,095	130,715	130,868	131,340	131,167	131,402	131,865	130,746	129,075	128,698	126,590	122,210	121,991	123,283	122,118	120,309
DP 3:	9,657	9,612	9,600	28,869	29,054	29,398	29,431	28,787	29,874	30,066	30,244	29,507	29,352	29,428	28,628	26,555	26,452	25,723	24,876	24,821
DP 4:	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
DP 5:	1,006	988	1,007	2,999	3,325	3,246	3,310	3,237	3,423	3,444	3,701	3,614	3,546	3,410	3,588	3,832	3,850	3,707	3,542	3,767
DP 6:	3,336	3,137	3,173	9,646	9,704	9,888	9,795	9,769	9,228	9,073	8,972	8,495	8,218	8,088	7,480	8,208	7,428	7,357	6,208	6,084
DP 7:	35,246	35,619	35,745	106,610	105,833	105,932	108,184	107,915	105,131	103,915	103,194	98,576	92,217	89,158	87,116	75,277	74,301	73,966	72,336	65,803
DP 8:	10,173	10,245	10,312	30,730	30,174	23,287	24,639	23,499	23,180	23,155	22,707	22,462	22,254	21,905	23,165	22,032	21,715	23,100	22,697	22,445
DP 9:	2,617	2,828	2,844	7,889	7,875	7,512	7,634	7,722	7,887	7,848	7,914	7,770	7,673	7,634	7,665	7,649	7,626	7,838	7,919	7,929
DP 10:	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
DP 11:	10,977	11,249	11,448	33,674	33,484	33,207	32,732	31,046	31,397	30,886	31,445	29,728	28,278	26,444	24,717	19,465	16,138	12,525	7,997	1,641

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

Consumer Issues

The AHS and DVHA have several mechanisms whereby consumer issues are tracked and summarized. The first is through the Managed Care Entity, Health Access Member Services. This is a contracted function for providing information on health care programs, assisting with the eligibility process, and helping beneficiaries to understand the benefits and responsibilities of their particular programs. The complaints received by Member Services are based on anecdotal weekly reports that the contractor provides to DVHA (see Attachment 2). Member services works to resolve the issues raised by beneficiaries, and their data helps DVHA look for any significant trends. The weekly reports are seen by several management staff at DVHA and staff asks for further information on complaints that may appear to need follow-up to ensure that the issue is addressed. When a caller is dissatisfied with the resolution that Member Services offers, the member services representative explains the option of filing a grievance and assists the caller with that process. It is noteworthy that Member Services receives an average approximately 25,000 calls a month. We believe that the low volume of complaints and grievances is an indicator that our system is working well.

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

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

Quality Assurance/Monitoring Activity

External Quality Review Organization

During this quarter, the AHS Quality Improvement Manager (QIM) worked with the External Quality Review Organization (EQRO) to prepare documents for the 2012 review activities. First, a work plan was created for each of the three required activities. These documents included the following information: key task, due date, responsible party, and any applicable comments. This document was shared with DVHA and its IGA partners and made final toward the end of the quarter. Second, the PIP summary form, compliance review tool, and performance measure review guide was developed by the EQRO with input from AHS QIM. These are the tools that will be used by the EQRO to gather data that will assess DVHA's performance relative to quality assessment and improvement as well as their ability to comply with State and Federal Medicaid managed care standards. Also this quarter, the AHS QIM finalized the scope of the EQRO review (i.e., performance measures subject to validation were named, performance improvement expectations were identified, and Medicaid managed care standards were agreed upon). This year's compliance review involves measurement & improvement standards. The performance measures that are subject to validation are the same as those validated in 2011. Performance improvement validation activities will be a continuation of last year's project. Finally, the AHS QIM worked with DVHA staff to help them prepare for the upcoming EQRO review activities. This included participating in a conference call between DVHA and the EQRO to determine how best to report PIP activities undertaken during the past year on the newly approved PIP Summary Form.

