

*State of Vermont*  
*Agency of Human Services*

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

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

**Quarterly Report for the period**  
**July 1, 2013 – September 30, 2013**

**Submitted Via Email on December 10, 2013**

## **Background and Introduction**

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

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

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

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

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

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

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

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

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

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

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

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

One of the Terms and Conditions of the Global Commitment Waiver requires the State “to submit progress reports 60 days following the end of each quarter. ***This is the third quarterly report for waiver year eight, covering the period from July 1, 2013 through September 30, 2013.***

#### Global Commitment to Health Waiver: Renewal

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

On February 14, a public notice was published in the Burlington Free Press noticing the availability of the draft renewal request, two public hearing dates, the online website, and the deadline for submission of written comments with contact information. Additionally, all district offices of the Department for Children and Families’ Economic Services Division, the division responsible for health care eligibility had notice posted and proposal copies available, if requested. The Burlington Free Press is the state’s newspaper with the largest statewide distribution and paid subscriptions. Between February 16-20<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, a public notice and link to the renewal documents was included on the banner page for Vermont’s Medicaid provider network.

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

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

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

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

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

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

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

Area	Proposed Change	Impact	Hypothesis
Eligibility Expansions	Eliminate VHAP, Catamount Health and ESI Expansion Populations and VScript, Vscript expanded and VHAP pharmacy programs.	Persons under 133% will move to traditional Medicaid and receive a fuller benefit package; persons over 133% will move into commercial products through the Exchange.	Vermont will retain a high rate of insured Vermonters; transition to Affordable Care Act rules will not diminish coverage rates.
ACA Transition	Adopting a “safe harbor” approach to transitioning current Medicaid beneficiaries: those who are due for eligibility recertification in the first three months of 2014 will be deferred for review and distributed throughout the remainder of the calendar year, and all beneficiaries due for review will be held harmless until March 31, 2014 or their review date, whichever is later.	Current Medicaid beneficiaries would not be required to submit any new information until their anniversary date.	Vermont will minimize coverage gaps, and limited to no new administrative burden will be placed on current beneficiaries.
Modified Adjusted Gross Income	Use new MAGI rules for all eligibility determinations as long as it does not adversely impact optional or expansion populations.	Administrative efficiency in eligibility determinations.	Streamlined and standardized rules will result in easier to understand information requests and timelier processing of health care program applications.
Benefits	Within state budget restrictions, expand the current menu of services offered in the Long Term Care Moderate Needs Group.  Enhance Hospice Benefits for persons within 12 months of end of life and allow delivery of both palliative and curative care.	Additional flexibility for current long term care service beneficiaries in available service options.	Long term care beneficiaries will remain in their homes longer and delay the need for nursing facility care.
Affordability	Include a state based, sliding scale premium subsidy for persons purchasing on the Exchange up to 300% FPL. Including Medicare premium subsidies for certain individuals who are low income.	To maintain affordability of Vermont programs at a level of expense substantially similar to former VHAP, Catamount and ESI programs.	Vermont will retain a high rate of insured Vermonters; transition to the Affordable Care Act rules will not diminish coverage rates.
Demonstration Consolidation	Consolidate Choices for Care, Dual Eligible Demonstrations and CHIP into GC under one demonstration.	Administrative simplification in the use of one federal regulatory structure for state and provider network.	Administrative efficiencies will be achieved.
Administrative	Streamline CMS reporting, state plan amendment, auditing and other processes as much as possible under the 42 CFR 438 regulatory structures.	Administrative simplification in the use of one federal regulatory structure for state and provider network.	Administrative efficiencies will be achieved.

CMS and AHS conducted numerous negotiation sessions during the quarter. CMS requested that

negotiations specific to consolidating the Choices for Care waiver and the Children’s Health Insurance Program (CHIP) into the Global Commitment to Health Waiver be deferred until the first quarter of 2014; AHS agreed to the request.

CMS and AHS recognized that at least one critical provision needed to be effective for October 1, 2013, therefore the Waiver renewal would need to be effective for October 1, 2013 instead of January 1, 2014.

**Enrollment Information and Counts**

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

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

Demonstration Population counts are person counts, not member months.

Demonstration Population	Current Enrollees Last Day of Qtr 9/30/2013	Previously Reported Enrollees Last Day of Qtr 6/30/2013	Variance 06/30/13 to 09/30/13
Demonstration Population 1:	145,446	145,178	0.18%
Demonstration Population 2:	131,481	132,125	-0.49%
Demonstration Population 3:	29,618	29,439	0.61%
Demonstration Population 4:	N/A	N/A	N/A
Demonstration Population 5:	2,657	2,748	-3.31%
Demonstration Population 6:	8,826	9,790	-9.85%
Demonstration Population 7:	107,354	109,242	-1.73%
Demonstration Population 8:	30,505	30,450	0.18%
Demonstration Population 9:	7,794	7,833	-0.50%
Demonstration Population 10:	N/A	N/A	N/A
Demonstration Population 11:	40,093	36,909	8.63%

**Outreach Activities**

**Member Relations**

The DVHA Provider and Member Relations Unit accepted corrective action plans (CAPs) from each of the primary care providers (PCPs) who had an access standard issue, which was discovered when completing timely access surveys distributed during early summer. Additionally, a Banner to outreach all PCPs regarding Access to Care & Waiting Time Standards reminds them to have provisions for access to 24/7 coverage that will assure practitioner availability in person or by phone, to maintain office-visiting hours at least four days per week for at least twenty-five hours per week for member appointments, and the standards for waiting times for access to care.

In anticipation of the new health insurance exchange, Vermont Health Connect, going live on October 1,

2013, the DVHA Provider and Member Relations Unit overhauled the current member website. The new website has an updated look, and is more streamlined and accessible, so that members can easily navigate the site and find relevant information. Information on Vermont Health Connect and how to apply for public plans is prominent on the new member site: [www.greenmountaincare.org](http://www.greenmountaincare.org).

## **Operational/Policy Developments/Issues**

### **Health Benefit Exchange**

The State of Vermont is prepared to launch Vermont Health Connect (VHC), a state-based health benefit exchange for individuals and small businesses on October 1, 2013. The Customer Service Center went live on September 1 to field eligibility questions and process telephonic applications. VHC continues to implement an ambitious outreach and education campaign and to collaborate with key stakeholders, including insurance carriers, brokers, small business owners, and community partners, and has developed a comprehensive training plan, and continues to work with agencies and departments to ensure that roles and responsibilities are clearly defined, business processes are fully mapped and adequate resources are in place to support operations.

### **Expenditure Containment Initiatives**

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

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

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

The VCCI supports and aligns with other State health care reform efforts, including the Blueprint for Health advanced practice medical homes and their local Community Health Teams (CHTs); and VCCI staff function as members of these local resource teams for patients and providers. Collaboration with the Blueprint CHT's is designed to facilitate transition between levels of service and reduce redundancies, with VCCI supporting the highest risk population. The VCCI eligible population includes all age groups and all conditions in the population accounting for the top 5% of expenses; as well as those with ambulatory sensitive conditions which adversely impact utilization trends, such as Emergency Department (ED) and inpatient admissions and readmissions. Most recent data for this cohort indicates that the top 5% accounts

for 39% of Medicaid spending. This includes 20% of all ACS ED costs; roughly 60% of ACS inpatient costs and 88% of hospital readmission costs. The strategy of embedding staff in high volume hospital and primary care sites continues to support population engagement in these high utilization areas and transitions in care between hospital and community settings.

The VCCI continues to expand embedded staffing model with licensed staff in high volume Medicaid primary care sites and hospitals that experience high rates of ambulatory sensitive ED visits and inpatient admissions/readmissions for ambulatory care sensitive conditions. The VCCI has staff in 18 locations including nine (9) Agency of Human Services (AHS) district offices, two (2) hospitals and seven (7) primary care provider locations. Additionally, all VCCI staff interface with hospital discharge planners and case managers as appropriate, to facilitate transitions in care including to their medical homes. Data exchanges from partner hospitals via secure FTP site transfers provide the VCCI team with daily inpatient data for both hospital inpatient and ED admissions. Currently four (4) hospitals including Vermont's tertiary care center provide these data sets electronically (FAHC, Copley, NWMC, and CVMC) while several others provide secure excel reports downloaded locally or fax transmittals. The goal is to secure data from all 14 hospitals.

The VCCI plans to continue to expand its onsite role in first quarter of FFY 2014 to include an RN onsite daily at the state's only tertiary care center - Fletcher Allen Health Care (FAHC), and to further partner with the state's largest FQHC - Community Health Center of Burlington (CHCB). VCCI leadership met with FQHC leadership in CHCB and there is renewed interest in trying to have a VCCI staff on site daily. VCCI also met with our FQHC in Springfield to formalize our working relationships, with a proposal made for embedding staff in the hospital and linking back to the primary care provider groups. The Springfield FQHC is the parent organization of the Springfield hospital. Due to internal challenges these discussions have not to date yielded a response from the FQHC. Embedding staff has helped foster relationships with providers and hospital partners and to secure direct referral for high risk populations, versus utilizing professional staff to perform outreach to eligible populations via 'cold calling' using aged claims for population identification. Experience has demonstrated that direct referrals at the community level are more likely to result in members 'engaging' with a VCCI staff. These referral sources, in addition to primary care and hospital partners, include AHS Field Directors and colleagues in economic services, probation and parole, vocational rehabilitation, as well as the local provider community (primary care, mental health, and substance treatment centers) and Blueprint Community Health Team (CHT) members.

VCCI continues to experience challenges related to timely recruitment (and retention) of nurses with the applicable background and experience in case management - including a passion for and commitment to working with this vulnerable population. This is attributed to the pay rate available in state government, which is significantly less than available from other insurance carriers, hospitals and/or care management organizations. Despite these challenges, the VCCI did add a new RN case manager in the last quarter including filling a long term vacancy in the Burlington service area; this was an internal RN promoted from another state nursing position.

CMS issued a Bulletin in July of 2013, which highlighted strategies to target the 'Super-utilizer' groups in Medicaid and which featured the VCCI as a model of excellence. As a result, CMS has referred other states interested in working with this population to Vermont. Partners from Maryland, who are SIM grantees, are slated to visit Vermont in the first quarter of FFY 2014.

The VCCI Director has become actively engaged in health care reform efforts including support of the SIM grant and now is a member of the Joint Insurance Carrier workgroup; as well as a recently formed care models and care management workgroup to support implementation of the Medicaid ACO and to assure VCCI integration and alignment with these services and related goals; clinical, social and financial.

