

State of Vermont
Agency of Human Services

Global Commitment to Health
11-W-00194/1

Section 1115
Demonstration Year: 6
(10/1/2010 – 9/30/2011)

Quarterly Report for the period
October 1, 2010 – December 31, 2010

February 18, 2011

Background and Introduction

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

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

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

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

Implemented October 1, 2005, the Global Commitment converts the Office of Vermont Health Access (DVHA), the state's Medicaid organization, to a public Managed Care Entity. Currently, AHS pays the Managed Care Entity a lump sum premium payment for the provision of all Medicaid services in the state (with the exception of the Long-Term Care Waiver, managed separately). A Global Commitment to Health Waiver Amendment, approved October 31st 2007 by CMS, allows Vermont to implement the Catamount Health Premium Subsidy Program with the corresponding commercial Catamount Health Program (implemented by state statute October 1, 2007). The Catamount Plan is a new health insurance product offered in cooperation with Blue Cross Blue Shield of Vermont and MVP Health Care. It provides comprehensive, quality health coverage at a reasonable cost no matter how much an individual earns. The intent of this program is to reduce the number of uninsured citizens of Vermont. Subsidies are available to those who fall at or below 300% of the federal poverty level (FPL). Vermont claims federal financial participation for those uninsured Vermonters who fall at or below 200% of the FPL. For those individuals who fall between 200 and 300% Vermont provides subsidies through general fund revenue. Benefits include doctor visits, check-ups and screenings, hospital visits, emergency care, chronic disease care, prescription medicines and more.

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

One of the Terms and Conditions of the Global Commitment Waiver requires the State "to submit progress reports 60 days following the end of each quarter. ***This is the first quarterly report for waiver year six, covering the period from October 1, 2010 through December 31, 2010.***

Enrollment Information and Counts

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

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

Enrollment counts are person counts, not member months.

Demonstration Population	Current Enrollees Last Day of Qtr 12/31/2010	Previously Reported Enrollees Last Day of Qtr 9/30/2010	Variance 09/30/10 to 12/31/10
Demonstration Population 1:	45,247	45,006	0.54%
Demonstration Population 2:	43,594	43,576	0.04%
Demonstration Population 3:	9,862	9,885	-0.23%
Demonstration Population 4:	N/A	N/A	N/A
Demonstration Population 5:	1129	1123	0.53%
Demonstration Population 6:	3,047	3,030	0.56%
Demonstration Population 7:	35,165	34,889	0.79%
Demonstration Population 8:	7,756	7,757	-0.01%
Demonstration Population 9:	2,629	2,631	-0.08%
Demonstration Population 10:	N/A	N/A	N/A
Demonstration Population 11:	10,355	10,364	-0.09%

Green Mountain Care Outreach / Innovative Activities

During this quarter, small community papers and public access television continued to play a role in Vermont’s outreach strategy. Papers published short articles and letters to the editor by satisfied customers of Green Mountain Care. A program by DVHA Commissioner Susan Besio and BISHCA Deputy Commissioner Christine Oliver covered topics relative to federal health care reform, while reminding viewers to check out their health insurance options under Green Mountain Care. This program played for two months on at least nine public access stations statewide.

The Director of Outreach and Enrollment, co-chaired the health committee of the Military Family and Community Network, an effort to ensure that returning soldiers and their family members have access to health insurance. Not all soldiers have access to TRICARE, or can afford their portion of the premiums. Green Mountain Care can provide access as well as premium assistance to help pay for TRICARE. Statewide outreach to military personnel and their family is underway through military training and family outreach events.

Website improvements have been made to the Green Mountain Care website to allow applicants to apply for health care on-line.

Green Mountain Care partnered with the Vermont Department of Labor to conduct outreach at a job fair for 350 people as well as assistance at two company lay offs effecting 13 people.

Enrollment and legislative action: As of the end of December there were 11,293 individuals enrolled in the premium assistance program components of Green Mountain Care (Catamount Health and Employer-Sponsored Insurance). We are not entirely sure why enrollment has decreased, but the bulk of the decrease was in the Catamount with premium assistance component, and the major Catamount carrier, Blue Cross Blue Shield of Vermont, reports that many young people between the ages of 18 and 26 are disenrolling from Catamount and enrolling in their parents' plans. This explanation seems plausible, in that enrollment in other health care program components has not decreased, and Catamount enrollment in the age range of 18-24 (page 3 of the most recent Green Mountain Care report) has decreased more dramatically than enrollment in other age ranges.

As required by the Vermont Appropriations Act of State Fiscal Year 2011, Vermont will be requesting an appropriation in the State Fiscal Year 2012 Budget Proposal to implement a palliative care program that would allow Medicaid children with life-limiting illnesses to receive concurrent curative and palliative care. We will work with CMS to determine if a waiver amendment is necessary or whether we have authority to implement this program under our Global Commitment waiver authority.

CMS approved Vermont's waiver request to reduce the waiting period required for uninsured people to enroll in VHAP and the premium assistance programs from 12 months to six months. DVHA submitted a report to the legislature in February 2010 on the estimated cost of implementing this change. The legislature did not act to move forward on implementation, so the waiting period remains at 12 months. We do not intend to raise this issue again unless required by the legislature.

Beginning January 1, 2011, the two Catamount Health carriers, Blue Cross Blue Shield of Vermont (BCBS) and MVP Health Care (MVP), will have very different monthly premiums. For unknown reasons, MVP's claims experience has resulted in a premium that will be significantly higher than BCBS's premium. Since enrollees are by law required to pay the difference in price between the higher- and lower-cost plans, which is now \$113 per month, we are beginning to see many of MVP's customers migrate to BCBS.

The Dental Dozen: Many Vermonters face challenges in receiving appropriate oral health care due to the limited number of practicing professionals, the affordability of services and a lack of emphasis on the importance of oral health care. Challenges frequently are more acute for low-income Vermonters, including those Vermonters participating in the State's public health care programs. The Dental Dozen recognizes oral health as a fundamental component of overall health and moves toward creating parity between oral health and other health care services.

The DVHA, in conjunction with the Vermont Department of Health (VDH), has implemented 12 targeted initiatives listed below to provide a comprehensive, balanced approach to improve oral health and oral health access for all Vermonters. Updates as of December 31, 2010 are summarized below:

Initiative #1: Ensure Oral Health Exams for School-age Children - The Vermont Department of Health (VDH), the Office of Vermont Health Access (DVHA) and the Department of Education (DOE) collaborated to reinforce the importance of oral health exams and encourage preventive care. Brochures were provided to schools for distribution in October, 2008 to educate parents and children on the importance of fluoride, sealants and regular checkups.

Initiative #2: Increase Dental Reimbursement Rates - The DVHA committed to increase Medicaid reimbursement rates over a three-year period to stabilize the current provider network, encourage new dentists to enroll as Medicaid providers and encourage enrolled dentists to see more Medicaid beneficiaries. Rates were increased by \$637,862 in SFY 2008 and by \$1,412,441 for SFY 2009. Rates were not increased for SFY 2010 due to budgetary constraints; however, dentists were held harmless from a 2% provider rate reduction experienced by many other Medicaid providers.

Initiative #3: Reimburse Primary Care Physicians for Oral Health Risk Assessments - The DVHA reimburses Primary Care Providers (PCPs) for performing Oral Health Risk Assessments (OHRAs) to promote preventive care and increase access for children from ages 0-3. An action plan has been developed to educate/train physicians on performing OHRA's, including online web links.

Initiative #4: Place Dental Hygienists in Each of the 12 District Health Offices – A successful pilot project resulted in the start of placement of part-time dental hygienists in District Health Offices. Current funding now covers one half-time dental hygienist in the Newport, Vermont District Office.

Initiative #5: Selection/Assignment of a Dental Home for Children - The DVHA introduced the capability to select/assign a primary dentist for a child, allowing for the same continuity of care as assigning a Primary Care Physician (PCP) for health improvement; most new enrollees select a dental home, emphasizing the importance of keeping oral health care on par with regular physicals and health checkups.

Initiative #6: Enhance Outreach - The DVHA and VDH conducted outreach and awareness activities to support understanding of the Dental Dozen and help ensure the success of the initiatives. In SFY 2009, work continued to promote benefits available to dental providers, highlight incentives designed to bring and keep more dentists in Vermont and continue outreach with schools, parents and children. A retired Vermont dentist, with grant assistance, is helping recruit and retain more dentists.

Initiative #7: Codes for Missed Appointments/Late Cancellations - Vermont introduced a code to report missed appointments and late cancellations. The DVHA plans to evaluate this data with the intent of exploring processes to reduce missed appointments and late cancellations in the future.

Initiative #8: Automation of the Medicaid Cap Information for Adult Benefits - The DVHA introduced a system upgrade to allow enrolled dentists to access Medicaid cap information for adult benefits automatically. Currently, the annual cap for adult benefits is set at \$495 and the DVHA will track provider use of this upgrade.

Initiative #9: Loan Repayment Program – In SFY 2008, Vermont awarded \$195,000 in loan repayment incentives to dentists in return for a commitment to practice in Vermont and serve low income populations; thirteen awards ranged from \$5,000 to \$20,000. Funding remained at \$195,000 for SFY 2009. Funding was set at \$97,500 for SFY 2010.

Initiative #10: Scholarships - Scholarships, administered through the Vermont Student Assistance Corporation, are awarded to encourage new dentists to practice in Vermont. The combined allocation of \$40,000 for SFY 2008/09 was distributed for the 2008-2009 academic year.

Initiative #11: Access Grants - In SFY 2008, a total of \$70,000 was awarded as an incentive for dentists to expand access to Medicaid beneficiaries. Seven grants ranged from \$5,000 to \$20,000. Funding remained at \$70,000 for SFY 2009 and into SFY 2010.

Initiative #12: Supplemental Payment Program – In SFY 2008, the DVHA distributed \$292,836 to recognize and reward dentists serving high volumes of Medicaid beneficiaries; 30 dentists qualified for semi-annual payouts. For SFY 2009, a distribution of \$146,418 was made in October, 2008 and another distribution of \$146,418 was made in the Spring of 2009; total \$292,836. The program continued on the same cycle and dollar amount for SFY 2010.

Expenditure Containment Initiatives

Vermont Chronic Care Initiative

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

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

The VCCI supports and aligns with other State health care reform efforts, including the Blueprint for Health and the Capitated Office-Based Medically Assisted Treatment (COBMAT) for Opioid Dependence initiative (see below). VCCI staff partner with providers, hospitals, community agencies and other Agency of Human Services (AHS) departments to support a patient-focused model of care committed to enhanced self-management skills, healthcare systems improvement, and efficient coordination of services in a climate of increasingly complex health care needs and scarce resources.

The VCCI focuses on beneficiaries identified as having a specified chronic health condition and are enrolled in Medicaid, VHAP, PCPlus or Dr. Dynasaur under the Vermont Health Access Program with approval by the Centers for Medicaid and Medicare; beneficiaries are not eligible for the VCCI if they receive Medicare or other third party insurance. Those targeted for enrollment in VCCI programs have at least one chronic condition including, but not limited to: Arthritis, Asthma, Chronic Obstructive Pulmonary Disease (COPD), Chronic Renal Failure, Congestive Heart Failure (CHF), Depression, Diabetes, Hyperlipidemia, Hypertension, Ischemic Heart Disease, and Low Back Pain. Eligible beneficiaries are identified and risk stratified by the DVHA's disease management vendor, APS Healthcare, using a proprietary disease identification and stratification system based on Adjusted Clinical Group predictive modeling. Referrals from physicians, hospitals, and other community agencies also are accepted. Beneficiaries at highest risk are referred to DVHA care coordinators for intensive face-to-face case management services and those considered at lower risk for complications are assigned to APS Healthcare for telephonic disease management provided by a RN health coach.