Quality Assurance Performance Improvement Committee (QAPI)

During this quarter, the Quality Assurance and Performance Improvement Committee held its quarterly meeting and continued ongoing communication between meetings. The Committee reviewed the compliance activities in three areas: health information systems, enrollee experience of care and performance measures. The health information system generates reports on beneficiaries, provides and utilization. DVHA also maintains a grievance and appeal data base. The Committee reviewed the 9 HEDIS measures currently reported on by DVHA. The Managed Care Medical Committee (MCMC) will further review the measures to identify areas for improvement and potential improvement projects. The MCMC will report back to QAPI on their findings and next steps. Each IGA partner representative presented their department's satisfaction surveys. Methodologies were reviewed as well as follow-up on survey results. Survey results are used to inform compliance with a number of quality standards. No recommendations for changes were made. The Committee continued to work on updating the Quality Plan and developing the Quality Work Plan. The QAPI Committee chair also met with the AHS Quality Improvement Manager to discuss the compliance activities. Should areas of improvement be identified by the Committee, a recommendation for a corrective action plan will be made to the AHS Quality Manager. During this quarter, no recommendations were made to the AHS Quality Manager for corrective action plans.

Quality Strategy

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

Demonstration Evaluation

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

Reported Purposes for Capitated Revenue Expenditures

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

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

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

Enclosures/Attachments

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

Attachment 1: Budget Neutrality Workbook

Attachment 2: Complaints Received by Health Access Member Services

Attachment 3: Medicaid Managed Care Entity Grievance and Appeal Reports

Attachment 4: Office of VT Health Access Ombudsman Report

Attachment 5: DVHA Managed Care Entity Investment Summary

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

State Contact(s)

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Managed Care Entity: Mark Larson, Commissioner
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Date Submitted to CMS: May 31, 2012

ATTACHMENTS

**Complaints Received by Health Access Member Services
January 1, 2012 – March 31, 2012**

Eligibility forms, notices, or process	22
ESD Call-center complaints (IVR, rudeness, hold times)	9
Use of social security number as identifiers	0
General premium complaints	6
Catamount Health Assistance Program premiums, process, ads, plans	1
Coverage rules	7
Member services	3
Eligibility rules	11
Eligibility local office	8
Prescription drug plan complaint	0
Copays/service limit	1
Pharmacy coverage	0
Provider issues (perceived rudeness, refusal to provide service, prices) (variety of provider types)	2
Provider enrollment issues	0
Chiropractic coverage change	0
Shortage of enrolled dentists	1
Green Mountain Care Website	2
DVHA	1
Total	74

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

The MCE is composed of various administrative areas within the Agency of Human Services (AHS). These include: the Department of Vermont Health Access (DVHA), the Department for Children and Families (DCF), the Department of Mental Health (DMH), the Department of Disabilities, Aging and Independent Living (DAIL), and the Department of Health (VDH). Also included in the MCE are the Designated Agencies (DA) and Specialized Service Agencies (SSA) that provide service authorizations for DMH and DAIL. Each entity should have at least one assigned grievance and appeal coordinator who enters data into the MCE database. This report is based on data compiled on April 3, 2012, from the centralized database for grievances and appeals that were filed from January 1, 2012 through March 31, 2012.

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

During this quarter, there were 7 grievances filed with the MCE; 1 was addressed during the quarter, none were withdrawn and six were still pending at the end of 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. The grievances were addressed in an average of 45 days. Acknowledgement letters of the receipt of a grievance must be sent within five days; the average was one day. Of the grievances filed, 57% were filed by beneficiaries and 43% were filed by a representative of the beneficiary. Of the 5 grievances filed, DMH had 72%, DCF had 14% and DVHA had 14%. There were no grievances filed for the DAIL, or VDH during this quarter.