Additionally, the VCCI Director and the Deputy Commissioner for Health Services will both be on the RFP review team for the Medicaid ACO, with anticipated launch date of January 2014.

#### Pediatric Palliative Care Program (PPCP):

The Pediatric Palliative Care Program (PPCP) is now statewide with a current active enrollment of roughly 32 children and families, with over 50 referrals to-date. Several children have transitioned off the program due to improved medical prognosis, while a few children have passed away while in the program. The PPCP is starting to secure early utilization reports and has begun to meet with partner home health agencies to assess quality, goals and capacity issues. There have been early efforts with the advisory board to create auditing tools with HHAs, as well as patient/family satisfaction surveys, to further enhance care quality. It is too early to secure enough utilization data to compare those getting PPCP services and resulting utilization from those who do not received PPCP services. We are in early discussions with partners, advisory board members, and others to begin to analyze this data.

VCCI partners supporting the PPCP include AHS/Integrated Family Services (IFS), Department for Children and Families/Children's Integrated Services (CIS), and Vermont Department of Health (VDH)/Children with Special Health Needs (CSHN). To further support integration with CSHN, the PPCP nurse case manager is available one day per week at the CSHN offices to facilitate collaboration and planning.

An extensive network of pediatric palliative care providers at Fletcher Allen Health Care (FAHC) and Dartmouth Hitchcock's Children's Hospitals, as well as primary care pediatric practitioners and pediatric oncologists, are new provider partners. Home Health agencies (hospice and palliative care units), the Vermont Ethics Network, and the Vermont Family Network are also collaborating service providers and partners.

The VCCI has scheduled a meeting with the Green Mountain Care Board (GMCB) to discuss how the PPCP fits into our state health care reform models including potential payment reforms.

#### High Risk Pregnancy

VCCI will launch a pilot for the High Risk Pregnancy Case Management program beginning October 1, 2013. This new service for vulnerable pregnant women and their unborn child(ren) is a partnership between DVHA and the Vermont Department of Health (VDH). This program will align with Health Homes to support individuals with substance abuse disorders, the Pediatric Palliative Care Program (PPCP), and the VDH programs and services available for maternal/child health. The high risk pregnancy case management program is being centrally administered, will focus on the system of care and coordination of services for the identified population, and ensure early identification of at-risk women, including via pharmacy indicators such as use of Makena, history of premature labor, and buprenorphine mono (subutex) for addicted women. Direct referrals from community partners will support early engagement including OB providers, substance use/abuse treatment teams (Hub and Spokes Health Home model), WIC programs, Children Integrated Services (CIS) team members, hospitals, and primary care providers. VCCI field staff may provide supplemental local support for the OB/GYN provider practice and pregnant woman based on needs.

#### APS Contract

Since 2007, DVHA has contracted with APS Healthcare for assistance in providing disease management assessment and intervention services to beneficiaries with chronic health conditions. DVHA and APS migrated away from the original model of support for those with chronic conditions to a full risk based contract focused on the top 5% beneficiaries accounting for highest service utilization, as long as the

condition and utilization patterns were ‘impactable’. DVHA has found this approach more effective because VCCI staff are able to communicate at the local level with providers, partners, patients, and their families.

This change in strategic approach required a different level of support from APS to better align with current needs and healthcare goals. APS provides enhanced information technology and more sophisticated decision support tools to assist VCCI in outreach for the most costly and complex beneficiaries, and supplemental population-based reports to support Advanced Practice Medical Homes, as well as Health Registries outlining gaps in evidence based care for select conditions, consistent with NCQA goals. DVHA/VCCI are also co-located in many primary care medical homes and work in partnership with the PCP and the local Blueprint community health team (CHT) staff to support case identification and management.

A new one year contract with APS was effective for July 1, 2013, with a one year option to renew. The APS contract continues to guarantee a 2:1 return on investment (ROI) by implementing enhancements in SFY 2014. APS’s early analysis of 2013 data suggests that DVHA is on target to exceed demonstrated SFY 2012 ROI of \$11.5 million, which included the DVHA employed staff expenses.

VCCI disseminated one population-based report (registry) on care gaps, with focus on CAD. This registry was distributed in July to 81 practitioners representing 21 practice sites, and included just over 200 members with CAD and associated gaps in clinical treatment. Also, APS’s data analytics team was able to develop hospital service area profiles on ED, IP and 30 day readmission rates by condition to help support primary care provider outreach/education and the adoption of the VCCI tools (registries, action plans, patient health briefs) for care improvement.

#### Highlights of the Vermont Chronic Care Initiative (VCCI)

- VCCI has been identified as a leader in working with “super-utilizer’ populations by CMS, resulting in consultation requests to work with SIM grantees working on this population. The VCCI has provided phone consultation to the state of Maryland SIM team, with a subsequent request for a site visit to Vermont to learn from partners and staff. This is scheduled for first quarter FFY 2014 (November 2013).
- The state of Alaska has requested a site visit to Vermont in December 2013.
- The VCCI Director is working with internal SIM stakeholders on payment reforms and interface opportunities. The VCCI Director will be part of the RFP review team for Medicaid ACO proposals, which are anticipated in November 2013.
- The VCCI Director has been invited to participate on the Joint Insurance workgroup, as well as the newly developed Care Models and Care Management workgroup that support both the SIM and Dual eligible requirements. This team will launch in October with the mission and vision of establishing methods to align services, enhance communication, and minimize redundancies.
- VCCI has developed an updated workflow identifying criteria for transition between programs, including the recently launched Blueprint for Health Hub and Spoke Health Homes model; work continues to be done to assure there is an interface with this effort without being duplicative.
- The APS Healthcare contract extension was implemented July 1, 2013; the local director tendered his resignation effective mid-October and recruitment is underway for a new Director. APS has advised of a new local reporting structure, with the Vermont Director now reporting to a regional director

from their Maryland office. Initial meetings between APS leadership and the DVHA/VCCI leadership were held in late September.

- RFP requirements gathering for the MMIS Care Management system was initiated as an enterprise level solution within AHS. A supplemental segment of the RFP will be for VCCI operational support, including data analytics and staffing support. The RFP is slated for release in the first quarter of FFY 2014.
- VCCI hired a new nurse for the Burlington district office to be the liaison to the large tertiary care hospital (Fletcher Allen Health Care) and a liaison to the large FQHC – Community Health Center of Burlington (CHCB).
- A Market Factor Analysis for nursing positions remains under consideration. Turnover and recruitment continues to be a challenge.
- The VCCI case load for the quarter was 746 with 1780 unique members for the FFY, which represents significant growth over the previous 3 quarters of the FFY, and is likely attributable to improved staffing during this period. An additional 508 members rolled over from the previous fiscal year, resulting in a total population served of 2,288 members in FFY 2013.
- VCCI disseminated a CAD registry to 21 practice sites, representing over 80 providers and 200 beneficiaries.
- The Pediatric Palliative Care Program (PPCP) will complete the first full year of operation.
- High Risk Pregnancy (HRP) staff have developed multiple tools for administering this new service with partners, starting with a Franklin County pilot to be launched in October 2013.
- Interim clinical management tracking systems and tools for both the PPCP and HRP efforts are in review, pending the new MMIS/Care Management system procurement. APS Healthcare does not have the capacity to include PPCP and HRP into the current contract, and subsequently, both programs are utilizing a supplemental data system that has been made available via the DVHA/Blueprint contract with Covisint. The system, called P-Link, allows for direct faxing and opening of a file history to support high level case management in partnership with community resources. These will go live in October.

#### *Hub and Spoke Initiative: Integrated Treatment for Opioid Dependence:*

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

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

coordination.

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

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

A total of five regional *Hubs* are planned that build upon the existing methadone OTPs and also provide buprenorphine treatment to a subset of clinically complex buprenorphine patients, as well as serve as the regional consultants and subject matter experts on opioid dependence and treatment. *Hubs* are replacing episodic care based exclusively on addictions illness with comprehensive health care and continuity of services. The first *Hub* was implemented under the first Health Home SPA on January 1, 2013. Two additional regional *Hubs* were implemented through the second SPA during the current reporting period (FFY 2013 Q4).

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

#### Highlights of the Hub and Spoke Initiative

- The second *Hub & Spoke* Health Home SPA was submitted to CMS, adding coverage to five additional counties. *Hub & Spoke* Health Homes now cover ten counties in the Northwest, Central, and Southeast regions of the state.
- Two additional *Hubs* were implemented to serve MAT patients in the Central and Southeastern regions of Vermont, bringing the number of fully operational *Hubs* to three (one with two locations), with a total caseload of approximately 1,151. In addition to providing methadone MAT as they have traditionally done, *Hubs* now also provide buprenorphine MAT to complex patients

(approximately 20% of total caseload), allowing *Spoke* physicians to focus on patients most appropriate for office-based care.

- 72% of the 36 new *Spoke* staff has been hired to work with 57 buprenorphine providers serving 1,750 Medicaid beneficiaries receiving MAT with buprenorphine. Spoke staffing is scaled at 1 RN and 1 licensed clinician for every 100 MAT patients.
- There are four regional Learning Collaboratives for *Spoke* physicians and practice teams, a statewide Learning Collaborative for *Hubs*, and a statewide Learning Community for the additional *Spoke* staff (RNs and licensed clinicians) who provide the Health Home services.
- Practice facilitators are working extensively with *Hub & Spoke* providers on common measurement, practice-level quality improvement, and implementation of evidence-based care.

### Hub Caseload

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

### Buprenorphine Providers, *Spoke* Funding & Staff Recruitment, and Medicaid MAT Beneficiaries by Region

Region	Providers	Medicaid Beneficiaries	Staff FTE Funding	Staff FTE Hired
<b>Bennington</b>	6	131	3	2.6
<b>St. Albans</b>	7	236	5	2.8
<b>Rutland</b>	5	206	4.5	2
<b>Chittenden</b>	12	352	7.25	7.35
<b>Brattleboro</b>	6	237	5	3.8
<b>Springfield</b>	3	41	1	1
<b>Windsor</b>	1	56	1.5	.75
<b>Randolph</b>	3	78	2	1.8
<b>Barre</b>	8	198	4	2
<b>Lamoille</b>	6	117	2.5	2
<b>Total</b>	<b>57</b>	<b>1,652</b>	<b>35.75</b>	<b>26.1</b>

### Manage Substance Abuse Services

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

*Team Care* (formerly called the lock-in program) designates one prescribing physician and one pharmacy (the *Pharmacy Home*) to improve coordination of care and decrease over-utilization and misuse of services by participants. Beneficiaries who exceed certain thresholds for opiates and other controlled substances or who utilize multiple prescribers and pharmacies to obtain controlled substance prescriptions are identified for *Team Care*. All beneficiaries receiving MAT with buprenorphine/Suboxone<sup>®</sup> have a *Pharmacy Home*

that dispenses all their prescriptions. In addition to overseeing these programs, the Substance Abuse Unit coordinates and facilitates prescriber reconsideration requests and appeals when prior authorizations for controlled substances are denied.