Service level needs are ultimately determined through both predictive modeling and clinical assessment, in accordance with national evidence-based, disease-specific clinical guidelines. The VCCI is designed to enable seamless transition between service tiers as a beneficiary's needs change.

The DVHA's care coordinators began providing face-to-face intensive case management services in 2006 to the highest risk, most medically complex beneficiaries. Especially among these high risk beneficiaries, chronic conditions and their management are often complicated by co-occurring mental health and substance abuse conditions, as well as challenges due to financial insecurity such as availability of food, safe and affordable housing, and transportation. The DVHA care coordinators, which include registered nurse case managers and medical social workers, facilitate a medical home, support the primary care provider in achieving the clinical plan of care, facilitate effective communication among service providers, and remove barriers to beneficiary success.

In July 2007, the DVHA considerably expanded operations beyond care coordination to provide a full spectrum of disease management interventions using contracted services from APS Healthcare. At that time, the DVHA VCCI implemented a tiered intervention protocol with services along a continuum from printed education and self-management information to telephonic health coaching and disease management services, to intensive face-to-face case management. This comprehensive model includes hospital-based nurses, community-based nurse case managers and medical social workers, as well as centrally located nurse, disease management, and social work staff. All staff shares the same vertically and horizontally integrated web-based chronic care data management system, APS CareConnection®. In addition to being a case tracking system and repository for information on every beneficiary served, the APS CareConnection® system enables secure communications among staff regarding co-managed beneficiaries, and also is accessible by medical providers as a means to be informed about a patient's activities, goals and progress.

The VCCI provides ongoing outreach, education and support to the primary care providers (PCPs) of participating beneficiaries. DVHA care coordinators or APS nurse health coaches collaborate with the beneficiary and their PCP to develop a customized plan of care (POC), and PCPs are provided periodic updates on patients' progress in completing goals established through the POC.

Vermont's state budget rescission for State Fiscal Year 2009 included elimination of approximately 25% from the funds budgeted for the APS Healthcare contract; as a result, efforts were refocused predominantly on very high, high and moderate risk beneficiaries most likely to benefit from face-to-face intensive care coordination services and/or telephonic disease management health coaching. Lower risk individuals are sent information on the program, may request information and educational materials, and are contacted twice each year to assess current needs. From July 1, 2009 through June 30, 2010, 3,226 beneficiaries received face-to-face case management services or telephonic disease management health coaching from a registered nurse.

Effective July 1, 2010, DVHA expanded its direct care coordination capacity in two areas of the state through the Challenges for Change initiative. The two trial areas were selected based on, among other factors, high disease prevalence and high health system utilization. The initiative adds three additional DVHA care coordination staff (two RNs and 1 Licensed Clinical Social Worker) in each of the two areas (Rutland and Franklin Counties). These staff will be co-located within doctors' offices and local hospitals, and will integrate closely with existing care coordination staff, Blueprint for Health Community Health Teams, and other community resources.

The DVHA has contracted with the University of Vermont (UVM) for VCCI program evaluation, and for assistance with identifying and implementing quality improvement projects. During the first half

of FFY 2010, UVM completed an evaluation of VCCI administrative (claims) data and a Medical Record Review (MRR) of 1,001 randomly selected VCCI beneficiary charts. A clinical performance improvement project (PIP) is being developed, focusing on congestive heart failure, which is one of the eleven high cost, high risk chronic conditions the VCCI targets. UVM will assist the VCCI in developing and implementing focused activities involving both beneficiaries and primary care providers to improve adherence to clinical best practice guidelines, patient self-management, and prevention of symptoms leading to avoidable hospital utilization.

Highlights of the Vermont Chronic Care Initiative for Quarter 1 of FFY 2011

- All analyses from UVM’s VCCI evaluation have been completed and a clinical performance improvement project (PIP) is being developed targeting congestive heart failure (CHF). The PIP will be implemented during 1st quarter FFY 2011.
- DVHA care coordinators expanded meetings and electronic data exchange systems with hospital emergency departments (EDs) for increased collaboration regarding emergency room utilization among VCCI beneficiaries.
- During the first quarter of FFY 2011, the average monthly program caseload was 1,559. Monthly caseload includes beneficiaries in active outreach by VCCI staff, as well as those successfully engaged and receiving care coordination or health coaching services.

1,233 unique beneficiaries were served by either DVHA care coordinators or APS disease management health coaches during FFY 2011 (10/01/2010 through 12/31/2010).

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	+ BONUS =	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		

On January 1, 2010, DVHA notified all buprenorphine providers and implemented an automated payment system for the CPTOD. All claims are now submitted directly to HP Enterprise Services and processed through the MMIS, enabling the DVHA to more accurately budget and track expenditures. The billing requirements are aligned with the treatment complexity levels outlined in the Buprenorphine Provider Agreements and the Buprenorphine Practice Guidelines. The total for the 1st Quarter (October 2010- December 31st 2010) is \$55,709 **(Figure 2)**.

(Figure 2)

Buprenorphine Program Payment Summary FFY 2011	
FIRST QUARTER	
Oct-10	\$ 22,701.28
Nov-10	\$ 15,774.28
Dec-10	\$ 17,233.56
Quarter Total	\$ 55,709.12

Mental Health – Vermont Futures Planning

Community System Development

Vermont Psychiatric Survivors, Inc., Vermont’s adult mental health consumer organization, is working with a newly established board of directors to finalize plans to create a peer-run alternative to traditional crisis stabilization services. The board of directors of the planned program is working with Vermont Psychiatric Survivors and the Department of Mental Health (DMH) to establish a start up budget and timeline to begin operations on July 1st, 2011. This new program will be called “Alyssum.”

The care management system design work has included the development of a consensus medical screening protocol for all hospital emergency departments to use when referring individuals for psychiatric inpatient care. This consensus document has been approved by the five psychiatric inpatient programs, and the medical screening was implemented in November 2010. DMH has also issued an RFP to develop a “bed board” to identify inpatient and crisis bed availability state-wide for use by the emergency and inpatient providers. Proposals are due by February 4th, 2011. In addition, the Department of Mental Health is close to finalizing a contract with Deerfield Health Systems to secure access to the LOCUS (Level of Care Utilization System) for all admissions to acute care (crisis beds) and residential beds. Vermont plans to begin statewide implementation of the web-based application in Spring 2011 as part of the care management system.

Secure Residential Recovery Treatment Program

In December 2010, DMH received approval from BISCHA for its Certificate of Need (CON) application to create a 15-bed, secure residential recovery treatment program. This 15-bed secure adult psychiatric treatment and recovery residential program is proposed on the grounds of the state office complex in Waterbury as described in the FFY 08 annual report and the last quarterly report. If constructed, the residential recovery treatment program will provide comprehensive, patient-centered care in a newly constructed facility.

Acute Psychiatric Inpatient Care

Per the Department of Mental Health Master Plan to replace the Vermont State Hospital (presented to the General Assembly in February, 2010), DMH has continued to explore inpatient development options with the Rutland Regional Medical Center, the Brattleboro Retreat, and the Veteran’s Administration Hospital in White River Junction, Vermont. The development of new or enhanced inpatient beds in collaboration with general medical hospitals is based on the Master Plan’s intent to achieve a new model of care focused on the of integration of mental health with general health care.

The Master Plan and the CON application for the Secure Recovery Residence are available at the DMH website: Mental Health.Vermont.gov

Financial/Budget Neutrality Development/Issues

AHS’ actuarial consultant, Aon, produced certified rate ranges for the FFY11 period in August, 2010. AHS delivered the FFY11 IGA, including actuarially sound rate methodology, to CMS on August 27, 2010.

On October 1, 2010, AHS began paying DVHA the monthly capitation payment rate for FFY11 per our existing process, under the GC waiver extension. AHS made PMPM payments as usual through QE1210.

Effective with the January 1, 2011 waiver renewal, AHS will pay DVHA a monthly PMPM estimate using the existing rates on file, in accordance with the new Special Terms and Conditions. This monthly payment will reflect the State’s monthly need for Federal funds based on estimated Global Commitment expenditures for the month. Effective QE0311, AHS will true up the federal claims from the monthly payments to the underlying Global Commitment expenditures incurred with the CMS-64 filing in April 2011.

Member Month Reporting

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

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

Demonstration Population	Month 1	Month 2	Month 3	Total for Quarter Ending 1st Qtr FFY '11	Total for Quarter Ending 4th Qtr FFY '10	Total for Quarter Ending 3 rd Qtr FFY '10	Total for Quarter Ending 2 nd Qtr FFY '10	Total for Quarter Ending 1st Qtr FFY '10	Total for Quarter Ending 4th Qtr FFY '09	Total for Quarter Ending 3rd Qtr FFY '09	Total for Quarter Ending 1st Qtr FFY '09	Total for Quarter Ending 4th Qtr FFY '08	Total for Quarter Ending 3rd Qtr FFY '08	Total for Quarter Ending 2nd Qtr FFY '08	Total for Quarter Ending 1st Qtr FFY '08
	10/31/2010	11/30/2010	12/31/2010												
Dem. Pop. 1:	45,441	45,456	45,247	136,144	134,256	132,168	131,930	131,513	129,656	128,203	125,825	123,997	122,281	121,926	120,113
Dem. Pop. 2:	43,938	43,635	43,594	131,167	131,402	131,865	130,746	129,075	128,698	128,590	122,210	121,981	123,283	122,118	120,309
Dem. Pop. 3:	10,076	9,936	9,862	29,874	30,068	30,244	29,567	29,352	29,428	28,628	26,555	26,452	25,723	24,676	24,821
Dem. Pop. 4:	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Dem. Pop. 5:	1,136	1,158	1,129	3,423	3,444	3,701	3,614	3,546	3,410	3,568	3,832	3,850	3,767	3,542	3,767
Dem. Pop. 6:	3,068	3,111	3,047	9,226	9,073	8,972	8,495	8,218	8,088	7,480	8,208	7,428	7,357	6,208	6,084
Dem. Pop. 7:	34,977	34,989	35,165	105,131	103,915	103,194	98,576	92,217	89,158	87,116	75,277	74,301	73,966	72,336	65,803
Dem. Pop. 8:	7,716	7,708	7,756	23,180	23,155	22,707	22,462	22,254	21,905	23,165	22,032	21,715	23,100	22,697	22,445
Dem. Pop. 9:	2,635	2,623	2,629	7,887	7,848	7,914	7,770	7,673	7,634	7,665	7,649	7,626	7,838	7,919	7,929
Dem. Pop. 10:	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Dem. Pop. 11:	10,625	10,417	10,355	31,397	30,986	31,445	29,728	28,278	26,444	24,717	19,465	16,136	12,525	7,997	1,641

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.