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

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

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

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

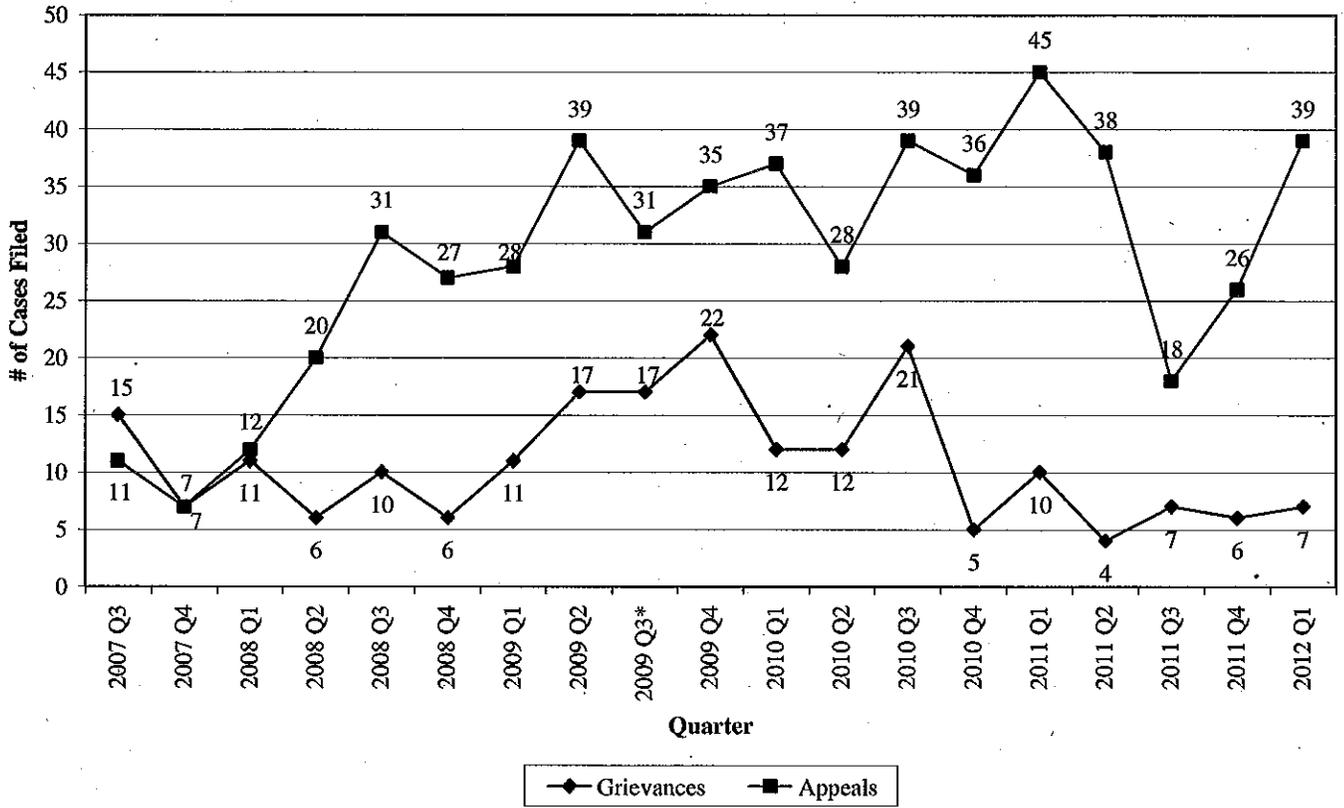
During this quarter, there were 39 appeals filed with the MCE; 12 requested an expedited decision with seven of them meeting criteria. Of these 39 appeals, 25 were resolved (67% of filed appeals), one was withdrawn (3%), and 13 were still pending (33%). In 11 cases (44% of those resolved), the original decision was upheld by the person hearing the appeal, eight cases (32% of those resolved) were reversed, five were approved by the applicable department/DA/SSA before the appeal meeting (20% of those resolved) and one had a modified decision (4% of those resolved).

Of the 25 appeals that were resolved this quarter, 100% were resolved within the statutory time frame of 45 days; 84% were resolved within 30 days. The average number of days it took to resolve these cases was 21 days. Acknowledgement letters of the receipt of an appeal must be sent within five days; the average was two days.

Of the 39 appeals filed, 17 were filed by beneficiaries (44%), 18 were filed by a representative of the beneficiary (46%) and 4 were filed by the provider (10%). Of the 39 appeals filed, DVHA had 77%, DAIL had 18%, and DMH had 5%.