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

### Buprenorphine Program

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

**(Figure 1)**

Complexity Level	Complexity Assessment	Rated Capitation Payment	+ <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 total for the four quarters (October 2012- September 2013) is \$185,752.78 (Figure 2).

**(Figure 2)**

Buprenorphine Program Payment Summary	
<b>FIRST QUARTER</b>	
Oct-12	\$23,454.82
Nov-12	\$24,081.24
Dec-12	\$16,365
<b>1<sup>st</sup> Quarter Total</b>	<b>\$63,901.36</b>
<b>SECOND QUARTER</b>	
Jan – 2013	\$9,818.74
Feb – 2013	\$8,341.92
March- 2013	\$13,541.08
<b>2<sup>nd</sup> Quarter Total</b>	<b>\$31,541.08</b>
<b>Grand Total</b>	<b>\$95,442.44</b>
<b>THIRD QUARTER</b>	
April - 2013	\$14,120.22

May - 2013	\$15,739.28
June - 2013	\$250,772.68
<b>3<sup>rd</sup> Quarter Total</b>	<b>\$50,632.18</b>
<b>FOURTH QUARTER</b>	
<b>July</b>	<b>\$18,775.70</b>
<b>August</b>	<b>\$8,341.92</b>
<b>September</b>	<b>\$12,560.56</b>
<b>4<sup>th</sup> Quarter Total</b>	<b>\$39,678.16</b>
<b>Grand Total</b>	<b>\$185,752.78</b>

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

340B Drug Discount Program

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

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

Covered entities include:

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

- Homeless clinics
- Urban Indian clinics
- Native Hawaiian health centers

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

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

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

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

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

Through a great deal of public engagement of various 340B stakeholders including pharmacies and covered entities in Vermont, in 2011 the DVHA applied for, and on January 10, 2012 received, federal approval for

a Medicaid pricing 340B methodology.

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

Claims are paid at the regular rates and a monthly true-up process calculates the 340B acquisition cost, dispensing fees, savings, and what is owed back to the state with payments due 30 days after the invoices are mailed. Currently, Community Health Pharmacy and its five FQHCs continue to participate. In addition, Notch Pharmacy, Central Vermont Medical Center, Planned Parenthood of Northern New England, and Fletcher Allen Health Care have all been enrolled with Medicaid since January 2011. In 2012, all of Fletcher Allen's outpatient pharmacies also enrolled and in 2013 Springfield Hospital and Indian Stream Health Care enrolled with Medicaid. DVHA continues to encourage Medicaid enrollment with the goal of enrolling all eligible and HRSA-enrolled covered entities in Vermont.

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

#### *Safeguards for Overprescribing*

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

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

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

DVHA's Drug Utilization Review and Program Integrity Unit's programs continue to develop and run data-mining queries to detect improper prescribing, dispensing, and reimbursement. Findings are discussed, as deemed necessary and appropriate, with various other departments and agencies including,

but not limited to the Pharmacy Unit, Clinical Utilization Review Board (CURB), Drug Utilization Review Board (DURB), and the Clinical Unit. If potential fraud is detected, the Program Integrity unit may refer cases to the Attorney General's Medicaid Fraud and Residential Abuse unit (MFRAU), the Vermont Medical Practice Board, and/or the Secretary of State's Office of Professional Regulations (OPR). Any Program Integrity investigation may also run parallel or in conjunction with any other investigation initiated by MFRAU, Vermont Medical Practice Board and/or OPR. Standard Program Integrity guidelines and protocols are utilized to ensure appropriate steps are taken.

### 340B Reimbursement and Calculation of Incentive Payment

#### Determination of Dispensing Fee and Savings Sharing Amounts

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

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

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

Vermont's proposed reimbursement methodology establishes a flat rate payment at the low end of this range (\$15.00) and presents the opportunity, subject to demonstrated Medicaid program savings, for entities to share in Medicaid savings. We believe the proposed approach represents an innovative payment strategy that reasonably reimburses pharmacies, encourages covered entity participation and promotes program savings. This methodology can enable substantial expansion participation in 340B. Using the Global Commitment authority, DVHA provides incentive payments to providers for their 340B participation that recognizes the additional administrative burden of the program. Because of the beneficial 340B pricing, both Vermont and CMS benefit from greater participation in the program.

Because of federal laws prohibiting "duplicate discounts" on Medicaid drug pricing related to the interaction of 340B and manufacturer rebate programs, Medicaid participation in 340B has been limited both in Vermont and nationally. Vermont has put in place an innovative, first in the nation methodology to maximize Medicaid participation in 340B pricing for Medicaid beneficiaries served by eligible prescribers at 340B enrolled covered entities. This methodology can enable substantial expansion participation in 340B. Using the Global Commitment authority, DVHA provides incentive payments to providers for their 340B participation that recognizes the additional administrative burden of the program. Because of the beneficial 340B pricing, both Vermont and CMS benefit from higher 340B covered entity-employed prescriber and Medicaid beneficiary participation in the program. For the reporting period, Vermont has realized \$319,634.503 for Q3 2013 Net Cost savings through Medicaid participation of a relatively small

number of eligible covered entities. Total savings to-date for CY 2013 is \$1,135,614.55. DVHA is focused on outreach and education of all Vermont covered entities to encourage enrollment in the 340B discount program.

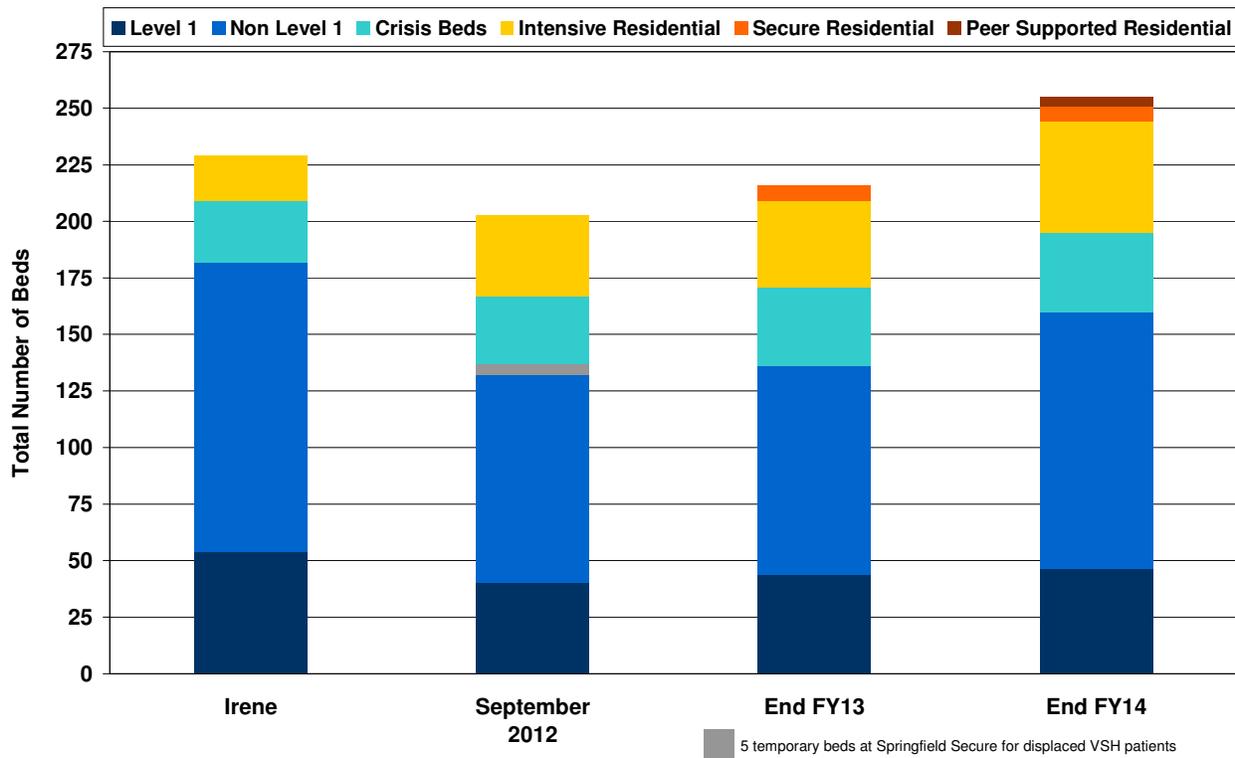
**Mental Health System of Care**

*State Hospital Inpatient Replacement Planning*

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

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

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



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

GMPCC secured its JCAHO accreditation during this period and anticipates receiving deemed status for its certification by the Centers for Medicare and Medicaid Services (CMS). All documentation for this has been submitted, revised, and accepted by JCAHO, and the notice of deemed status is expected shortly.

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

Development of two additional residential programs continue to move forward. Pathways-Vermont is on-track to open a five-bed residential program as an alternative treatment option for individuals seeking to avoid or reduce reliance on medication, and Rutland Mental Health Services continues to work toward the completion of a 4-bed intensive residential recovery program in Rutland with room for expanding the building to eight beds without changing the building footprint.

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

### Community System Development

Act 79 authorized significant investments in a more robust publicly funded mental health services system for Vermont. Fiscal Year 13 funding supports the implementation of service expansion in several support and services areas that will offer a stronger continuum of care for the public mental health system. Each new initiative carries reporting requirements to inform the Department of Mental Health (DMH) regarding overall contribution to the system of care and impacts to persons served. A full report of Act 79 funded initiatives and early outcomes were submitted to the Vermont Legislature on January 15, 2013. The report provided an overview of the significant program development areas and preliminary data collection and outcomes findings.