Consumer Issues

The AHS and DVHA have several mechanisms whereby consumer issue are tracked and summarized. The first is through the Managed Care Entity, Health Access Member Services. This is a contracted function for providing information on health care programs, assisting with the eligibility process, and

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

The second mechanism to assess trends in consumer issues is the Managed Care Entity Grievance and Appeal report. This report is based on data entered by grievance and appeal coordinators in various locations throughout the Managed Care Entity (see Attachment 3). The unified Managed Care Entity database in which they enter information helps them track the timeframes for responding to the grievances and appeals, as well as assists DVHA and AHS in monitoring compliance and assessing if there are trends that may benefit from a performance improvement project.

The third mechanism to track consumer issues is the report for the Office of Health Care Ombudsman (HCO) is a comprehensive report of all contacts with beneficiaries (see Attachment 4). These include inquiries, requests for information, and requests for assistance. HCO's role is to assist individuals to navigate health care insurance systems, and help to resolve eligibility and coverage problems. The data is not broken down into requests for assistance as opposed to complaints.

Quality Assurance/Monitoring Activity

External Quality Review Organization:

During this quarter, the Performance Improvement Project (PIP) work group met to discuss the MCE sponsorship of a new PIP as well as to identify a transition plan for the current PIP. Beginning in FFY11, a new PIP aimed at improving the care provided to beneficiaries with chronic conditions will begin. Work with this population has already begun with the Chronic Care Initiative (CCI) as well as its sponsorship of Vermont's Blueprint for Health. Members of the workgroup met with the EQRO via a conference call to review the Federal PIP requirements. It was decided that the first PIP would become part of an informal performance improvement process and no longer be subject to EQRO validation.

Also during this quarter staff met to discuss performance on eleven HEDIS measures. During this meeting, potential issues impacting the validity of current rates/results were identified and possible solutions to increase validity discussed. It was also agreed that the MCO would eliminate one measure reported last year. Specifically, the State is already required through Vermont Statute to report on lead screening rates for all Vermont children and the rates can be disaggregated by payer, it is redundant to report rates/results for only Global Commitment beneficiaries. During the next quarter, the AHS Quality Improvement Manager will work with the EQRO to finalize all review documents.

During this quarter, the AHS Quality Improvement Manager worked with the EQRO to develop a review tool that will be used by the EQRO to assess DVHA's ability to comply with Federal and State Medicaid MCO standards. During the 2010-2011 review period, the EQRO will review the Medicaid Managed Care Structure & Operation standards.

Finally, during this quarter, the AHS Quality Improvement Manager reviewed and received a final copy this year's EQRO Annual Technical Report. This document combines the results of all three external quality review activities and identifies strengths and challenges associated with the three activities as well as making recommendations to improve the timeliness, access, and quality of services provided by the MCE. A copy of this report is to be sent to both CMS and the MCE.

Quality Assurance Performance Improvement Committee (QAPI): The Quality Assessment and Performance Improvement Committee (Committee) continued working on the restructuring and format of the Committee. It was agreed that the Committee will continue to address the monitoring and oversight needs of the Agency as well as the quality assessment and performance improvement needs of the MCE. It is anticipated that the new structure will be fully implemented during next quarter. During this quarter, a new MCE chairperson and IGA Partner committee members were identified to represent various aspects of the MCE. Also, quarterly meetings were scheduled for January, April, July, and October. It is anticipated that a subset of quality assessment/performance improvement activities will be discussed at these meetings.

The Committee members continued to communicate between meetings and developed the new purpose statement, roles and responsibilities. Specific items discussed include the following: MCE Quality Plan, monitoring schedule, monitoring tool, corrective action plan format, and process. The Operating Procedures for the FY 2011 MCE Toolkit were reviewed and feedback was provided from Committee members. The MCE and IGA Partners continued their compliance activities with the Committee members reporting back to the MCE on these activities as scheduled. Committee members also participated in the activities related to the 2009-2010 EQRO Corrective Action Plan. In addition, folders on a shared drive have been created to log the receipt of MCE reports re: QAPI activities. Finally, monthly meetings have been scheduled between AHS and DVHA to address any concerns that might arise between the quarterly meetings.

Quality Strategy: Now that the MCE monitoring/oversight structure has changed, it is anticipated that the members of the MCE QAPI committee will review the Quality Strategy during one of their monthly meetings. If any issues are identified, the AHS Quality Improvement Manager will meet with them to discuss. Any necessary or agreed upon modifications will be made by the AHS Quality Improvement Manager.

Demonstration Evaluation

At the end of FFY09, the interim evaluation report of the Global Commitment to Health 1115 Waiver prepared by Pacific Health Policy Group (PHPG) accompanied the State's formal waiver extension request to CMS. The AHS Quality Improvement Manager will meet with the PHPG project manager to modify the current evaluation work plan to correspond with the time period agreed upon in the newly revised STC's.

Reported Purposes for Capitated Revenue Expenditures

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

- Reduce the rate of uninsured and/or underinsured in Vermont;
- Increase the access of quality health care to uninsured, underinsured, and Medicaid beneficiaries;

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

Please see Attachment 6 for a summary of Managed Care Entity Investments, with applicable category identified, for State fiscal year 2009.

Enclosures/Attachments

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

Attachment 1: Catamount Health Enrollment 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 VT Health Access Ombudsman Report

Attachment 6: DVHA Managed Care Entity Investment Summary

State Contact(s)

Fiscal:	Jim Giffin, CFO VT Agency of Human Services 103 South Main Street Waterbury, VT 05671-0201	802-241-2949 (P) 802-241-1200 (F) jim.giffin@ahs.state.vt.us
Policy/Program:	Suzanne Santarcangelo, Director AHS Health Care Operations, Compliance, and Improvement VT Agency of Human Services 103 South Main Street Waterbury, VT 05671-0203 suzanne.santarcangel@ahs.state.vt.us	802-241-3155 (P) 802-241-4461 (F)
Managed Care Entity:	Susan W. Besio, PhD, Commissioner Department of VT Health Access 312 Hurricane Lane, Suite 201 Williston, VT 05495	802-879-5901 (P) 802-879-5952 (F) susan.besio@ahs.state.vt.us

Date Submitted to CMS: February 18, 2011

ATTACHMENTS



Department of Vermont Health Access
 SFY 11 Catamount Health Actual Revenue and Expense Tracking
 Friday, January 21, 2011

	SFY '11 BAA			Consensus Estimates for SFY to Date			Actuals thru 12/31/10			
	<=200%	>200%	Total	<=200%	>200%	Total	<=200%	>200%	Total	% of SFY to-Date
TOTAL PROGRAM EXPENDITURES										
Catamount Health	41,787,258	15,432,576	57,219,834	19,863,166	7,305,775	27,168,941	18,312,075	8,811,610	27,123,685	99.83%
Catamount Eligible Employer-Sponsored Insurance	1,557,244	802,257	2,359,501	740,034	372,131	1,112,166	531,249	243,071	774,320	69.62%
Subtotal New Program Spending	43,344,502	16,234,833	59,579,335	20,603,201	7,677,906	28,281,107	18,843,324	9,054,682	27,898,005	98.65%
Catamount and ESI Administrative Costs	1,554,749	1,142,276	2,697,025	777,375	571,138	1,348,513	777,375	571,138	1,348,513	100.00%
TOTAL GROSS PROGRAM SPENDING	44,899,251	17,377,109	62,276,360	21,380,575	8,249,044	29,629,620	19,620,698	9,625,820	29,246,518	98.71%
TOTAL STATE PROGRAM SPENDING	16,046,131	7,316,623	23,362,755	6,422,725	3,475,646	9,898,371	5,894,058	3,972,576	9,866,633	99.68%
TOTAL OTHER EXPENDITURES										
Immunizations Program	-	2,500,000	2,500,000	-	1,250,000	1,250,000	-	1,250,000	1,250,000	100.00%
VT Dept. of Labor Admin Costs Assoc. With Employer Assess.	-	394,072	394,072	-	197,036	197,036	-	197,036	197,036	100.00%
Marketing and Outreach	500,000	-	500,000	250,000	-	250,000	250,000	-	250,000	100.00%
Blueprint	-	1,846,713	1,846,713	-	923,357	923,357	-	923,357	923,357	100.00%
TOTAL OTHER SPENDING	500,000	4,740,785	5,240,785	250,000	2,370,393	2,620,393	250,000	2,370,393	2,620,393	100.00%
TOTAL STATE OTHER SPENDING	206,350	4,740,785	4,947,135	103,175	2,370,393	2,473,568	75,100	2,370,393	2,445,493	98.86%
TOTAL ALL STATE SPENDING	16,252,481	12,057,408	28,309,890	6,525,900	5,846,039	12,371,939	5,969,158	6,342,968	12,312,126	99.52%
TOTAL REVENUES										
Catamount Health Premiums	5,775,190	4,653,264	10,428,454	2,772,532	2,255,290	5,027,823	2,477,890	2,208,110	4,686,000	93.20%
Catamount Eligible Employer-Sponsored Insurance Premiums	411,090	355,978	767,068	191,783	167,554	359,337	164,944	127,863	292,807	81.49%
Subtotal Premiums	6,186,279	5,009,242	11,195,522	2,964,315	2,422,845	5,387,160	2,642,834	2,335,973	4,978,807	92.42%
Federal Share of Premiums	(3,965,450)	(2,941,143)	(6,906,593)	(2,073,835)	(1,422,937)	(3,496,771)	(1,848,927)	(1,371,917)	(3,220,844)	92.11%
TOTAL STATE PREMIUM SHARE	2,220,829	2,068,100	4,288,929	890,480	999,908	1,890,388	793,907	964,056	1,757,963	92.99%
Cigarette Tax Increase (\$.60 / \$.80)			9,408,500			4,704,250			5,439,270	115.62%
Employer Assessment			7,600,000			3,800,000			4,686,000	123.32%
Interest			-			-			1,123	0.00%
TOTAL OTHER REVENUE			17,008,500			8,504,250			10,126,393	119.07%
TOTAL STATE REVENUE	2,220,829	2,068,100	21,297,429	890,480		10,394,638	793,907		11,884,357	114.33%
State-Only Balance			(7,012,461)			(1,977,300)			(427,769)	
Carryforward			793,641			793,641			793,641	
CATAMOUNT FUND (DEFICIT)/SURPLUS			(6,218,820)			(1,183,659)			365,872	
General Fund BAA to GC on Behalf of Catamount			7,822,019			3,911,010			3,911,010	100.00%
ALL FUNDS THAT SUPPORT CATAMOUNT (DEFICIT)/SURPLUS			1,603,199			2,727,350			4,276,882	