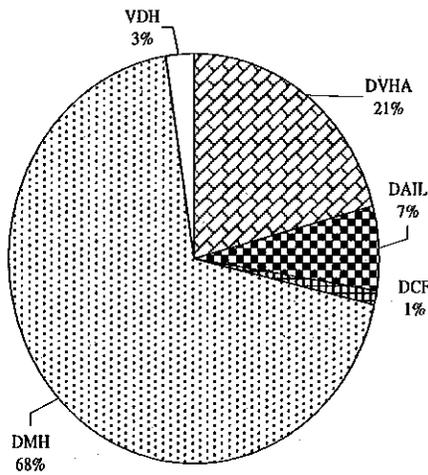
Beneficiaries can file an appeal and a fair hearing at the same time, and they can file a fair hearing if their appeal is not decided in their favor. There was one fair hearing filed this quarter and it was for DAIL.

Medicaid MCE Grievances & Appeals

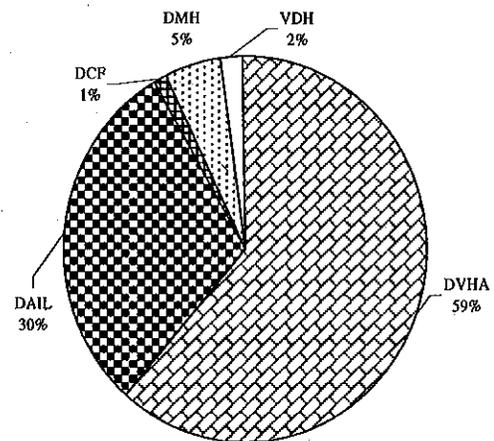


**MCE Grievance & Appeals by Department
From July 1, 2007 through March 31, 2012**

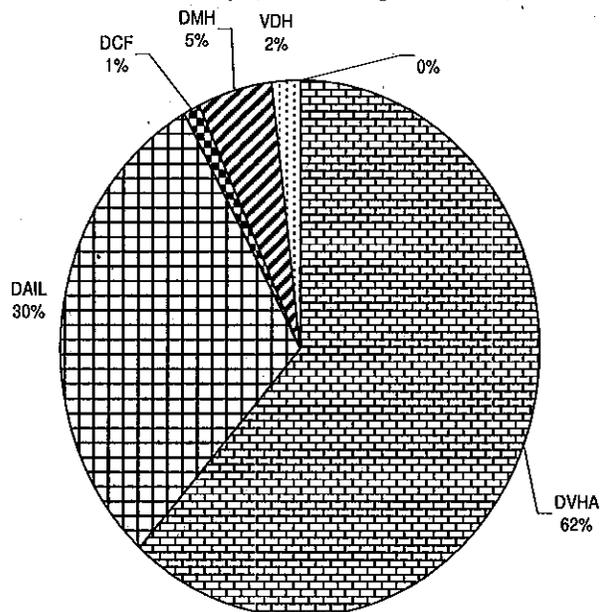
Grievances



Appeals



**MCE Appeal Resolutions
from July 1, 2007 through March 31, 2012**



OFFICE OF HEALTH CARE OMBUDSMAN

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QUARTERLY REPORT

January 1, 2012 – March 31, 2012

to the

DEPARTMENT OF FINANCIAL REGULATION

and the

DEPARTMENT OF VERMONT HEALTH ACCESS

submitted by

Trinka Kerr, Vermont Health Care Ombudsman

April 19, 2012

I. Overview

This is the Office of Health Care Ombudsman's (HCO) report to the Department of Financial Regulation (DFR) and the Department of Vermont Health Access (DVHA) for the quarter January 1, 2012 through March 31, 2012.

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

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

A. Total call volume increased 6.8% compared to last quarter.

All Calls

The HCO received 777 calls this quarter, compared to 727 in the October to December 2011 quarter, a 6.8% increase. Call volume was significantly lower than the same quarter in 2011, when we received 856 calls. At that time we were seeing major problems with the Department for Children and Families (DCF) eligibility system related to the Modernization effort. Those problems seem to have abated somewhat, although the number of complaints about communicating with DCF went up 38% over the last quarter, and the number of calls related to eligibility went up almost 18%.