As referenced in last quarter's report, a number of community initiatives continue to move forward, many of which were authorized by Act 79 as significant investments in a more robust publicly funded mental health services system for Vermont. Fiscal Year 13 funding supports the implementation of service expansion in several support and services areas that will offer a stronger continuum of care for the public mental health system. A highlight of initiatives include::

- Vermont Psychiatric Survivors began operation of a peer-based outreach program for individuals with mental health disorders who have recently experienced incarceration, substance abuse issues, homelessness, and/or inpatient hospitalization and are at risk for additional hospitalization or incarceration.

- DMH partnered with its designated community mental health agencies and other stakeholders to create the *Vermont Cooperative for Practice Improvement and Innovation* (VCPI), and independent organization focused on mental health workforce development and practice improvement for Vermont’s mental health and substance abuse services and related systems.
- Law enforcement and mobile mental health program trainings focusing on response to individuals with mental illness have continued through a dedicated trainer/facilitator contractor and a cadre of mental health and peer participants.
- DMH continues to work with Designated Agencies to expand their capacity to provide mobile crisis response and expanded adult outpatient services for individuals not eligible for Community Rehabilitation Services.
- DMH continues to provide a system “snapshot” of service capacity and utilization for legislative review in order to apprise legislators and key stakeholders of:
  - occupancy rates of both crisis and intensive residential programs;
  - forensic screenings and their outcomes;
  - statewide suicide statistics;
  - stably housing service recipients;
  - intensive residential recovery program occupancy
  - wait times for psychiatric inpatient care from Emergency Departments; and
  - inpatient psychiatric admission and length of stay trends to Designated Hospitals

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

- Increasing access to supported employment services in Designated Agencies and Peer-Run Support Programs;
- Service support and access to DOC involved individuals and families either in the community or in correctional facilities
- Mental Health service capacity for older Vermonters
- Service capacity for individuals with both intellectual and mental health disability
- Access to non-categorical case management services
- Technical Assistance to Designated Agencies and Hospitals for complex need individuals
- Health Reform efforts encompassing new State grant opportunities, including the roll out of Vermont Health Connect;
- Information technology enhancement that will support data collection and reporting capacities

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

#### Integrated Family Services (IFS) Initiative

The AHS continues to act on opportunities to improve quality and access to care, within existing budgets, using managed care flexibilities and payment reforms available under 42 CFR 438 and the Global Commitment (GC) waiver. This includes such items as: integration of administrative structures for

programs serving the same or similar populations; opportunities to increase access to services by decreasing administrative burdens on providers; reviewing pre-GC waiver operations to determine if separate administrative and Medicaid reimbursement structures can be streamlined under GC. Several such projects have emerged in the Children's and EPSDT service area.

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

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

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

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

- Increased ability to provide the right services to children and their families more immediately.
- Increased ability to provide services in a child's natural setting.
- Increased ability to work with a variety of providers and bring resources together to support families.
- Reduction in separate and conflicting paperwork having a positive impact on the number of hours clinicians can spend on direct services.
- A more immediate response to families who ask for help who, prior to this pilot, were "not sick enough" to meet funding criteria.
- Unified local efforts to offer a single onsite response to families combining multiple state and federal programs that would otherwise be offered at differing times and places.

The financial model supporting this agreement includes a monthly PMPM rate established for the reimbursement of all Medicaid-covered sub-specialty services. Member month rates are based on agreed upon annual allocations for covered services divided by the minimum Medicaid caseload expectation. The

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

This shift continues to be addressed both programmatically and financially. There is a review of the method used to establish the PMPM to see if there is a more effective method. There are currently three other regions interested in undertaking this model. The second pilot region will be in effect January 1, 2014 with a third potential in effect July 1, 2014. We have also applied for a CMMI grant to bring resources to this project to more fully develop the funding and service delivery model. The interest in moving state-wide continues and more providers including Federally Qualified Health Centers are expressing interest in being a part of this initiative. Additionally IFS continues to work on state-wide healthcare reform and aligning approaches in order to achieve an integrated behavioral health and physical health system.

### **Financial/Budget Neutrality Development/Issues**

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

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

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

AHS has received deferral notices from CMS for its QE1212 GlobalRx MEG claim on March 28, 2013, a deferral notice from CMS for its QE0313 GlobalRx MEG claim on June 27, 2013. AHS has been working since the first deferral notification to provide CMS with assurance that the claiming is appropriate for this MEG, so that the Federal financial participation for these claims will be released. Additionally, it is the AHS’s position that this issue is resolved with waiver renewal and updated STC language; AHS awaits confirmation from CMS to this effect. AHS has had to absorb the cash flow shortfalls caused by these deferrals and have requested that CMS Regional Office recognize that AHS could claim these costs as MCO Investments until the overall issue of whether or not this is an allowable program cost is resolved.

## Member Month Reporting

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

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

Demonstration Population	Month 1 7/31/20 13	Month 2 8/31/20 13	Month 3 9/30/20 13	Total for Quarter Ending 4th Qtr FFY '13	Total for Quarter Ending 3rd Qtr FFY '13	Total for Quarter Ending 2nd Qtr FFY '13	Total for Quarter Ending 1st Qtr FFY '13	Total for Quarter Ending 4th Qtr FFY '12	Total for Quarter Ending 3rd Qtr FFY '12
Demonstration Population 1:	48,499	48,513	48,434	145,446	145,178	146,690	145,618	145,197	142,952
Demonstration Population 2:	43,858	43,906	43,717	131,481	132,125	136,453	130,969	131,709	132,537
Demonstration Population 3:	9,869	9,939	9,810	29,618	29,439	29,377	29,302	29,326	29,076
Demonstration Population 4:	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Demonstration Population 5:	896	883	878	2,657	2,748	2,769	3,024	2,955	3,012
Demonstration Population 6:	2,980	2,926	2,920	8,826	9,790	9,871	10,063	9,795	9,536
Demonstration Population 7:	35,935	35,751	35,668	107,354	109,242	108,099	106,273	107,004	107,528
Demonstration Population 8:	10,116	10,167	10,222	30,505	30,450	30,236	29,808	29,086	30,939
Demonstration Population 9:	2,607	2,599	2,588	7,794	7,833	7,962	8,101	7,970	7,874
Demonstration Population 10:	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Demonstration Population 11:	13,069	13,406	13,618	40,093	36,909	35,775	36,702	35,797	35,175

There were two Demonstration Populations that had a fluctuation greater than 5%: Demonstration Population 6 and 11. As the State prepares to implement Vermont Health Connect, it is anticipated these fluctuations are due to impending eligibility changes. The overall population, in sum, between FFY13 Q3 and FFY13 Q4 is different by 0.0001% (n=60).

## Consumer Issues

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

weekly reports are seen by several management staff at DVHA and staff ask for additional information on complaints that may appear to need follow-up to ensure that the issue is addressed.

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

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

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

### **Quality Assurance/Monitoring Activity**

During this quarter the three required External Quality Review activities took place (i.e., validation of performance improvement project, validation of performance measures, and review of compliance with standards). For this year's 2012–2013 performance improvement project validation, DVHA submitted its continuing PIP topic: *Increasing Adherence to Evidence-Based Pharmacy Guidelines for Members Diagnosed with Congestive Heart Failure*. The PIP topic addresses the appropriate use of medications for the treatment of congestive heart failure (CHF). In its PIP evaluation and validation, the EQRO used the Centers for Medicare & Medicaid Services (CMS) publication, *Validating Performance Improvement Projects: A Protocol for Use in Conducting Medicaid External Quality Review Activities*, final protocol, Version 1.0, May 1, 2002 (CMS PIP Protocol).

During the review, the EQRO evaluated the technical structure of the PIP to ensure that DVHA designs, conducts, and reports the PIP in a methodologically sound manner, meeting all State and federal requirements. The EQRO's review determined that the PIP design (e.g., study question, indicator(s), population, sampling techniques, data collection methodology, and data analysis plan) and implementation was based on sound methodological principles and could reliably measure outcomes. The PIP received an overall *Met* validation status when originally submitted. DVHA elected not to resubmit the PIP for a second and final validation because the one evaluation element that received a *Not Met* validation score was related to indicator outcomes and could not be improved with a resubmission. Overall, 96 percent of all applicable evaluation elements received a score of *Met*. The percentage of applicable evaluation elements *Met* remained the same as the 2011–2012 validation score with the same evaluation element in Activity IX receiving a *Not Met* score.

The EQRO conducted the validation of performance measures activities as outlined in the Centers for Medicare & Medicaid Services (CMS) publication, *EQR Protocol 2: Validation of Performance Measures Reported by the MCO: A Mandatory Protocol for External Quality Review (EQR), Version 2.0, September 1, 2012*. The EQRO conducted the review via the following off site activities: *Information Systems Capabilities Assessment Tool (ISCAT) and supporting documents, source code (programming language) for performance measures, and SFY 2011–2012 Validation of Performance Measures report*. On-site

activities included the following: evaluation of system compliance, overview of data integration and control procedures, and opening/closing conferences.

The EQRO determined that all performance measures were fully compliant with the specified standards and AHS should accept the measures as reliable and valid. Finally, the EQRO reviewed DVHA's ability to comply with the Centers for Medicare & Medicaid Services (CMS) Access Standards (42 CFR 438 §206-210), the enrollment and disenrollment requirements from the CMS Structure and Operation Standards, at 42 CFR §438.226 as well as state-specific requirements contained in the AHS/DVHA intergovernmental agreement (IGA). The EQRO performed an office-based desk review of DVHA's documents as well as an on-site review that included reviewing additional documents, observing demonstrations of DVHA's information system capabilities related to areas such as coordination of care, and conducting interviews with key DVHA staff members. Of the 71 applicable requirements, DVHA obtained a score of *Met* for 69 of the requirements and a score of *Partially Met* for 2 elements. As a result, DVHA obtained a total percentage of compliance score of 98.59 percent across the applicable elements, for a rounded score of 99.0 percent compliance. DVHA's performance represented a substantive improvement from its performance in the EQRO's 2009–2010 review of the same standards.

### *DVHA Quality Improvement and Compliance*

The DVHA Quality Committee held meetings to finalize the Quality Plan and Work Plan, identify performance/process improvement projects, approve a new formal performance improvement project, and receive ongoing updates on the progress of the Adult Quality Measures Grant. Members of the DVHA Quality Unit met with representatives of each of the IGA partners to assist in the development of their Quality Plans. Work continues on identifying the quality indicators that each of the IGA partners will be reporting to the DVHA Quality Committee.