NOTE: The total program expenditures include both claims and premium costs

Green Mountain Care Enrollment Report
December 2010
TOTAL ENROLLMENT BY MONTH

	Jul-07	Nov-07	Jul-08	Nov-08	Dec 09	Jan 10	Feb 10	Mar 10	Apr 10	May 10	June 10	July 10	Aug 10	Sept 10	Oct 10	Nov 10	Dec 10	
Adults:																		
VHAP-ESIA	-	35	672	759	968	958	954	952	942	923	926	926	921	906	873	871	899	
ESIA	-	21	336	499	698	708	744	749	745	759	729	702	731	729	768	760	764	
CHAP	-	320	4,608	6,120	9,138	9,339	9,503	9,755	10,163	9,902	9,943	9,823	9,839	10,087	9,891	9,898	9,630	
Catamount Health	-	120	697	932	2,088	2,186	2,217	2,267	2,277	2,307	2,349	2,463	2,474	2,491	2,483	2,552	2,498	
Total	-	496	6,313	8,310	12,892	13,191	13,418	13,723	14,127	13,891	13,947	13,914	13,965	14,213	14,015	14,081	13,791	
Adults:																		
VHAP	23,725	24,849	26,441	26,860	33,067	33,469	33,965	35,010	36,010	34,801	34,570	35,329	35,408	35,852	36,019	35,730	36,669	
Other Medicaid	69,764	69,969	70,947	35,601	38,411	37,852	39,053	39,181	39,483	39,266	39,368	39,481	39,590	38,663	39,913	39,777	39,414	
Children:																		
Dr Dynasaur	19,738	19,733	19,960	20,511	20,472	20,503	20,489	20,602	20,707	20,262	19,882	19,898	19,608	19,891	20,051	20,141	21,120	
SCHIP	3,097	3,428	3,396	3,527	3,451	3,405	3,432	3,514	3,564	3,513	3,478	3,478	3,500	3,508	3,613	3,587	3,539	
Other Medicaid*	Included	Included	Included	34,015	38,116	38,261	38,678	38,531	38,862	39,325	39,157	39,846	38,015	39,142	39,349	38,942	38,265	
Total	116,324	117,979	120,744	120,514	133,517	133,490	135,617	136,838	138,626	137,167	136,455	138,032	136,121	137,056	138,945	138,177	139,007	
TOTAL ALL	116,324	118,355	127,057	128,824	146,409	146,681	149,035	150,561	152,753	151,058	150,402	151,946	150,086	151,269	152,960	152,258	152,798	

KEY:

* Prior to November 2008, the numbers for Other Medicaid included both children and adults enrolled in this eligibility category

VHAP-ESIA = Eligible for VHAP and enrolled in ESI with premium assistance

ESIA = Between 150% and 300% and enrolled in ESI with premium assistance

CHAP = Between 150% and 300% and enrolled in Catamount Health with premium assistance

Catamount Health = Over 300% and enrolled in Catamount Health with no premium assistance

VHAP = Enrolled in VHAP with no ESI that is cost-effective and/or approvable

Dr. Dynasaur = Enrolled in Dr. Dynasaur

SCHIP = Enrolled in SCHIP

Totals do not include programs such as Pharmacy, Choices for Care, Medicare Buy-in

Data on the range and types of ESI plans has not been included in this report, but will be included as soon as the data is available.

Green Mountain Care Enrollment Report
December 2010 Demographics

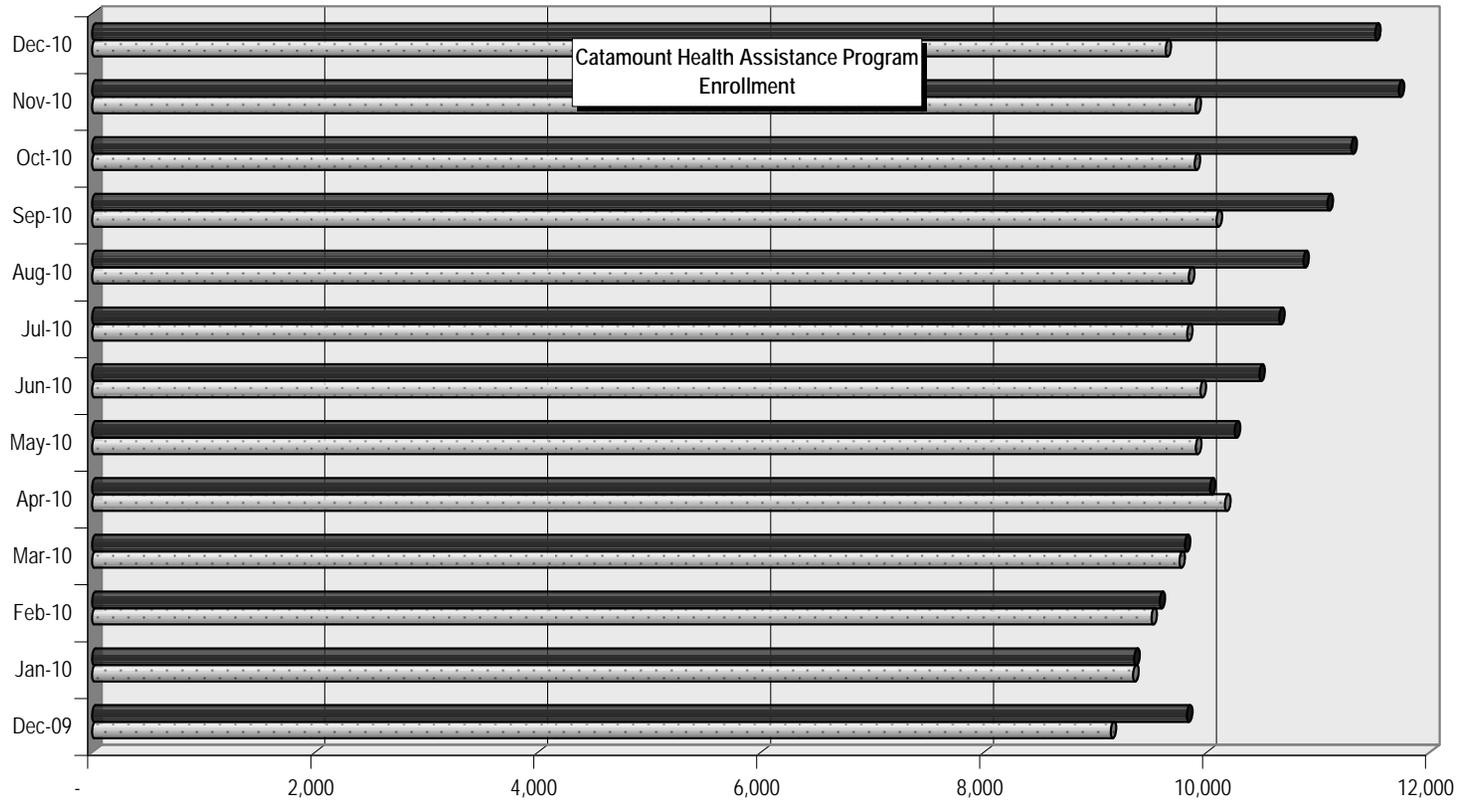
Income	VHAP-ESIA*	ESIA*	CHAP*	TOTAL
0-50%	13	1	523	
50-75%	36	1	91	
75-100%	112	3	100	
100-150%	453	7	342	
150-185%	267	235	3522	
185-200%	8	267	2352	
200-225%	6	135	1257	
225-250%	3	65	870	
250-275%	1	43	441	
275-300%	-	7	132	
Total	899	764	9,630	11,293

Age	VHAP-ESIA	ESIA	CHAP	TOTAL
18-24	53	92	1860	
25-35	280	191	1765	
36-45	328	215	1511	
46-55	197	194	2001	
56-64	41	72	2471	
65+	-	-	22	
Total	899	764	9,630	11,293

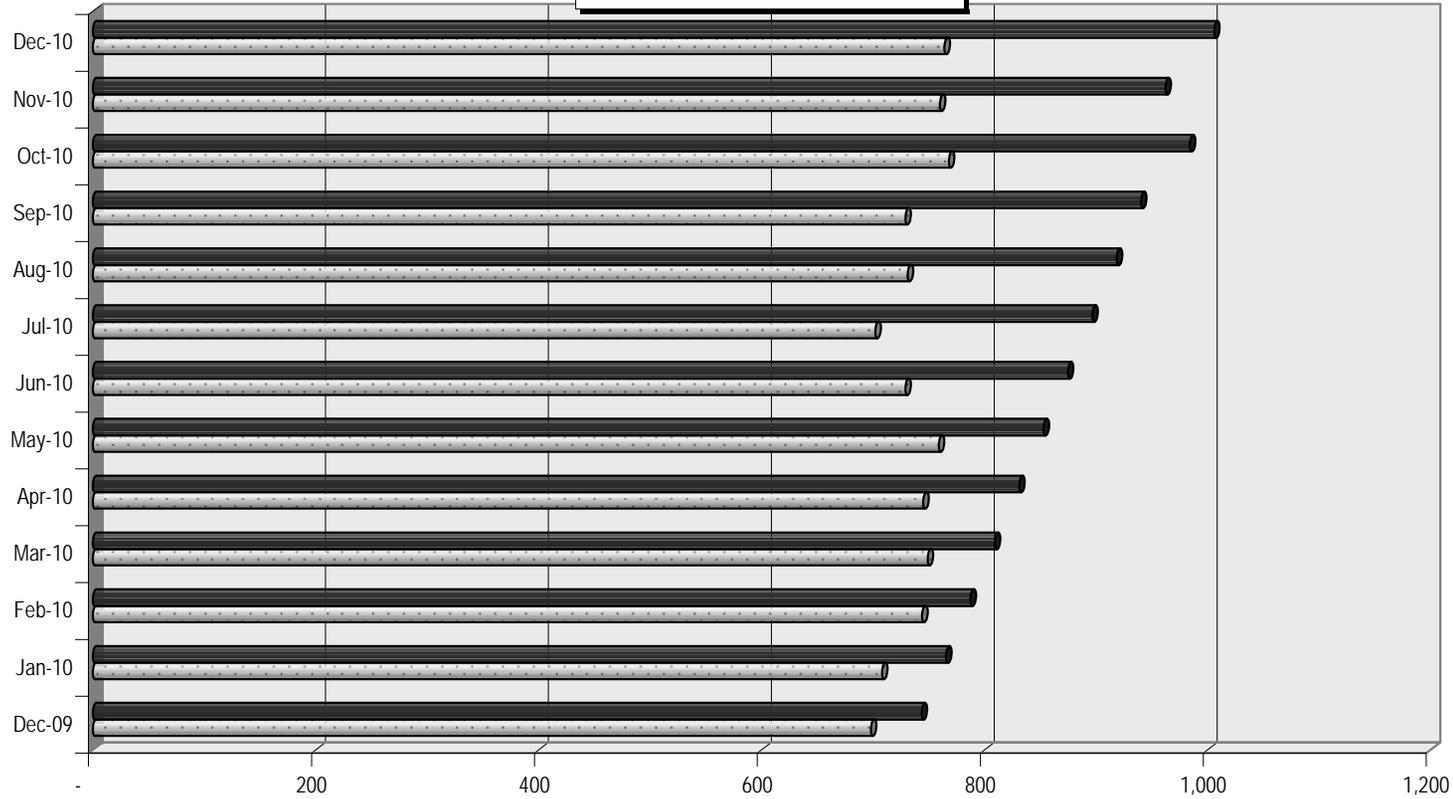
Green Mountain Care Enrollment Report (continued)
December 2010 Demographics

Gender	VHAP-ESIA	ESIA	CHAP	TOTAL
Male	327	278	4123	
Female	572	486	5507	
Total	899	764	9,630	11,293