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

DVHA Beneficiary Calls

We received 308 calls (39.63% of all calls) from individuals on state programs this quarter, compared to 288 calls (39.6% of all calls) last quarter. Thus, we received about the same percentage of our calls from individuals on state programs over both quarters.

B. The top ten issues generating calls were:

This section includes both primary and secondary issues.

All Calls

1. Affordability 118 (87 last quarter)
2. Complaints about Providers 83 (83)
3. Eligibility for VHAP 74 (72)
4. Access to Prescription Drugs 72 (75)
5. Eligibility for Medicaid 71 (77)
6. Information about applying for DVHA programs 69 (63)
7. Medicaid Spend Down 50
8. Communication Problems with DCF 47 (34)
9. Medicare (both Consumer Education and Eligibility) 45 (66)
10. Claim Denials 44 (22)

DVHA Beneficiary Calls

1. Complaints about Providers 39 (37 last quarter)
2. Eligibility for Medicaid 30 (32)
3. Transportation 29 (17)
4. Affordability 28 (28)
5. Communication Problems with DCF 27 (14)
6. Access to Prescription Drugs 24 (31)
7. Eligibility for VHAP 24 (29)
8. Fair Hearings 23 (26)
9. Access to Dental Care (and Dentists) 17 (14)
10. Medicaid Spend Down 16 (12)

C. The affordability of health care remains an issue.

We started tracking Affordability as an access issue at the end of 2009, and since then it has been an increasingly common complaint. This quarter we had 118 calls from consumers saying they had problems affording health care (looking at primary and secondary issues), compared to 87 last quarter, and 100 in the quarter before that.

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

- DVHA programs: 28 calls; 5 calls as a primary issue, 23 as a secondary;
- Commercially insured: 26 calls; 5 calls as a primary issue (3 of the 5 had employer sponsored insurance), 21 as a secondary;

- Uninsured: 22 calls; 3 calls as a primary issue, 19 as a secondary; and
- In the remaining 21 calls we did not get the caller's insurance status.

D. The number of complaints about providers remained the same.

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

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

The HCO received 34 calls this quarter, including both primary and secondary issue codes, regarding access to dental care, dentists, dentures, and orthodontists. Last quarter we received 20 such calls.

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

F. Access to pain management continues to be a problem.

The HCO continued to get a significant number of difficult calls from individuals who were having trouble getting adequate treatment for pain. We received 23 such calls (primary and secondary issue) this quarter, the same number as last quarter. Ten of these calls were from DVHA beneficiaries; one was from an individual with commercial insurance.

G. Access to substance abuse treatment also continues to be a problem.

We received 17 calls regarding access to substance abuse treatment (primary and secondary issue) this quarter. Eleven of these were from DVHA beneficiaries; none was from a commercially insured individual. The previous quarter we received 14 such calls, and 8 were from DVHA beneficiaries, and one was from a commercially insured person.

H. The HCO increased its staff.

As of mid-March, the HCO added three new staff members: a staff attorney and two new advocates. Training is ongoing. The HCO staff now includes the director, two staff attorneys and five health care advocates who directly assist consumers through the hotline. For several years the HCO had just one staff attorney and four advocates.

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

- A table showing monthly totals for All Calls at the end of this narrative, and
- Four data reports based on type of insurance coverage:

- **All calls/all coverages:** 777 calls;
- **DVHA beneficiaries:** 308 calls or 40% of total calls;
- **Commercial plan beneficiaries:** 134 calls or 17%; and
- **Uninsured Vermonters:** 73 callers or 9%.