The Managed Care Medical Committee approved a new performance improvement project focusing on improving follow-up care after psychiatric hospitalization. The project will be led by the DVHA Quality Unit and monitored by the Quality Committee. The DVHA Quality Unit made significant progress on the two performance improvement projects funded by the Adult Quality Measures Grant. The two projects are focused on increasing breast cancer screenings and improving initiation and engagement in substance abuse treatment. Project teams have identified the study populations and have developed interventions. Both projects include partners across the Agency of Human Services as well as community partners and stakeholders. In addition to the three formal performance improvement projects, DVHA continues to participate in the Agency Improvement Model (AIM) trainings and has three informal process improvement projects underway. These three projects focus on improving the out-of-state referral process, decreasing the time for out-of-state provider enrollment exceptions, and increasing awareness of the psychiatric emergency bed programs. The DVHA Quality Unit and the DVHA Policy Unit met to review the grievance and appeal reporting process to develop improved data output to identify areas for improvement. The DVHA Quality Improvement Director attended the AHS Performance Accountability Committee meetings during this quarter.

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

The Managed Care Medical Committee performed the final review of the Buprenorphine Practice Guidelines and the guidelines were approved. A new provider mapping tool was presented to the committee which will improve the committee's ability to assess access to services. The new tool will

provide the committee with data on travel times to PCPs and specialty care providers.

During this quarter, the AHS Performance Accountability Committee (PAC) reviewed the AHS strategic plan and Medicaid/Commercial Share Savings payment/reporting measures. It is expected that the group will use the AHS strategic plan to inform the quality strategy. The group is tasked with reviewing and recommending performance measures that can be used to evaluate the performance of the AHS strategic plan, Vermont's Managed Care Medicaid program, and Vermont's Long Term Care Medicaid program. When selecting performance measures, the group will draw from various measure sets that support a variety of health reform initiatives in Vermont. Data sets include: but are not limited to the following: Medicaid child/adult core measures, meaningful use, NQF, MSSP, CAHPS, and HEDIS.

### Quality Strategy

Once the final EQRO Annual Technical Report is published, the AHS Performance Accountability Committee (PAC) will re-evaluate the strategy using the findings. 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.

### **Demonstration Evaluation**

During this quarter, the AHS QIM continued to work with staff at the Pacific Health Policy Group (PHPG) on the evaluation. It is important that the evaluation be informed by the various health reform activities taking place in Vermont and their respective evaluations.

### **Reported Purposes for Capitated Revenue Expenditures**

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

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

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

### **Enclosures/Attachments**

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

Attachment 1: Catamount Health Enrollment and Expenditure Report

Attachment 2: Budget Neutrality Workbook

Attachment 3: Complaints Received by Health Access Member Services

Attachment 4: Medicaid Managed Care Entity Grievance and Appeal Reports

Attachment 5: Office of Health Care Ombudsman Report

Attachment 6: DVHA Managed Care Entity Investment Summary

**State Contact(s)**

Fiscal:	Jim Giffin, CFO VT Agency of Human Services 208 Hurricane Lane Williston, VT 05495	802-871-3005 (P) 802-871-3001 (F) <a href="mailto:jim.giffin@state.vt.us">jim.giffin@state.vt.us</a>
Policy/Program:	Stephanie Beck, Director AHS Health Care Operations, Compliance, and Improvement VT Agency of Human Services 208 Hurricane Lane Williston, VT 05495	802-871-3265 (P) 802-871-3001 (F) <a href="mailto:stephanie.beck@state.vt.us">stephanie.beck@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: December 10, 2013**

## **ATTACHMENTS**



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

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

**The Department of Vermont Health Access**  
**Caseload and Expenditure Report - All AHS Medicaid Spend**  
**All AHS YTD '14**  
 Wednesday, November 13, 2013

	SFY '14 Appropriated			SFY '14 Actuals thru Sept. 30, 2013			% of Approp. Spent to Date
	Caseload	Expenses	PMPM	Caseload	Expenses	PMPM	
ABD Adult	14,360	\$ 179,018,321	\$ 1,038.85	14,492	\$ 41,887,624	\$ 963.44	23.40%
ABD Dual	17,800	\$ 204,134,462	\$ 955.68	17,220	\$ 41,033,752	\$ 794.30	20.10%
General Adult	11,993	\$ 78,498,571	\$ 545.46	11,194	\$ 18,550,564	\$ 552.38	23.63%
VHAP	37,652	\$ 102,350,924	\$ 453.06	37,960	\$ 42,765,847	\$ 375.53	41.78%
VHAP ESI	785	\$ 718,777	\$ 152.54	790	\$ 366,029	\$ 154.44	50.92%
Catamount	12,372	\$ 31,247,379	\$ 420.94	11,685	\$ 17,953,933	\$ 512.16	57.46%
ESIA	789	\$ 617,260	\$ 130.39	760	\$ 239,014	\$ 104.78	38.72%
New Adult	34,490	\$ 86,353,450	\$ 418.10			N/A	
Exchange Premium Assistance	40,748	\$ 6,586,587	\$ 13.47			N/A	
Exchange Cost Sharing	44,954	\$ 1,484,460	\$ 2.75			N/A	
ABD Child	3,740	\$ 90,359,755	\$ 2,013.24	3,648	\$ 20,851,918	\$ 1,905.33	23.08%
General Child	55,762	\$ 234,168,217	\$ 349.95	55,390	\$ 49,843,081	\$ 299.95	21.29%
Underinsured Child	993	\$ 2,137,306	\$ 179.38	928	\$ 450,519	\$ 161.88	21.08%
SCHIP	4,180	\$ 9,928,458	\$ 197.95	3,883	\$ 2,019,504	\$ 173.35	20.34%
Pharmacy Only	12,669	\$ 2,795,616	\$ 18.39	12,689	\$ 1,673,430	\$ 43.96	59.86%
Choices for Care	3,850	\$ 200,240,791	\$ 4,333.90	3,894	\$ 51,129,157	\$ 4,377.12	25.53%
<b>Total Medicaid</b>	<b>297,138</b>	<b>\$ 1,230,640,335</b>	<b>\$ 345.14</b>	<b>174,534</b>	<b>\$ 288,764,372</b>	<b>\$ 551.50</b>	<b>23.46%</b>



**State of Vermont**  
**Department of Vermont Health Access**  
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 [Phone] 802-879-5900  
 [Fax] 802-879-5651

**The Department of Vermont Health Access**  
**Caseload and Expenditure Report ~ DVHA Only Medicaid Spend**  
**DVHA YTD '14**  
 Wednesday, November 13, 2013

	SFY '14 Appropriated			SFY '14 Actuals thru Sept. 30, 2013			% of Approp. Spent to Date
	Caseload	Expenses	PMPM	Caseload	Expenses	PMPM	
ABD Adult	14,360	\$ 103,769,271	\$ 602.18	14,492	\$ 25,906,578	\$ 595.87	24.97%
ABD Dual	17,800	\$ 49,420,740	\$ 231.37	17,220	\$ 11,848,250	\$ 229.35	23.97%
General Adult	11,993	\$ 70,661,558	\$ 491.00	11,194	\$ 16,876,881	\$ 502.54	23.88%
VHAP	37,652	\$ 90,183,196	\$ 350.51	37,960	\$ 40,429,564	\$ 355.02	44.83%
VHAP ESI	785	\$ 718,777	\$ 150.76	790	\$ 365,650	\$ 154.28	50.87%
Catamount	12,372	\$ 31,247,379	\$ 411.99	11,685	\$ 17,953,933	\$ 512.16	57.46%
ESIA	789	\$ 617,260	\$ 130.34	760	\$ 239,014	\$ 104.78	38.72%
New Adult	34,490	\$ 86,353,450	\$ 418.10			N/A	
Exchange Premium Assistance	40,748	\$ 6,586,587	\$ 13.47			N/A	
Exchange Cost Sharing	44,954	\$ 1,484,460	\$ 2.75			N/A	
ABD Child	3,740	\$ 29,286,530	\$ 652.51	3,648	\$ 10,364,191	\$ 947.02	35.39%
General Child	55,762	\$ 122,779,838	\$ 183.49	55,390	\$ 31,155,658	\$ 187.49	25.38%
Underinsured Child	993	\$ 650,907	\$ 54.63	928	\$ 187,590	\$ 67.41	28.82%
SCHIP	4,180	\$ 7,019,478	\$ 139.95	3,883	\$ 1,948,740	\$ 167.27	27.76%
Pharmacy Only	12,669	\$ 2,795,616	\$ 18.39	12,689	\$ 1,673,430	\$ 43.96	59.86%
Choices for Care	3,850	\$ 200,240,791	\$ 4,393.62	3,894	\$ 51,129,157	\$ 4,377.12	25.53%
<b>Total Medicaid</b>	<b>297,138</b>	<b>\$ 803,815,839</b>	<b>\$ 225.43</b>	<b>174,534</b>	<b>\$ 210,078,637</b>	<b>\$ 401.22</b>	<b>26.14%</b>

Global Commitment Expenditure Tracking

QE	Quarterly Expenditures									Net Program PQA	Net Program Expenditures as reported on 64	non-MCO Admin Expenses	Total columns J-K for Budget Neutrality calculation	Cumulative Waiver Cap per 1/1/11 STCs	Variance to Cap under/(over)	
	PQA: WY1	PQA: WY2	PQA: WY3	PQA: WY4	PQA: WY5	PQA: WY6	PQA: WY7	PQA: WY8	PQA: WY9							
1205	\$ 178,493,793										\$ 178,493,793					
0306	\$ 189,414,365	\$ 14,472,838									\$ 14,472,838	\$ 203,887,203				
0606	\$ 209,647,618	\$ (14,172,165)									\$ (14,172,165)	\$ 195,475,453				
0906	\$ 194,437,742	\$ 133,350									\$ 133,350	\$ 194,571,092				
WY1 SUM	\$ 771,993,518	\$ 434,023									\$ 434,023	\$ 782,159,845	\$ 4,620,302	\$ 786,780,147	\$ 841,266,663	\$ 54,486,516
1206	\$ 203,444,640	\$ 8,903									\$ 8,903	\$ 203,453,543				
0307	\$ 203,804,330	\$ 8,894,097									\$ 8,894,097	\$ 212,698,427				
0607	\$ 186,458,403	\$ 814,587	\$ (68,408)								\$ 746,179	\$ 187,204,582				
0907	\$ 225,219,267	\$ -	\$ -								\$ -	\$ 225,219,267				
WY2 SUM	\$ 818,926,640	\$ 9,717,587	\$ (68,408)								\$ 9,649,179	\$ 802,884,359	\$ 6,464,439	\$ 809,348,797	\$ 1,684,861,317	\$ 88,732,372
Cumulative														\$ 1,596,128,945	\$ 2,604,109,308	\$ 119,793,211
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														\$ 2,484,316,097	\$ 2,604,109,308	\$ 119,793,211
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														\$ 3,425,180,534	\$ 3,606,430,571	\$ 181,250,037
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														\$ 4,444,110,832	\$ 4,700,022,174	\$ 255,911,342
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														\$ 5,495,525,000	\$ 5,865,213,737	\$ 369,688,737
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														\$ 6,635,802,617	\$ 7,113,290,903	\$ 477,488,286
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	\$ 1,193,737,131	\$ 6,187,003	\$ 1,199,924,134	\$ 8,450,684,486	\$ 614,957,735
Cumulative														\$ 7,835,726,751	\$ 8,450,684,486	\$ 614,957,735
1213											\$ -	\$ -				
0314											\$ -	\$ -				
0614											\$ -	\$ -				
0914											\$ -	\$ -				
WY9 SUM	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	
Cumulative														\$ 7,835,726,751	\$ 8,955,886,798	\$ 1,120,160,047
	\$ 7,599,180,016	\$ 10,166,327	\$ (16,042,281)	\$ 79,876,130	\$ 41,153,315	\$ 19,453,990	\$ 4,878,725	\$ 48,036,100	\$ 2,037,093	\$ -		\$ 7,788,739,415	\$ 46,987,336			