County	VHAP-ESIA	ESIA	CHAP	TOTAL
Addison	50	39	554	
Bennington	80	81	629	
Caledonia	24	35	577	
Chittenden	171	183	1880	
Essex	9	4	127	
Franklin	76	47	622	
Grand Isle	10	3	113	
Lamoille	63	48	483	
Orange	45	27	455	
Orleans	56	45	525	
Other	-	1	3	
Rutland	111	88	1003	
Washington	74	58	933	
Windham	56	57	781	
Windsor	74	48	945	
Total	899	764	9,630	11,293

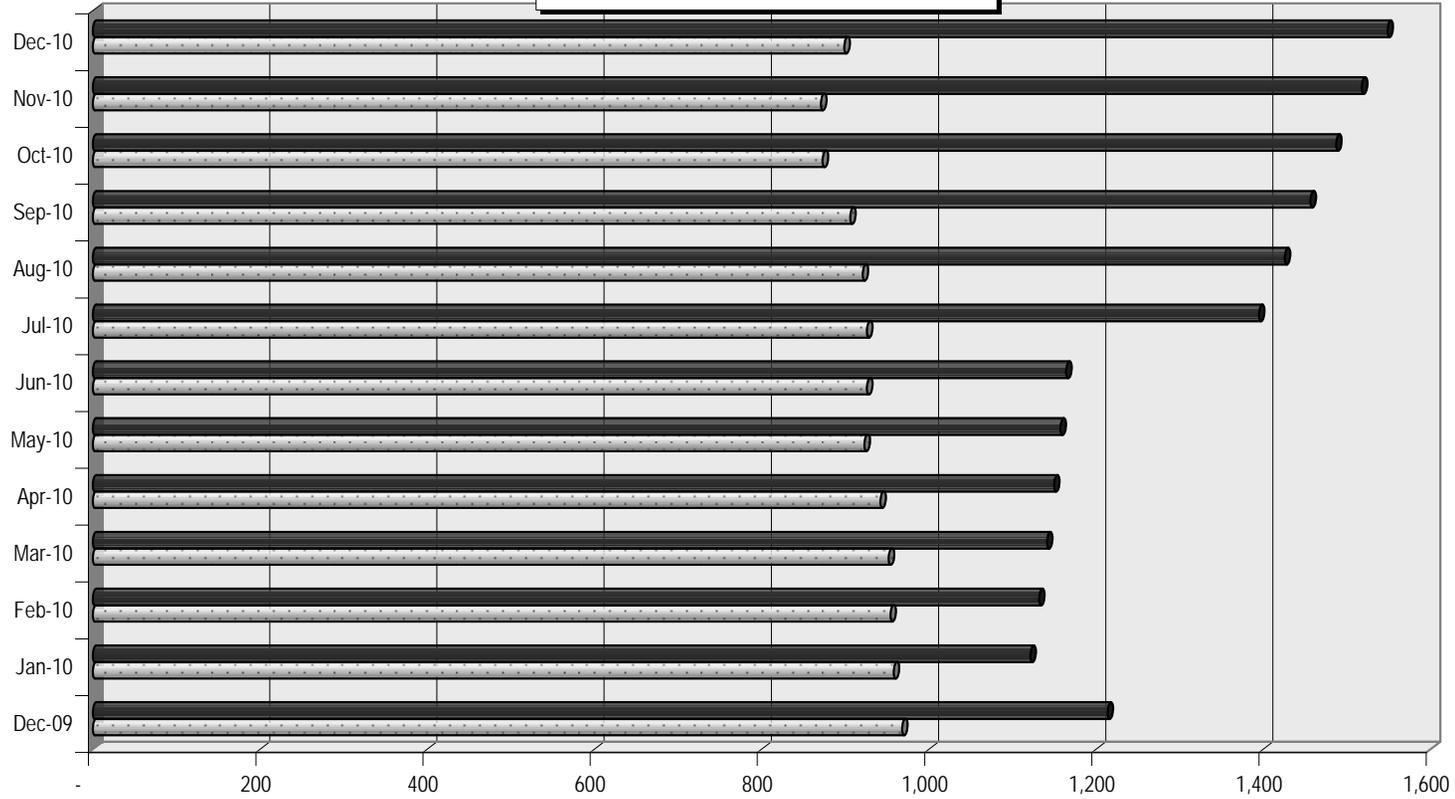


	Dec-09	Jan-10	Feb-10	Mar-10	Apr-10	May-10	Jun-10	Jul-10	Aug-10	Sep-10	Oct-10	Nov-10	Dec-10
■ Projected	9,822	9,349	9,577	9,803	10,028	10,250	10,472	10,649	10,867	11,083	11,297	11,722	11,510
▤ Actual	9,138	9,339	9,503	9,755	10,163	9,902	9,943	9,823	9,839	10,087	9,891	9,898	9,630

Employer Sponsored Insurance Assistance Enrollment


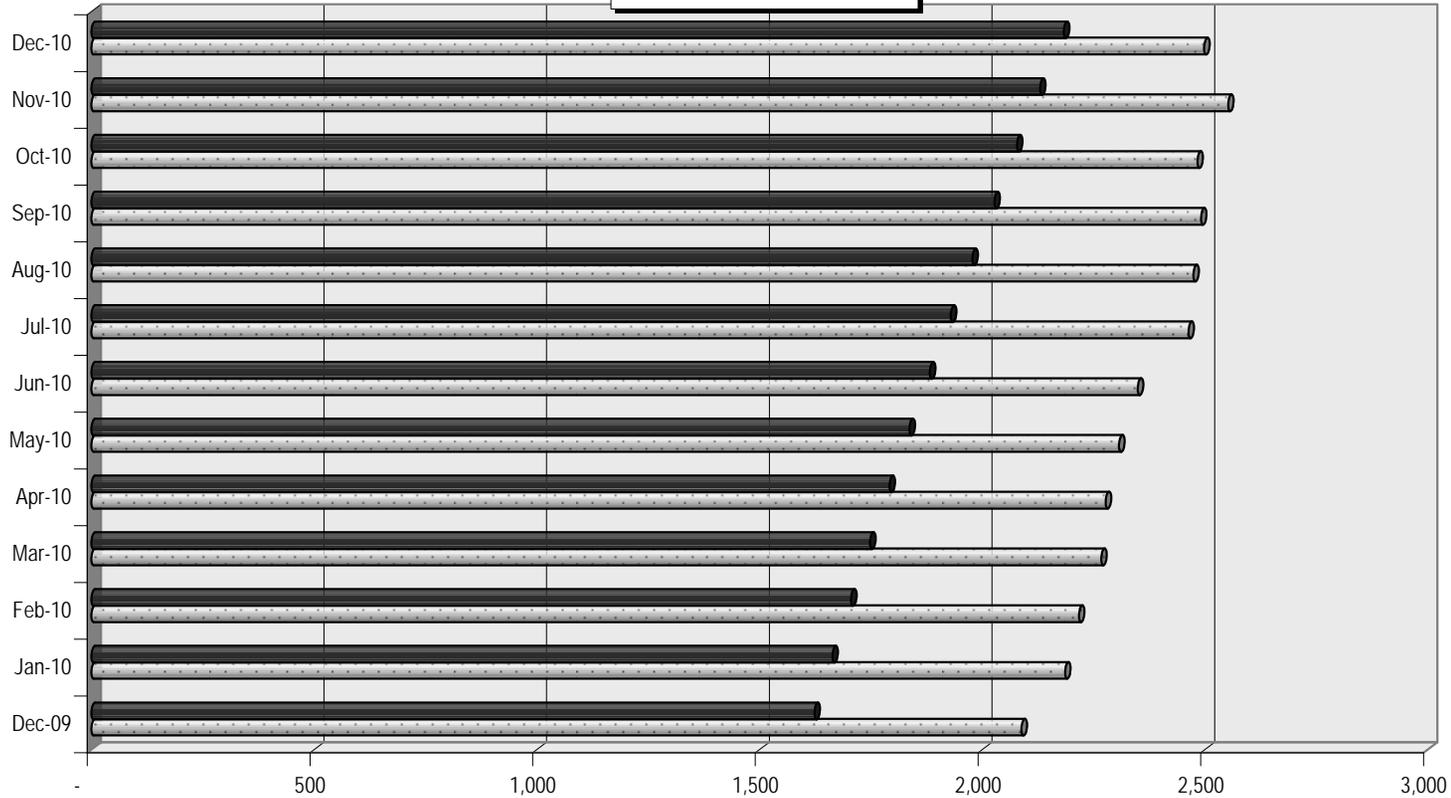
	Dec-09	Jan-10	Feb-10	Mar-10	Apr-10	May-10	Jun-10	Jul-10	Aug-10	Sep-10	Oct-10	Nov-10	Dec-10
■ Projected	744	765	787	809	831	853	875	897	919	940	984	962	1,006
□ Actual	698	708	744	749	745	759	729	702	731	729	768	760	764

VHAP - Employer Sponsored Insurance Assistance
 Enrollment



	Dec-09	Jan-10	Feb-10	Mar-10	Apr-10	May-10	Jun-10	Jul-10	Aug-10	Sep-10	Oct-10	Nov-10	Dec-10
■ Projected	1,214	1,122	1,132	1,141	1,150	1,157	1,164	1,395	1,426	1,456	1,487	1,518	1,549
□ Actual	968	958	954	952	942	923	926	926	921	906	873	871	899

Catamount Health - Unsubsidized Enrollment



	Dec-09	Jan-10	Feb-10	Mar-10	Apr-10	May-10	Jun-10	Jul-10	Aug-10	Sep-10	Oct-10	Nov-10	Dec-10
■ Projected	1,623	1,664	1,705	1,748	1,792	1,836	1,882	1,929	1,978	2,027	2,078	2,130	2,183
▨ Actual	2,088	2,186	2,217	2,267	2,277	2,307	2,349	2,463	2,474	2,491	2,483	2,552	2,498