II. Green Mountain Care Board and Rate Review Activities

In mid-March the HCO began receiving a new grant under the Affordable Care Act through DFR. Accordingly, this is our first report on our activities under that grant, for which we did the following:

- Attended five Green Mountain Care Board (GMCB) meetings, and had one monthly meeting (by phone) with the executive director of the GMCB.
- Attended one GMCB advisory board meeting.
- Submitted two sets of written comments on proposed GMCB rate review regulations.
- Exchanged information and comments with other consumer groups about the section on Opportunities for Public Participation in the draft rate review regulations.
- Attended two meetings with the GMCB executive director related to the rate review regulations.
- Met with an expert on rate reviews at DFR and continue to have ongoing discussions with him about the process.
- Monitored and reviewed rate review filings.
- Participated in one national conference call run by Families USA regarding quality measure and consumer protections.
- Discussed basic elements of a benefits package for Green Mountain Care, including a medical necessity definition and principles about cost sharing, with the Vermont Workers Center.
- Began to review the DFR and GMCB web sites with the Vermont Public Interest Group to prepare comments that would make the consumer information on these sites more complete and accessible for consumers.
- Monitored and testified regarding H. 559 in the legislature.
- In addition, we began tracking complaints from consumers who called our hotline about premium rates. We received one complaint about a rate increase involving employer sponsored insurance, and six calls with complaints that premiums were too high (although these were coded as secondary issues so there could be overlap). One of these was from a DVHA beneficiary, who did not have a commercial plan.

III. Call volume by type of insurance:

The HCO received 777 total calls this quarter. Callers had the following insurance status:

- **DVHA programs** (Medicaid, VHAP, VHAP Pharmacy, Premium Assistance, VScript, VPharm, or both Medicaid and Medicare aka dual eligibles) insured **40%** (308 calls), compared to 40% (288) last quarter;
- **Medicare** (Medicare only, Medicare and a Medicare Supplemental Plan aka Medigap, Medicare and Medicaid aka dual eligibles, Medicare and Medicare Savings Program aka Buy-In program, Medicare and Part D, or Medicare and VPharm) insured **25%** (198), compared to 36% (261) last quarter;

- 12% of all callers (91) had Medicare only;
- 12% (93) had both Medicare coverage and coverage through a state program such as Medicaid, a Medicare Savings Program aka a Buy-In program, or VPharm; and
- Less than 1% (2) had a Medicare Supplemental plan.
- Commercial carriers (employer sponsored insurance, individual or small group plans, and Catamount Health plans) insured 17% (134), compared to 16% (119) last quarter; and
- 9% (73) identified themselves as Uninsured, compared to 12% (86) last quarter.
- In the remainder of calls the insurance status was either unknown or not relevant.

IV. Disposition of cases

All Calls

We closed 786 cases this quarter, compared to 745 last quarter:

- 43% (341 cases) were resolved by brief analysis and advice;
- 24% (187) were resolved by brief analysis and referral;
- 24% (186) were resolved by direct intervention, including calling an insurance company, calling providers, writing letters, gathering supporting medical documentation, etc. (these numbers include complex interventions);
- 10% (80) of the cases were complex interventions, which involves complex analysis and more than two hours of an advocate's time;
- 3% (27) of the cases involved appeals; and
- 1% (5) of the cases were resolved in the initial call.
- In the remaining calls clients either withdrew or resolved the issue on their own.

DVHA Beneficiary Calls

We closed 305 DVHA cases this quarter, compared to 300 last quarter:

- 39% (119 calls) were resolved by brief analysis and advice ;
- 21% (65 calls) were resolved by brief analysis and referral;
- 33% (100 calls) were resolved by direct intervention on the caller's behalf, including advocacy with DVHA and providers, writing letters, and gathering medical information (these numbers include complex interventions);
- About 13% (41 calls) were considered complex intervention, which involves complex analysis and more than two hours of an advocate's time;
- 6% (19) involved appeals (Fair Hearings); and
- Less than 1% of calls (2) from DVHA beneficiaries were resolved in the initial call.
- In the remaining calls clients either withdrew or resolved the issue on their own.

V. Outcomes

All Calls

The HCO prevented 18 insurance terminations or reductions and got 25 people onto insurance. We assisted 9 people with applications and estimated the eligibility for state programs for 18

individuals. We got 29 claims paid or written off on behalf of consumers. We provided 529 individuals with advice and education.

DVHA Beneficiary Calls

We prevented 16 terminations or reductions in coverage for DVHA beneficiaries, and got 4 more onto different DVHA programs. We estimated the eligibility for other programs for 3 DVHA beneficiaries. We got 19 claims paid or written off. We provided 196 DVHA beneficiaries with advice or education.