PQA = Prior Quarter Adjustments

**Complaints Received by Health Access Member Services**  
**July 1, 2013 – October 5, 2013**

Eligibility forms, notices, or process	23
ESD Call-center complaints (IVR, rudeness, hold times)	0
Use of social security number as identifiers	0
General premium complaints	4
Catamount Health Assistance Program premiums, process, ads, plans	3
Coverage rules	2
Member services	1
Eligibility rules	0
Eligibility local office	0
Prescription drug plan complaint	0
Copays/service limit	0
Pharmacy coverage	0
Provider issues (perceived rudeness, refusal to provide service, prices) (variety of provider types)	2
Provider enrollment issues	0
Chiropractic coverage change	0
Shortage of enrolled dentists	0
Green Mountain Care Website	0
DVHA	0
<hr/> Total	<hr/> 35



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

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

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

During this quarter, there were 18 grievances filed with the MCE; eleven were addressed during the quarter one was withdrawn and two were filed to late. 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 three days. Of the grievances filed, 83% were filed by beneficiaries, and 17% were filed by a representative of the beneficiary. Of the 18 grievances filed, DMH had 83% and DVHA had 17%. There were no grievances filed for the DAIL, DCF, or VDH during this quarter.

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

There were no Grievance Reviews filed this quarter.

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

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

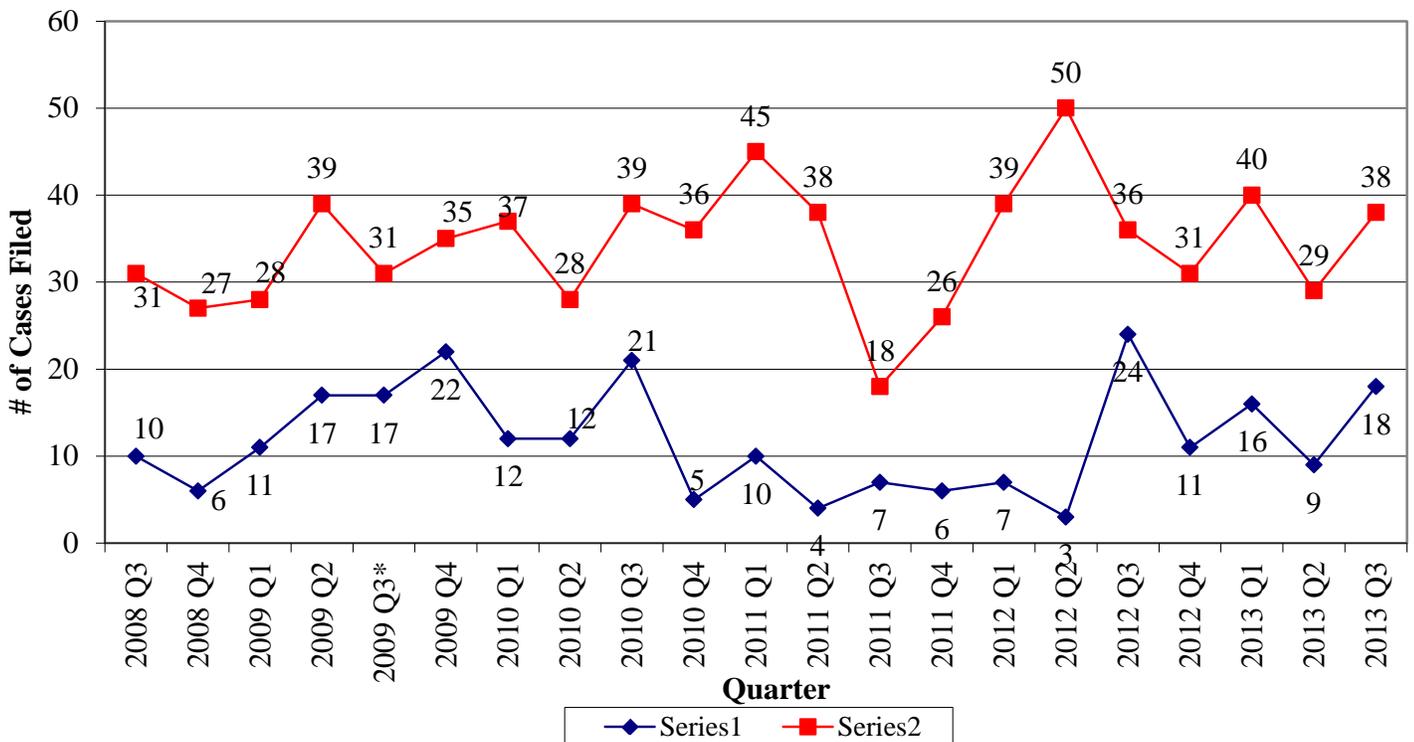
During this quarter, there were 38 appeals filed with the MCE; 9 requested an expedited decision with seven of them meeting criteria. Of these 38 appeals, 25 were resolved (66% of filed appeals), 12 were still pending (31%), and one was withdrawn (3%). In thirteen cases (52% of those resolved), the original decision was upheld by the person hearing the appeal, ten cases (40% of those resolved) were reversed, and two were approved by the applicable department/DA/SSA before the appeal meeting (8% of those resolved).

Of the 25 appeals that were resolved this quarter, 92% were resolved within the statutory time frame of 45 days; 88% were resolved within 30 days. The average number of days it took to resolve these cases was 13 days. Acknowledgement letters of the receipt of an appeal must be sent within five days; the average was one day.

Of the 38 appeals filed, 25 were filed by beneficiaries (66%), 8 were filed by a representative of the beneficiary (21%) and 5 were filed by the provider (13%). Of the 38 appeals filed, DVHA had 55%, DAIL had 24%, VDH had 13% and DMH had 8%.

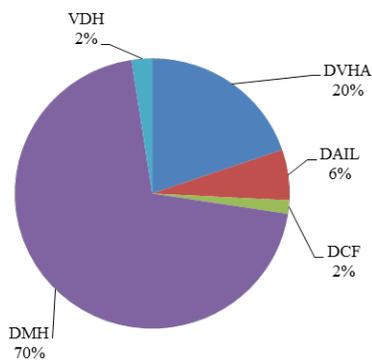
Beneficiaries can file an appeal and a fair hearing at the same time, and they can file a fair hearing if their appeal is not decided in their favor. There was one fair hearing filed this quarter.

### Medicaid MCE Grievances & Appeals

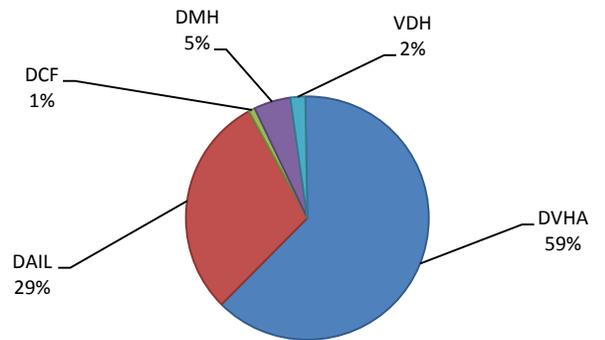


### MCE Grievance & Appeals by Department From July 1, 2008 through September 30, 2013

#### Grievances



#### Appeals



# VERMONT LEGAL AID, INC.

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## QUARTERLY REPORT

July 1, 2013 – September 30, 2013

to the

DEPARTMENT OF FINANCIAL REGULATION

and the

DEPARTMENT OF VERMONT HEALTH ACCESS

submitted by

Trinka Kerr, Vermont Health Care Ombudsman

October 21, 2013

### I. Introduction

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 July 1, 2013, through September 30, 2013. In addition to operating a hotline to provide individual consumer assistance, the HCO also engages in consumer protection activities such as representing the public in Green Mountain Care Board rate reviews.

The following information is contained in this quarterly report:

- This narrative section which includes **Individual Consumer Assistance, Consumer Protection Activities** and a **Website update**
- Five data reports
  - **All calls/all coverages:** 751 calls
  - **DVHA beneficiaries:** 367 calls or **49%** of total calls
  - **Commercial plan beneficiaries:** 103 calls or **14%**
  - **Uninsured Vermonters:** 85 calls or **11%**
  - **Health Website Usage Report**

### II. Individual Consumer Assistance

The HCO provides assistance to consumers through our statewide hotline. In preparation for the launching of Vermont Health Connect in October, this quarter we hired two new advocates. This means we now have a total of seven advocates to provide help to individuals through our hotline and our website. We also leased new space at the back of our current building which is being renovated to accommodate this increase in staffing.

With regard to services we provide to individuals, note that our case management 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 202 cases had Eligibility for DVHA programs as the primary issue, there were actually a total of 399 calls in which we spent a significant amount of time assisting consumers regarding access to health insurance. In each section of this narrative we record whether we are referring to data based on just primary issues, or both primary and secondary issues. 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 other than the primary reason for their call.]