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																	
1207	\$ 213,871,059	\$ -	\$ 1,010,348								\$ 1,010,348	\$ 214,881,406					
0308	\$ 162,921,830	\$ -	\$ -								\$ -	\$ 162,921,830					
0608	\$ 196,466,768	\$ 14,717	\$ -	\$ 40,276,433							\$ 40,291,150	\$ 236,757,918					
0908	\$ 228,593,470	\$ -	\$ -	\$ -							\$ -	\$ 228,593,470					
WY3 SUM	\$ 801,853,126	\$ 14,717	\$ 1,010,348	\$ 40,276,433							\$ 41,301,498	\$ 881,729,256	\$ 6,457,896	\$ 888,187,152	\$ 2,604,109,308	\$ 119,793,211	
Cumulative																	
1208	\$ 228,768,784	\$ -	\$ -								\$ -	\$ 228,768,784					
0309	\$ 225,691,930	\$ (16,984,221)	\$ 38,998,635	\$ (4,144,041)							\$ 17,870,373	\$ 243,562,303					
0609	\$ 204,169,638	\$ -	\$ 686,851	\$ 5,522,763							\$ 6,209,614	\$ 210,379,252					
0909	\$ 235,585,153	\$ -	\$ 30,199	\$ 34,064,109							\$ 34,094,308	\$ 269,679,461					
WY4 SUM	\$ 894,215,505	\$ -	\$ (16,984,221)	\$ 39,715,685	\$ 35,442,831						\$ 58,174,295	\$ 935,368,819	\$ 5,495,618	\$ 940,864,437	\$ 3,425,180,534	\$ 3,606,430,571	\$ 181,250,037
Cumulative																	
1209	\$ 241,939,196	\$ -	\$ -	\$ 5,192,468							\$ 5,192,468	\$ 247,131,664					
0310	\$ 246,257,198	\$ -	\$ -	\$ 531,141	\$ 4,400,166						\$ 4,931,306	\$ 251,188,504					
0610	\$ 253,045,787	\$ -	\$ -	\$ 248,301	\$ 5,260,537						\$ 5,508,838	\$ 258,554,625					
0910	\$ 252,294,668	\$ (115,989)	\$ (261,426)	\$ 3,348,303							\$ 2,970,888	\$ 255,265,556					
WY5 SUM	\$ 993,536,849	\$ -	\$ -	\$ (115,989)	\$ 5,710,484	\$ 13,009,006					\$ 18,603,501	\$ 1,012,990,839	\$ 5,949,605	\$ 1,018,940,444	\$ 4,444,120,978	\$ 4,700,022,174	\$ 255,901,196
Cumulative																	
1210	\$ 262,106,988	\$ -	\$ -	\$ -	\$ 6,444,984						\$ 6,444,984	\$ 268,551,972					
0311	\$ -	\$ -	\$ -	\$ -	\$ -						\$ -	\$ -					
0611	\$ -	\$ -	\$ -	\$ -	\$ -						\$ -	\$ -					
0911	\$ -	\$ -	\$ -	\$ -	\$ -						\$ -	\$ -					
WY6 SUM	\$ 262,106,988	\$ -	\$ -	\$ -	\$ 6,444,984	\$ -					\$ 6,444,984	\$ 262,106,988	\$ 1,669,286	\$ 263,776,274	\$ 5,865,213,737	\$ 1,157,316,485	
Cumulative																	
1211	\$ -	\$ -	\$ -	\$ -	\$ -						\$ -	\$ -					
0312	\$ -	\$ -	\$ -	\$ -	\$ -						\$ -	\$ -					
0612	\$ -	\$ -	\$ -	\$ -	\$ -						\$ -	\$ -					
0912	\$ -	\$ -	\$ -	\$ -	\$ -						\$ -	\$ -					
WY7 SUM	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -					\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	
Cumulative																	
1212	\$ -	\$ -	\$ -	\$ -	\$ -						\$ -	\$ -					
0313	\$ -	\$ -	\$ -	\$ -	\$ -						\$ -	\$ -					
0613	\$ -	\$ -	\$ -	\$ -	\$ -						\$ -	\$ -					
0913	\$ -	\$ -	\$ -	\$ -	\$ -						\$ -	\$ -					
WY8 SUM	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -					\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	
Cumulative																	
1213	\$ -	\$ -	\$ -	\$ -	\$ -						\$ -	\$ -					
WY9 SUM	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -					\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	
Cumulative																	
	\$ 4,542,632,626	\$ 10,166,327	\$ (16,042,281)	\$ 79,876,130	\$ 41,153,315	\$ 19,453,990	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 4,677,240,106	\$ 30,657,146	\$ 4,707,897,252	\$ 8,955,886,798	\$ 4,247,989,546	

PQA = Prior Quarter Adjustments



Office of Vermont Health Access
 312 Hurricane Lane Suite 201
 Williston, VT 05495-2086
www.ovha.state.vt.us
 [phone] 802-879-5900

Agency of Human Services

**Complaints Received by Health Access Member Services
 October 1, 2010 – December 31, 2010**

Eligibility forms, notices, or process	23
ESD Call-center complaints (IVR, rudeness, hold times)	7
Use of social security number as identifiers	2
General premium complaints	6
Catamount Health Assistance Program premiums, process, ads, plans	0
Coverage rules	5
Member services	3
Eligibility rules	4
Eligibility local office	3
Prescription drug plan complaint	1
Copays/service limit	0
Pharmacy coverage	0
Provider issues (perceived rudeness, refusal to provide service, prices) (variety of provider types)	5
Provider enrollment issues	0
Chiropractic coverage change	0
Shortage of enrolled dentists	0
Green Mountain Care Website	0
DVHA	3
<hr/> Total	<hr/> 62



**Grievance and Appeal Quarterly Report
Medicaid MCO All Departments Combined Data
October 1, 2010 – December 31, 2010**

The MCO 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 MCO 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 MCO database. This report is based on data compiled on January 3, 2011, from the centralized database for grievances and appeals that were filed from October 1, 2010 through December 31, 2010.

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

During this quarter, there were 5 grievances filed with the MCO; 3 were addressed during the quarter, none were withdrawn and two were still pending at the end of the quarter. Grievances must be addressed within 90 days of filing, so having pending cases at the end of the quarter is to be expected. The grievances were addressed in an average of 20 days. Acknowledgement letters of the receipt of a grievance must be sent within five days; the average was three days, although one letter was sent late. Of the grievances filed, 20% were filed by beneficiaries, 60% were filed by a representative of the beneficiary and 20% were filed by another source. Of the 5 grievances filed, DMH had 80% and DAIL had 20%. There were no grievances filed for the DVHA, DCF, or VDH during this quarter.

There were five cases that were pending from all previous quarters, one was withdrawn and four were resolved this quarter.

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

Appeals: Medicaid rule 7110.1 defines actions that an MCO 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 MCO 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 36 appeals filed with the MCO; 2 requested an expedited decision and both met the criteria. Of these 36 appeals, 24 were resolved (67% of filed appeals), one was withdrawn, one was filed to late, and 10 were still pending (28%). In 14 cases (58% of those resolved), the original decision was upheld by the person hearing the appeal, nine cases (38% of those resolved) were reversed, and one was approved by the applicable department/DA/SSA before the appeal meeting.

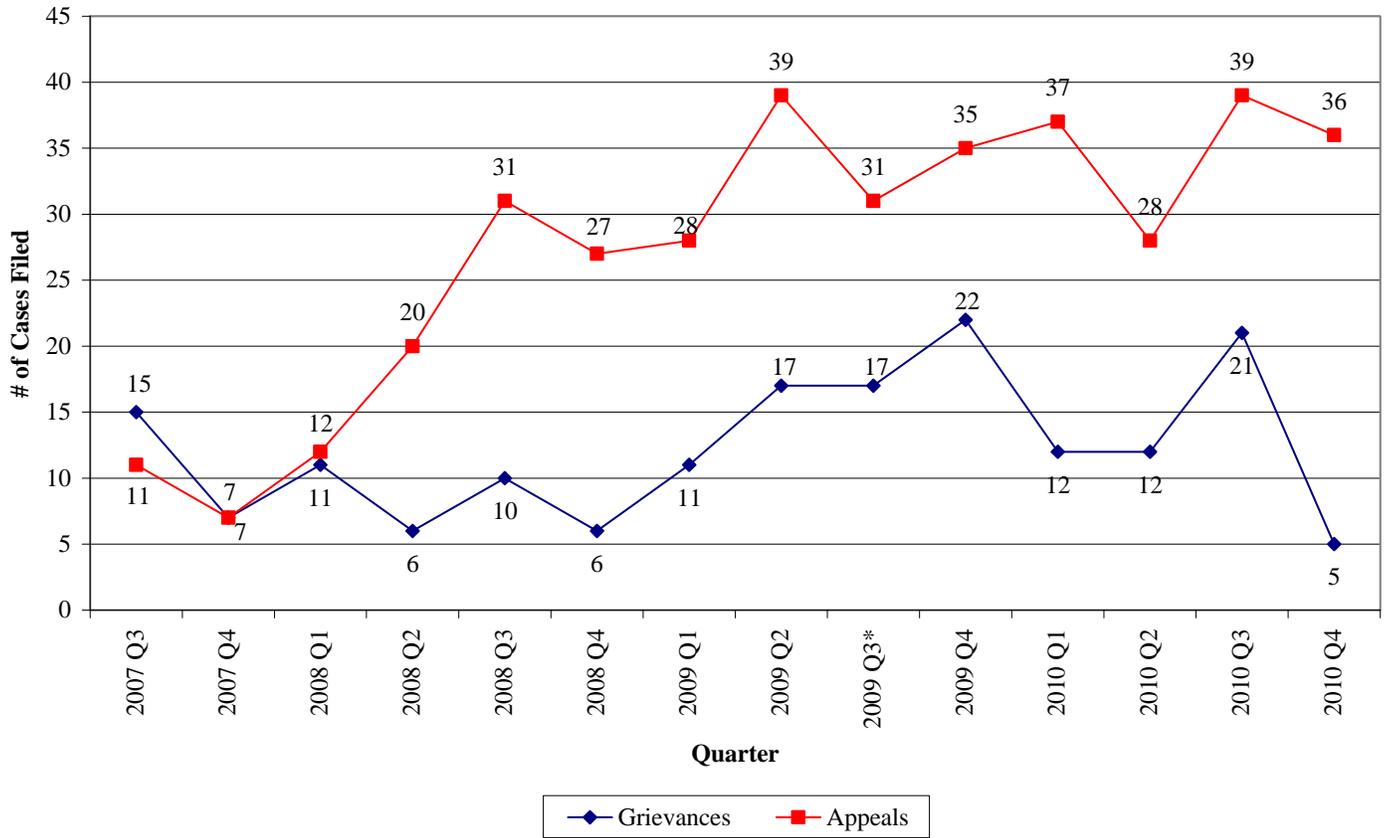
Of the 36 appeals that were resolved this quarter, 100% were resolved within the statutory time frame of 45 days; 58% were resolved within 30 days. The average number of days it took to resolve these cases was 25 days. 100% of appeals resolved this quarter were resolved within the maximum time frame of 59 days (the statutory time frame of 45 days plus an allowed 14 day extension). Acknowledgement letters of the receipt of an appeal must be sent within five days; the average was two days, although one letter was sent late.

Of the 36 appeals filed, 17 were filed by beneficiaries (47%) and 19 were filed by a representative of the beneficiary (53%). Of the 36 appeals filed, DVHA had 61%, DAIL had 25%, and DCF had 14%.

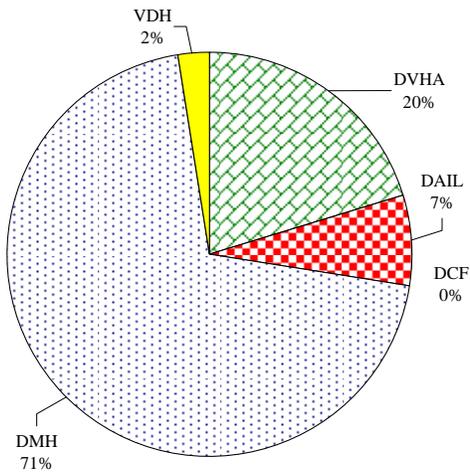
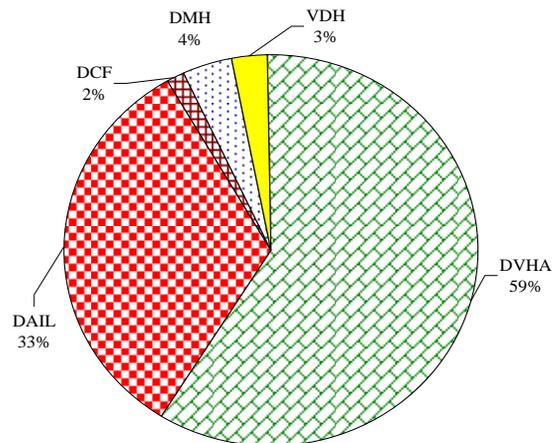
There were two DAIL and one VDH cases filed between April 1, 2010, and June 30, 2010 that were still pending at the beginning of this quarter. In addition, there were two DAIL cases that were still pending from before April 1, 2010. There were twelve pending cases that were resolved this quarter; 66% of these cases were upheld (three for DVHA and 5 for DAIL), two were reversed (17%), none were modified or withdrawn, and two were approved before the appeal hearing. 25% of these cases were resolved within 30 days, 67% in 45 days, and 83% within 59 days, 16% were over 59 days. On December 31, 2010 there were three cases still pending; two for DAIL and one for VDH.