VI. Issues

The HCO database allows us to track more than one issue per case, so we can see the total number of calls that involved a particular problem. For example, although only 60 cases had Consumer Education as the primary issue, there were actually a total of 229 calls in which we spent a significant amount of time educating consumers about insurance. See the breakouts of the issue numbers in the data reports for a more detailed look at how many callers had questions about issues other than the primary reason for their call.

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

- **28.70%** (223) of our total calls were regarding **Access to Care**;
- **13.51%** (105) were regarding **Billing/Coverage**;
- **1.03%** (8) was questions regarding **Buying Insurance**;
- **7.72%** (60) were **Consumer Education**;
- **27.54%** (214) were regarding **Eligibility** for state programs, Medicare and Catamount Health plans; and
- **21.49%** (167) were categorized as **Other**, which includes Medicare Part D, communication problems with providers or plans, accessing medical records, changing providers or plans, enrollment problems, confidentiality issues, and now complaints about rates.

A. Access to Care (28.70% of all calls)

We received 223 calls from individuals for whom the primary issue was difficulty getting specific health care, up from 217 last quarter. The top ten Access to Care issues, out of over 35 codes were, in descending order:

- 46 calls were for problems obtaining Prescription Drugs, not including Medicare Part D, compared to 39 last quarter;
- 28 Transportation to medical appointments, compared to 18;
- 24 Dental, Dentists, Dentures or Orthodontic care, compared to 17;
- 18 Affordability of health care, compared to 17;
- 17 Specialty Care, compared to 6;
- 16 Durable Medical Equipment (DME), Supplies and Wheelchairs, compared to 17;
- 12 Pain Management, compared to 16;
- 11 Mental Health, compared to 10 (not including Substance Abuse);
- 7 Substance Abuse, compared to 9; and

- 6 Prior Authorizations (criteria and delays), compared to 3.

B. Billing/Coverage (13.51%)

We received 105 calls related to primary issues with billing, compared to 91 last quarter.

The top five billing related issues were:

- 21 Hospital billing;
- 19 Claim denials by insurers;
- 11 Provider problems;
- 8 Insurance coverage/contract questions; and
- 6 Out of state billing for state programs.

C. Consumer Education (7.72%)

We received 60 calls in which consumer education was the primary issue, compared to 69 last quarter. The top five consumer education issues were:

- 21 Information about applying for DVHA programs;
- 8 General questions about insurance;
- 7 Fair Hearings;
- 6 Medicare; and
- 6 Catamount programs.

D. Eligibility (27.54%)

We received 214 calls from individuals for whom eligibility for state programs was the primary issue, as compared to 182 last quarter. The top five issues in this category were:

- 39 Medicaid;
- 34 VHAP;
- 28 Catamount, Premium Assistance, and VHAP-ESIA; and
- 27 Medicaid Spend Down; and
- 18 Buy In Programs (aka Medicare Savings Programs).

E. Other (21.49%)

We received 167 calls in this category for which the primary issue was categorized as Other, compared to 162 last quarter. The top five issues in this category were:

- 35 Communication/Complaints: Providers;
- 10 Provider error/medical malpractice;
- 10 Communication/Complaint: Plan;
- 9 Access to medical records; and
- 8 DCF ID card problems.

VII. Table of All Calls by Month and Year

All Cases	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
January	241	252	178	313	280	309	240	218	329	282
February	187	188	160	209	172	232	255	228	246	233
March	177	257	188	192	219	229	256	250	281	262
April	161	203	173	192	190	235	213	222	249	
May	234	210	200	235	195	207	213	205	253	
June	252	176	191	236	254	245	276	250	286	
July	221	208	190	183	211	205	225	271	239	
August	189	236	214	216	250	152	173	234	276	
September	222	191	172	181	167	147	218	310	323	
October	241	172	191	225	229	237	216	300	254	
November	227	146	168	216	195	192	170	300	251	
December	226	170	175	185	198	214	161	289	222	
Total	2578	2409	2200	2583	2560	2604	2616	3077	3209	777

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

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