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

#### **A. Total call volume increased 4% from last quarter.**

The HCO received 751 calls this quarter, compared to 721 last quarter. We received 769 calls in the third quarter of 2012. July's call volume was 270, higher than last year's July total of 255. August's was 224, significantly lower than last year's August total of 263. And September's call volume of 256 was close to last September's 251. There was no identifiable reason for the decrease in August.

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

- **25.83%** (194) of our total calls were regarding **Access to Care**;
- **15.31%** (115) were regarding **Billing/Coverage**;
- **1.73%** (13) were questions regarding **Buying Insurance**;
- **9.05%** (68) were **Consumer Education**;
- **26.90%** (202) were regarding **Eligibility** for state programs, Medicare and Catamount Health plans; and
- **21.17%** (159) were categorized as **Other**, which includes Medicare Part D, communication problems with providers or plans, access to medical records, changing providers or plans, enrollment problems, confidentiality issues, and complaints about insurance premium rates.

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

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

All Calls (751, compared to 721 last quarter)

1. Affordability 137 (compared to 116 last quarter)
2. Information about applying for DVHA programs 127 (113 last quarter)
3. Complaints about Providers 105 (104 last quarter)
4. Eligibility for VHAP 79 (69 last quarter)
5. Eligibility for Medicaid 64 (57 last quarter)
6. Communication Problems with ESD 56 (69 last quarter)
7. Access to Prescription Drugs 51 (73 last quarter)
8. Eligibility for Premium Assistance 39 (30 last quarter)
9. Consumer Education about Fair Hearings 37 (31 last quarter)
10. Medicaid Buy In programs 36 (20 last quarter)
11. Consumer Education about Medicare 33 (28 last quarter)
12. Medicaid Spend Down program 31 (27 last quarter)  
Hospital Billing 31 (19 last quarter)
13. Consumer Education about the ACA 30 (24 last quarter)  
Access to Specialty Care 30 (29 last quarter)
14. Transportation to medical care 25 (30 last quarter)  
Billing-Premiums 25 (10 last quarter)
15. Marketplace inquiries-general 24 (not tracked last quarter)
16. ESD Eligibility Mistake 23 (17 last quarter)
17. Access to Mental Health treatment 22 (38 last quarter)  
Medicare Billing 22 (18 last quarter)
18. Hospital Financial Assistance 21 (11 last quarter)
19. Communication Problems with insurer 20 (16 last quarter)
20. Consumer Education about health care reform 19 (9 last quarter)  
Access to Pain Management treatment 19 (16 last quarter)

Three issues that fell off the list this quarter were:

- Access to Substance Abuse treatment 10 (22 last quarter)
- Access to Durable Medical Equipment & Supplies 16 (19 last quarter)
- Access to Dental Care 16 (18 last quarter)

DVHA Beneficiary Calls (367, compared to 364 last quarter)

1. Complaints about Providers 66 (56 last quarter)
2. Information about applying for DVHA programs 56 (43 last quarter)
3. Affordability 43 (49 last quarter)
4. Eligibility for VHAP 34 (34 last quarter)
5. Communication Problems with ESD 27 (37 last quarter)
6. Consumer Education about Fair Hearings 25 (28 last quarter)
7. Transportation to medical care 24 (27 last quarter)  
Eligibility for Medicaid 24 (25 last quarter)
8. Access to Prescription Drugs 23 (43 last quarter)
9. Access to Specialty Care 21 (16 last quarter)
10. Access to Primary Care Doctor 16 (9 last quarter)

11. Eligibility for Medicaid Spend Down 15 (13 last quarter)
  - Hospital Billing 15 (7 last quarter)
  - ESD Eligibility Mistake 15 (7 last quarter)
12. Medicaid Billing 14 (13 last quarter)
13. Access to Durable Medical Equipment & Supplies 13 (11 last quarter)
  - Buy In Programs 13 (9 last quarter)
14. Access to Pain Management Treatment 12 (11 last quarter)
15. Consumer Education about HIPAA 12 (1 last quarter)
16. Consumer Education about the ACA 11 (5 last quarter)
  - Eligibility for Premium Assistance 11 (9 last quarter)
17. Access to Mental Health treatment 10 (20 last quarter)
  - Access to Dental Care 10 (8 last quarter)
  - Billing Problems with providers 10 (11 last quarter)
  - Consumer Education about Health Care Reform 10 (3 last quarter)
  - Consumer Education about VHC 10 (not tracked last quarter)

One issue fell off the list from last quarter:

- Access to Substance Abuse treatment 4 (15 last quarter)

**C. The HCO did not see a big increase in calls leading up to the October launch of Vermont Health Connect, but more consumers did ask questions about the marketplace .**

Our calls about the exchange or marketplace did not increase as much as we expected this quarter. This may be because people are going to Vermont Health Connect’s website, calling the expanded VHC Customer Support line and going to Navigators for information as the State’s education and outreach effort has recommended.

However, the HCO is continuing to get more callers asking about what the changes will mean for them. We coded these cases as “Info re the ACA”. This quarter we received 30 such inquiries. Last quarter we received 24, and just 10 the quarter before that. See the next section about how we are coding calls about health care reform.

We expect to get more calls and questions as the roll out of VHC continues.

**D. The HCO needs to improve its coding related to health care reform and the launch of Vermont Health Connect.**

The above analysis brings out some issues with our data collection right now. Because it is relatively easy for us to add new issue fields to our case management system, we have added several related to health care reform in the last few months. Here are the codes we had this quarter to track Affordable Care Act related issues, along with the number of times we received calls about the issue and coded it as the primary reason for the call:

#### Billing/Coverage

- Lifetime caps – 0 calls

#### Buying Insurance

- Buying QHPs through VHC - 1
- Marketplace Inquiries – 6
- Individual/Small group – 2
- Tax advisor problem - 0

#### Consumer Education

- Health Care Reform - 3
- Info re ACA – 10
- Info re VHC – 7

#### Eligibility

- College student/young adult – 4
- MAGI Medicaid – 0
- Premium Tax Credit – 0
- Seasonal Employment -0
- Small business owner – 1
- Young adults & parental plans – 0

#### Other

- Exchange – 0
- Family Law interface with health insurance – 5
- Pre-existing condition – 0
- VHC complaints - 0

We will spend some time in the next few weeks clarifying what each of these codes means and when they should be used, as well as determining what new codes we should create. We are open to suggestions about what issues we should track.

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

The high cost of health care continued to be the most-identified barrier to access to health care. The HCO had 137 calls, 18% of all calls, in which the consumer said that cost was making it difficult for them to get care. This is slightly higher than the percentage of such calls last quarter. Of these 137 calls, 43 or 31 % were from DVHA beneficiaries. The inability to access care due to the cost of a service, or the cost of insurance, is an issue for consumers across all groups, those insured by state programs, federal programs, private companies, and the uninsured.

#### **F. Desire for more information about DVHA programs remains high.**

The HCO continues to provide consumer education about DVHA programs to a high percentage of callers, which is related to the affordability problem. It was once again the second most common issue overall, with 127 calls. Interest in DVHA's programs is due to a number of factors: the cost of commercial plans and health care generally, the high degree of complexity of the programs which results in questions about the rules and navigating the requirements for eligibility, confusing notices from the Economic Services Division (ESD), and insufficient education provided by ESD eligibility staff or Member Services.

#### **G. Complaints about providers continue, especially from DVHA beneficiaries.**

Call volume about problems with providers was about the same as last quarter, 105 versus 104, or about 14% of all calls. Of those, 66 calls or 63% were from DVHA beneficiaries, compared to 56 last quarter. The reasons for these calls are varied. They range from claims of rude treatment to medical malpractice.

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

The HCO received 751 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 **49%** (367 calls), compared to 50% (363) last quarter;
- **Medicare** (Medicare only, Medicare Advantage Plans Medicare and a Medicare Supplemental Plan aka Medigap, Medicare and Medicaid aka dual eligibles, Medicare and Medicare Savings Program aka Buy-In program, Medicare and Part D, or Medicare and VPharm) insured **31%** (236), compared to 30% (209) last quarter;
- **Commercial carriers** (employer sponsored insurance, individual or small group plans, and Catamount Health plans) insured **14%** (103), compared to 15% (111) last quarter; and
- **Uninsured** callers made up **11%** (85) of the calls, compared to 9% (67) 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 746 cases this quarter, compared to 745 last quarter.

- 29% (217 cases) were resolved by brief analysis and advice;
- 32% (236) were resolved by brief analysis and referral;
- 17% (125) of the cases were complex interventions, which involves complex analysis, usually direct intervention, and more than two hours of an advocate's time;

- 14% (108) were resolved by direct intervention, including calling an insurance company, calling providers, writing letters, gathering supporting medical documentation, etc.;
- Less than 1% (7) 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: 26 cases involved direct help with appeals, and 43 involved consumer education about appeals.

#### DVHA Beneficiary Calls

We closed 353 DVHA cases this quarter, compared to 301 last quarter.

- 29% (102 cases) were resolved by brief analysis and advice;
- 31% (111) were resolved by brief analysis and referral;
- 15% (54) were considered complex intervention, which involves complex analysis, usually direct intervention, and more than two hours of an advocate's time;
- 20% (72) were resolved by direct intervention on the caller's behalf, including advocacy with DVHA and providers, writing letters, and gathering medical information;
- Less than 1% of calls (3) from DVHA beneficiaries were resolved in the initial call.
- In the remaining cases, clients withdrew, resolved the issue on their own, or had some other outcome.
- Appeals: 12 cases involved help with DVHA program appeals, of which 1 was an internal MCO appeal and 11 were Fair Hearings.

#### **J. Case outcomes**

##### All Calls

The HCO helped 36 people get insurance and prevented 20 insurance terminations or reductions. We obtained coverage for services for 20 people. We got 27 claims paid, written off or reimbursed. We assisted 10 people complete applications for DVHA programs and estimated program eligibility for 37 more. We provided other billing assistance to 16 individuals. We obtained hospital patient assistance for 7 people. We provided 398 individuals with advice and education. We obtained other access or eligibility outcomes for 56 more people, many who will be approved for medical services and state insurance. We encourage clients to call us back if they are subsequently denied insurance or a medical service. In total, this quarter the **HCO saved individual consumers \$75,234.96.**

##### DVHA Beneficiary Calls

The HCO prevented 18 terminations or reductions in coverage for DVHA beneficiaries, and got 4 more people onto different DVHA programs. We estimated the eligibility for other programs for 11 DVHA beneficiaries. We obtained coverage for services for 16 individuals. We got 15 claims paid, written off or reimbursed. We got other billing assistance for 9 people and hospital

patient assistance for 1 individual. We provided 203 DVHA beneficiaries with advice or education, and obtained other access or eligibility outcomes for 31 more people.