Beneficiaries can file an appeal and a fair hearing at the same time, and they can file a fair hearing if their appeal is not decided in their favor. There were four fair hearings filed this quarter. Two for DVHA, one for DAIL and one for DMH. There are a total of three fair hearings still pending as of the end of this quarter, one for DAIL and two for DVHA.

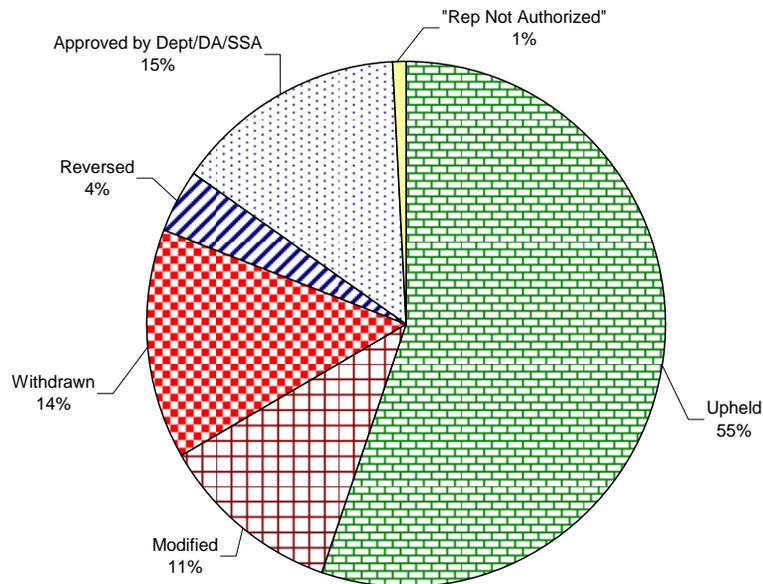
Medicaid MCO Grievances & Appeals



MCO Grievance & Appeals by Department From July 1, 2007 through December 31, 2010

Grievances

Appeals


MCO Appeal Resolutions from July 1, 2007 through December 31, 2010



Grievance and Appeal Quarterly Report
 Medicaid MCO All Departments Combined Data
 for the period: October 1, 2010 – December 31, 2010

Grievances

Total number of grievances filed: 5

Number pending: 2 *DMH*

Average number of days to send grievance review acknowledgement letter: N/A

Number withdrawn: 0

Number addressed: 3 *2-DMH, 1-DAIL*
 Within 90 days: 100% *2-DMH, 1-DAIL*
 Exceeding 90 days: 0%

Number of grievance reviews addressed: 0

Number of grievances filed too late: 0

Source of grievance request:
 Beneficiary: 1 20%
 Beneficiary Representative: 3 60%
 Other: 1 20%

Average number of days from "pertinent issue" to filing grievance: 13

Number related to:
 DVHA: 0 0%
 DAIL: 1 20%
 DCF: 0 0%
 DMH: 4 80%
 VDH: 0 0%

Average number of days from filing to entering into database: 3

Average number of days from filing to being addressed: 20

Average number of days to send acknowledgement letter: 3

Top services grieved:
 1. Mental Health Services (3)
 2. Other (2)
 3. ()

Number of late acknowledgement letters: 1 *DHM*

Number of grievance reviews requested: 0

* * * * *

Number pending from all previous quarters: 0

Number of grievances still pending at the end of this quarter: 2

Number that were pending in previous quarters and withdrawn this quarter: 1

Number of grievance reviews pending from all previous quarters: 0

Number that were pending in previous quarters and addressed this quarter: 4
 Within 90 days: 100% *3-DMH, 1-DAIL*
 Exceeding 90 days: 0%

Number of pending grievance reviews addressed this quarter: 0

Appeals

Number of appeals filed: 36

Number pending: 10 5-DVHA, 5-DAIL

Number withdrawn: 1 DAIL

Number resolved: 24

Number upheld: 14 58% 9-DVHA, 3-DAIL, 2-DMH

Number reversed: 9 38% 7-DVHA, 2-DMH

Number modified: 0 0%

Number approved by Dept/DA/SSA:
1 4% DVHA

Number of cases extended: 0

by beneficiary: 0

by MCO: 0

Resolved time frames

Within 30 days: 58% 9-DVHA, 4-DMH, 1-DAIL

Within 45 days: 100% 17-DVHA, 5-DMH, 2-DAIL

Within 59 days: 100%

Extended (0) vs. Late (0)

Over 59 days: 0%

Number of appeals filed too late: 1

Average number of days from NOA to filing appeal:
15

Average number of days from filing to entering
data into database: 2

Average number of days from filing to resolution:
25

Average number of days to send acknowledgement
letter: 2

Number of late acknowledgement letters: 1 DMH

Average number of days from filing to withdrawing:
12

Average number of days to send withdrawal letter:
0

Number of late withdrawal letters: 0

Source of appeal request:

Beneficiary: 17 47%

Beneficiary Representative: 19 53%

Provider: 0 0%

Other: 0 0%

Number related to:

DVHA: 22 61%

DAIL: 9 25%

DCF: 5 14%

DMH: 0 0%

VDH: 0 0%

Top services appealed:

1. Personal Care Services (6)

2. Transportation (5)

3. Prescriptions (5)

4. Chiropractic Services (3)

Number of beneficiaries that requested that their
services be continued: 9 25%

Of those that requested their services be
continued:

Number that met criteria: 8 89%

Number that did not meet criteria: 1 11%

Expedited Appeals

Number of expedited appeals filed: 2 2-DVHA

Number of expedited appeals that:

Met criteria: 2

Did not meet criteria: 0

For those MEETING criteria

Number pending:0

Number of late resolutions: 1 50%

Number of expedited appeals filed too late: 0

Source of appeal:

Number resolved: 2

Number upheld: 0 0%

Number reversed: 1 50% DVHA

Number modified: 0 0%

Number approved by Dept/DA/SSA:
1 50% DVHA

Beneficiary: 2 100%

Beneficiary Representative: 0 0%

Provider: 0 0%

Other: 0 0%

Top service appealed: Prescriptions (1)

Average number of days from Notice of Action to filing expedited appeal: 2

Number related to:

DVHA: 2 100%

DAIL: 0 0%

DCF: 0 0%

DMH: 0 0%

VDH: 0 0%

Average number of days from filing to entering data into database: 4

Average number of days from filing to resolution: 2

Number by category:

- | | |
|---|---|
| 1. Denial or limitation of authorization of a requested service or eligibility for service: | 2 |
| 2. Reduction/suspension/termination of a previously authorized covered service or service plan: | 0 |
| 3. Denial, in whole or in part, of payment for a covered service: | 0 |
| 4. Failure to provide clinically indicated covered service when the MCO provider is a DA/SSA: | 0 |
| 5. Denial of a beneficiary request to obtain covered services outside the network: | 0 |
| 6. Failure to act in a timely manner when required by state rule: | 0 |

NOT meeting criteria:

Average number of business days to orally notify beneficiary of not meeting criteria: 1

Average number of business days to notify beneficiary in writing of not meeting criteria: 1

Number late letters: 0

* * * * *

Number pending from last quarter: 0

Number pending from previous quarters: 3 2-DAIL (6/24/10,9/4/09); 1-VDH (5/10/10)

Total pending from ALL quarters: 13 7-DAIL, 5-DVHA, 1-VDH

Number of total pending that were resolved this quarter: 12

Number upheld:	8	66%	5-DAIL, 3-DVHA
Number reversed:	2	17%	2-DVHA
Number modified:	0	0%	
Number approved by Dept/DA/SSA:	2	17%	2-DVHA
Number withdrawn:	0	0%	

Resolution time frames for resolving above cases:

Within 30 days:	25%	2-DVHA, 1-DAIL
Within 45 days:	67%	2-DVHA, 2-DAIL
Within 59 days:	83%	6-DVHA, 4-DAIL
Extended (0) vs. Late (0)		
Over 59 days:	16%	1-DVHA (60 days); 1-DAIL

Number of appeals still pending from all previous quarters: 3 2-DAIL, 1-VDH

Fair Hearings

Total number of Fair Hearings filed: 4 2-DVHA, 1-DAIL, 1-DMH

Number of Fair Hearings filed with a concurrent appeal: 1 1-DMH

Number of Fair Hearings filed after appeal resolution: 3 2-DVHA, 1-DAIL

Number pending: 3 2-DVHA, 1-DAIL

Number resolved: 1

Number upheld:	1	DMH
Number reversed:	0	
Number modified:	0	
Number dismissed:	0	
Number withdrawn:	0	

Average number of days for resolution: 11

* * * * *

Number of pending Fair Hearings from previous quarters: 2 1-DVHA, 1-DAIL

Number of pending Fair Hearings from previous quarters resolved this quarter: 0

Number upheld:	0
Number reversed:	0
Number modified:	0
Number dismissed:	0
Number withdrawn:	0

Average number of days for resolution for pending Fair Hearings from previous quarters: 0

Number of pending Fair Hearings from previous quarters still pending at the end of this quarter: 2 1-DVHA, 1-DAIL

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QUARTERLY REPORT
October 1, 2010 – December 31, 2010
to the
DEPARTMENT OF VERMONT HEALTH ACCESS
Submitted by
Trinka Kerr, Vermont Health Care Ombudsman

I. Overview

This is the Office of Health Care Ombudsman's (HCO) report to the Department of Vermont Health Access (DVHA) for the quarter October 1, 2010 through December 31, 2010. We received 377 calls (42% of all calls) from DVHA program beneficiaries this quarter, compared to 318 (39%) last quarter.

There are three parts to this report: this narrative section, which includes a table of all calls received per month and year; the Issue Summary page from the All Calls data report, which is part of the report that goes to the Department of Banking, Insurance, Securities and Health Care Administration (BISHCA); and a 20 page data report specifically about DVHA beneficiaries who call us.

A. Call volume goes even higher.

Overall call volume this quarter was once again extremely high. The total number of all cases/all coverages that we opened this quarter was 889, compared to 815 last quarter. This was the highest quarterly call volume ever. The number of calls received this quarter was **63% higher** than the number of calls received during this same quarter in 2009. The HCO received the highest number of calls it has ever received in each of the months in this quarter. October was the busiest October ever (300 calls), November the busiest November (300 calls), and December the busiest December (289 calls). [See the table at the end of this narrative for further detail.]

In fact, calendar year 2010 was our busiest year ever as well, largely due to a sharp, 46%, increase in Eligibility calls over 2009. Calls in other categories increased as well, but not so significantly. We received total 3,079 calls in 2010, compared to 2,616 in 2009, an overall increase for the calendar year of about 18%.