### **K. Case examples**

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

#### The HCO successfully appealed a commercial carrier's denial of coverage for a specialized rehabilitation device.

Mr. A suffered a Traumatic Brain Injury that left him with multiple disabilities, including difficulty walking. His doctor and physical therapist had prescribed a device to help him improve his ability to walk. Mr. A's insurer denied coverage for the device, claiming it was experimental. The HCO advocate helped the client appeal this decision by compiling research and working with his providers to show that the device was not experimental, and that it was actually the only device that met Mr. A's particular needs. After submitting our research, medical information and arguments and while we were waiting for the external review to be scheduled, the insurance company reversed its decision and agreed to cover the device, which cost about \$8,000.

#### The HCO worked with ESD to get immediate insurance coverage so that an extremely low income individual could have imminent surgery covered.

Ms. B called the HCO in a panic on the day before she was to have knee surgery. She was unable to work because of her knee problems and was living on a small disability benefit from her employer. Because she had less income, she was unable to afford her employer sponsored insurance. Because she had not paid the last premium for the ESI, her insurance had been cancelled. Without insurance, she was not going to be able to afford the surgery. Without the surgery, she was not going to be able to go back to work. She had applied for VHAP but was denied because she had not been uninsured for twelve months. Her HCO advocate realized that because her income had fallen below 75% of the federal poverty level, she met an exception to the twelve month rule. The advocate communicated this to ESD, which immediately enrolled her in VHAP. This enabled Ms. B to have her surgery the next day.

### **L. Recommendations to DVHA**

*Maximus should increase its training for customer service representatives.* The biggest issue we had this quarter related to DVHA was problems with Maximus due to the switchover from DVHA's Member Services to VHC's Customer Support Center. This was a huge expansion for the call center which meant that starting in September they had a high proportion of very new customer service representatives who had only a few weeks of training. As a result, every time we called Maximus for information, the calls took longer because the new CSRs often had to check with supervisors before they gave out information. We have heard that there is also a fairly high rate of turnover with the Maximus CSRs, so we have some concerns about how soon Maximus will be able to get back to its previous high level of service. We have just recently begun biweekly meetings with Maximus to improve communication and discuss issues.

*ESD should assign designated HAEU workers to assist individuals with Medicaid Spenddowns.* This is a repeat request. We continue to get calls from Vermonters who have difficulty navigating the eligibility requirements for this program. This quarter we received 20 calls in which the primary reason for the call was Medicaid Spenddown eligibility, and 11 more in which it was a secondary reason for the call. In each of the previous two quarters we had 13 such calls.

**M. Table of all calls by month and year**

All Cases	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
January	241	252	178	313	280	309	240	218	329	282	289
February	187	188	160	209	172	232	255	228	246	233	283
March	177	257	188	192	219	229	256	250	281	262	263
April	161	203	173	192	190	235	213	222	249	252	253
May	234	210	200	235	195	207	213	205	253	242	228
June	252	176	191	236	254	245	276	250	286	223	240
July	221	208	190	183	211	205	225	271	239	255	270
August	189	236	214	216	250	152	173	234	276	263	224
September	222	191	172	181	167	147	218	310	323	251	256
October	241	172	191	225	229	237	216	300	254	341	
November	227	146	168	216	195	192	170	300	251	274	
December	226	170	175	185	198	214	161	289	222	227	
<b>Total</b>	<b>2578</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>2306</b>

**III. Consumer protection activities**

**A. Rate Reviews**

There were relatively few rate filings which were ready for review by the Green Mountain Care Board (GMCB) in this calendar quarter. The HCO filed notices of appearance and legal memoranda in six new rate cases. No contested hearings were held during the quarter.

One rate review proceeding that generated some publicity involved a significant premium increase proposed by Blue Cross Blue Shield of Vermont for its Catamount Health plan. The state is ending the Catamount program as of December 31, 2013, so the proposed increase was for a six month period. The GMCB issued its decision on this filing, which had been pending at the end of last quarter, on July 16, 2013. BCBSVT had proposed a rate increase of 24.4%. The Commissioner of DFR recommended modifications to the rates which would have reduced the rate increase to 13.9%, and we recommended further reductions. Ultimately the GMCB adopted some but not all of the modifications supported by the HCO. It approved an increase of 11.9%. This increase would have affected 15,351 people, except that 11,902 of them had state premium subsidies. For them, the state absorbed the increase. The remaining 3,449 are paying the increased rates until the program ends.

In five other cases the HCO supported modifications recommended by the Commissioner of DFR and suggested additional reductions in rates. The GMCB accepted the DFR recommendations but did not adopt the HCO's additional suggested modifications.

The HCO worked on the new GMCB proposed rate review regulations which are being promulgated pursuant to changes in statute made in Act 79 of 2013. These rules will take effect in January 2014. The HCO met with the GMCB General Counsel and attended a public hearing with the GMCB and the carriers about these new rules. We also submitted written comments which largely focused on maximizing opportunities for consumers to obtain information and offer input in the rate review cases. The GMCB adopted many of the HCO's suggested changes in the version of the proposed regulations it filed with the Secretary of State in September. The changes clarified the process by which an individual or group can request interested part status, added to the information that will be made available to the public on the GMCB's website, ensured that the parties in the rate review filings will have timely access to the answers to questions posed by the GMCB actuary to the carrier and made changes to the procedures followed by the GMCB during its 30 day review period.

As part of our efforts to encourage public involvement in rate review proceedings, we worked with the HCO's outreach specialist to develop consumer education materials about the rate review process for our new website. See Section III below, Website Update. We also attended a presentation about the new DFR/GMCB website materials explaining rate review.

The HCO continued to work with its law school intern, Kroopa Desai, through August 2, 2013. Kroopa assisted with research, writing memoranda and hearing preparation for rate review cases, helped to draft comments on the proposed GMCB rate review regulations and assisted with developing materials describing the rate review process for the Vermont Law Help web site.

The HCO hired a new independent actuary during the quarter, NovaRest, a firm based in Sahuarita, AZ.

## **B. Hospital Budget Reviews**

This quarter the GMCB performed its second annual hospital budget review. In preparation, we reviewed the hospitals' budget materials and Community Needs Assessments, researched related issues, and submitted suggested questions for the GMCB to pose to the hospitals. We attended the fourteen hearings and submitted comments on the budgets to the GMCB. Our general comments focused largely on increasing consumer input on hospital planning and budgeting and on hospitals' treatment of individuals with mental illness. In addition, we commented on each hospital's specific budget.

### **C. Other Activities**

Pursuant to Act 48 of 2011 and Act 171 of 2012, the GMCB is required to consult with the HCO about various health care reform issues. This quarter we:

- Attended nine GMCB meetings including six meetings related to hospital budget review;
- Met monthly with General Counsel for the GMCB;
- Participated in four meetings of the Accountable Care Organization (ACO) Measures Work Group convened by the GMCB's Director of Payment Reform and one meeting of the Patient Experience Survey Subgroup. We also submitted written comments. This ACO work group is one of three groups working to support the GMCB's initiative to establish population-based payment pilots with ACO's. The group has been working to identify standardized measures that will be used for commercial plans and Medicaid to evaluate the performance of Vermont's ACO's, qualify and modify shared savings payments and guide improvements in health care delivery;
- Participated in three meetings of the ACO Standards Work Group as it began to review the measures developed by the Measures Work group and to develop ACO governance standards; and
- Worked with the GMCB on new proposed rate review regulations based on legislative revisions of the rate review process;
- The Health Care Ombudsman attended three State Innovation Model (SIM) steering committee meetings and three Medicaid and Exchange Advisory Board meetings as a member. She also now chairs the new Improving Access MEAB workgroup which is working with stakeholders and DVHA to improve prompt consumer access to Medicaid services.
- The HCO, working with other attorneys at Vermont Legal Aid, submitted extensive comments on the Vermont Health Connect regulations and engaged in further discussions with VHC attorneys to try to improve this mammoth set of rules. We will continue to do this over the next few months as the Agency of Human Services promulgates more emergency rules.

Finally, this quarter we hired a health care policy analyst who will start working with us on November 4<sup>th</sup>. We expect that this new staff member will help with analysis of hospital budgets, certificates of need, payment reform and other policy issues.

### **IV. Website update**

Vermont Legal Aid and Law Line of Vermont maintain a statewide website called Vermont Law Help. The site includes a Health section, which is maintained by the HCO. With funding from the federal government through the Affordable Care Act, the HCO developed an all new website which went live in early September. The site can be seen at [www.vtlawhelp.org/health](http://www.vtlawhelp.org/health).

We reviewed, revised or deleted all of the health contents from the old site and developed text for a large number of new topics including health care reform in Vermont. We made significant

efforts to enhance the consumer experience with the site, including adding advanced search functionality and greatly improved navigation. We added Google translate buttons that enable users to translate the site into seven languages that are common in Vermont, and we added a tool to help those with vision problems easily re-size the text. We provide links to Vermont Health Connect, the state's online insurance marketplace. Finally, the HCO added an **online intake button** to all health-related pages to make it easier for Vermonters to request HCO assistance 24/7.

The new site platform and underlying structure will help us to obtain more accurate and specific information about website usage via Google Analytics. The new platform is also device-responsive, which means that the 23.84% of visitors who access our site from mobile devices will find a site that is both readable and navigable on those devices.

The number of visits to the entire Vermont Law Help website increased modestly during this reporting period – from 27,494 in 2012 to 30,833 in 2013, or 12.14%. However, the number of pageviews increased dramatically from 60,487 to 80,648, or 33.33%. While the numbers for the health-related page views are small by comparison, the increases are substantial. There were 2,065 health-related views this quarter, compared to 209 for the same period last year, an increase of 888%. Unique page views also increased significantly, from 167 last year to 979 during this reporting period – an increase of 486%.

The average time viewers spent on a health page decreased this year by 69%, and the bounce rate improved by 22.56%. These changes demonstrate our successful efforts to create shorter, more focused pages and to assist the user in finding specific information quickly and easily. [See the attached report called Health Website Usage Report for more detail.]

We will continue to improve the site and add additional content over the next few months.

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

### SFY13 Final MCO Investments

9/4/13

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