The increase in Eligibility calls was largely due to problems the Department for Children and Families (DCF) has been having processing applications and reviews for all its public benefit programs, including the health care programs. While attempting to modernize its eligibility processing system, DCF also had a significant reduction in staff, an increase in demand as a result of the Great Recession, and problems with its new software. Over the summer the

processing problems increased and the HCO's call volume escalated as a result. By the fall, when the problems didn't abate, Vermont Legal Aid (VLA) threatened to sue DCF for its failure to comply with federal timelines for benefit processing. Ultimately, in December DCF and VLA agreed on an action plan, which DCF is implementing. However, as of the writing of this report, it is not clear that the number of Eligibility calls to the HCO is decreasing yet.

B. Affordable Care Act funding results in increased HCO staffing.

The call volume increase over the past six months severely stretched the HCO's capacity to help Vermonters. In addition, over the summer of 2010 two of the four HCO advocates left, and two new advocates were hired. Their training is ongoing. In early September, the Vermont Department of Banking, Insurance, Securities and Health Care Administration (BISHCA) and the HCO jointly submitted a grant application for additional funding for the HCO through the federal Affordable Care Act (ACA). In October we learned that we had been awarded the grant. As a result of this new funding, the HCO hired a new advocate in December and increased the hours of its staff attorney. Training of the new advocate has begun. It typically takes at least six months to adequately train new health care advocates. The HCO's staffing pattern is now equal to what it was in June 2007 (director, staff attorney, five advocates), when the call volume was 20 % lower. Therefore, if the call volume stays high, or gets higher, the HCO will continue to have to prioritize calls and provide more limited services to some callers.

C. Complaints about lack of affordability continue to increase.

Last quarter we began tracking the number of callers who told us that they could not afford health care, often even when they had insurance. This quarter we had 101 (as both a primary and a secondary issue) calls about this, compared to 64 last quarter. Of these 101 calls, 35 were from Medicare beneficiaries (compared to 29 last quarter), 51 were from DVHA beneficiaries (compared to 24), 21 were from commercially insured individuals (compared to 23), and 10 were from uninsured Vermonters (compared to 15).

There does not seem to be one single reason for the big jump in complaints from DVHA program beneficiaries who are upset about affordability. Per DVHA's request after the last quarterly report, here is some greater detail regarding the 32 cases coded as involving DVHA beneficiaries: 7 involved Medicare cost sharing (for VPharm beneficiaries), 4 involved individuals transitioning from VHAP to CHAP, 3 involved failure to meet criteria for prior authorizations, 2 involved the cost of Medicaid prescription co-pays, 2 involved the cost of VHAP premiums, 2 involved inability to get eyeglasses, 1 involved the transition from VHAP to Medicare, 1 involved the transition from Medicaid to VHAP, 1 involved employer sponsored insurance plan cost-sharing for a Catamount ESIA beneficiary, 1 involved an out of state provider who refused to take Vermont Medicaid, 1 involved the inadequacy of the Healthy Vermonters Program, 1 involved a doctor who refused to assist with a Medicare Part D appeal, 1 involved a temporary, incorrect termination from a state program, 1 involved the Medicaid dental cap, 1 involved a VHAP beneficiary unable to afford dental care, 1 involved the inability of a VHAP beneficiary to see her providers because she could not afford transportation, 1 involved illegal balance billing by a mental health provider, 1 involved inability to afford

dentures. In all of these cases individuals specifically told the HCO that their lack of money prevented them from getting medical services.

A number of Medicare beneficiaries told us they were going without care because they couldn't afford the cost-sharing. This may be connected to the continued high level of calls related to eligibility for the Medicare Buy In programs: 34 this quarter compared to 32 last quarter and only 14 the quarter before that. The Buy In or Medicare Savings Programs are federal subsidies through the state that are available to individuals below 135% of the Federal Poverty Level.

D. Issues with highest call volumes remain the same.

The issues (primary and secondary) with the highest call volumes were: VHAP eligibility (144 calls), Medicaid eligibility (115), access to prescription drugs (111), affordability (101), communication problems or complaints about providers (101), and premium assistance eligibility (81).

II. Issues

A. Eligibility

The percentage of calls related to eligibility for state programs has remained consistently high since Catamount Health went into effect. In 2009 eligibility calls hovered around 25% of all calls. This year they have risen to above 30% for the last two quarters. This quarter we had 305 calls related to eligibility or 34.31% of all calls. Last quarter we received 271, or 33.25% of all calls. Calls related to eligibility can be inquiries about the programs generally, or about specific problems with the application process, a denial or a termination. They also can be from people who are already insured seeking information about the programs because they cannot afford the insurance they are on.

The total number of calls from the uninsured was 100, compared to 99 last quarter, which had jumped from 55 the previous quarter. These calls are usually about eligibility for state programs. This quarter 77% (77) of those calls were regarding eligibility, with access to care a distant second at 14% (14).

We continue to see significant numbers of problems related to state program eligibility determinations. A look at both primary and secondary issues, reveals some serious problems in this area. Note that this means some of the numbers below overlap; that is; some of the 38 DCF Mistake cases could also involve lost paperwork, for example. Of the 676 total calls about eligibility this quarter:

- 15 involved application processing delays (compared to 18 last quarter);
- 34 involved the Buy In (Medicare Savings) Programs (compared to 32);
- 38 involved DCF mistakes (compared to 29);
- 15 involved lost paperwork, meaning that callers said they submitted paperwork to DCF and were subsequently told there was no record of it (compared to 20);
- 8 involved problems with the U.S. Postal Service;
- 25 involved the Medicaid Spend Down program (compared to 31);

- 3 involved an error by Member Services (compared to 4); and
- 15 involved specific DCF Modernization complaints, listed in the issue section “Other,” as these are not necessarily related to eligibility problems (compared to 7).

B. Access to Care

This quarter we had a total of 256 calls related to Access issues or 28.80% of all calls. Of these, 141 (55%) were from DVHA beneficiaries. In the previous quarter we had 213 total Access calls, with 105 (49%) coming from DVHA beneficiaries. Since about 42% of our total calls were from DVHA callers, this is a comparatively high percentage of calls regarding Access issues, and remains a cause of some concern. The percentage of calls from DVHA beneficiaries about access consistently runs about 35%; this quarter it was slightly higher at 37.40%. For beneficiaries of commercial carriers it usually runs about 20-25%. This quarter only 17.05% of calls from commercially insured individuals called us about access issues. Access is clearly a bigger issue for DVHA beneficiaries.

Two areas of particular concern this quarter are:

1. Access to Pain Management

The number of calls from DVHA beneficiaries related to pain management as the primary issue was the same this quarter as last quarter, at 12 calls. However, 17 calls involved pain management as a primary or secondary issue. We received a total of 27 calls overall related to pain management, so the DVHA calls made up 63% of these calls. We had only one caller on commercial insurance with a pain management issue. Thus, this continues to be primarily a state program problem. These continue to be some of our most difficult calls, as we are generally not able to do much to help callers.

2. Access to Substance Abuse Treatment

We received seven calls coded as access to substance abuse treatment as the primary issue this quarter. Of these, six were from DVHA beneficiaries. The previous quarter we received four such calls, and two were from DVHA beneficiaries. The HCO only received 17 calls in all of 2010 which were coded as access to substance abuse treatment as the primary issue, so receiving seven in one quarter was a significant increase. Access to substance abuse treatment, in particular for opiate addiction and specifically for methadone treatment is a growing concern.

III. Call volume by type of insurance:

- **DVHA programs** (Medicaid, VHAP, VHAP Pharmacy, a Premium Assistance program, VScript, VPharm, or both Medicaid and Medicare) insured **42%** (377 calls), compared to 39% (318) last quarter;
- **Medicare** (Medicare only, Medicare and a Medicare Supplemental Plan aka Medigap, Medicare and Medicaid, Medicare and a Medicare Savings Program

aka a Buy-In program, or Medicare and VPharm) insured **21%** (188), compared to 24% (192) last quarter;

- 12% (103) had Medicare only;
- 10% (85) had both Medicare coverage and coverage through a state program such as Medicaid, a Medicare Savings Program aka a Buy-In program, or VPharm;
- **Commercial carriers** (employer sponsored insurance, individual or small group plans, including Catamount Health plans) insured **20%** (176), compared to 17% (137) last quarter;
- **11%** (100) identified themselves as **uninsured**, compared to 12% (99) last quarter;
- **6%** (49) had a **Catamount Health** plan, compared to 4% (32) last quarter; and
- The remainder of callers' insurance status was either unknown or not relevant.

IV. Disposition of DVHA cases

We closed 379 DVHA cases this quarter, compared to 303 last quarter:

- About 5% (18 calls) from DVHA beneficiaries were resolved in the initial call, compared to 4% (12 calls) last quarter;
- 58% (220 calls) were resolved by advice or referral, after an analysis of the problem. Last quarter 59% (178 calls) were resolved in this manner;
- 21% (79 calls) were resolved by direct intervention on the caller's behalf, including advocacy with DVHA and providers, writing letters, gathering medical information, and representation at fair hearings. Last quarter 25% (77 calls) were resolved in this manner;
- About 8% (31 calls) were considered complex intervention, which involves complex analysis and more than two hours of an advocate's time, compared to 3% (10 calls) last quarter. **The number of complex cases thus more than tripled this quarter.**

V. Issues raised by DVHA beneficiaries

We opened 377 cases from DVHA beneficiaries, compared to 318 last quarter. Of these:

- 37.40% (141 calls) involved Access to Care, compared to 33.92% (105 calls) last quarter;
- 11.67% (44 calls) involved Billing/Coverage, compared to 15.09% (48 calls) last quarter;
- 1.33% (5 calls) were coded as Consumer Education, compared to 2.52% (8 calls) last quarter;
- 32.63% (123 calls) involved Eligibility, compared to 32.39% (103 calls) last quarter; and 16.45% (62 calls) involved Other issues, compared to 16.35% (52 calls) last quarter, which includes Medicare Part D calls.

A. Access to Care

Access to Care cases involve situations where the individual is seeking care and is having some difficulty obtaining access to it. These tend to be our highest priority cases.

We received 141 DVHA Access to Care calls, compared to 105 last quarter. The top call volume primary issues within this category were:

- 31 calls involved access to Prescription Drugs, compared to 17 last quarter;
- 17 involved Dental, Dentists or Orthodontics, compared to 8;
- 14 involved Transportation, compared to 9;
- 12 involved Pain Management, compared to 11;
- 10 involved Affordability; and
- 6 involved Substance Abuse.

The top access issues when both primary and secondary issues (258 calls) were considered were:

- 56 Prescription Drug;
- 32 Affordability;
- 25 Specialty Care;
- 20 Dental, Dentists or Orthodontia;
- 17 Transportation;
- 16 Primary Care Doctor; and
- 12 Transition/Continuity of Care.

B. Billing/Coverage

Billing and Coverage cases are those in which the individual has already received the health care service and the issue is related to payment for that service.

We received 44 DVHA primary issue calls in this category, compared to 48 last quarter:

- 20 involved Medicaid/VHAP Managed Care, compared to 21 last quarter;
- 3 involved Claim Denials; and
- 6 involved Hospital Billing.

C. Eligibility

Eligibility cases are those in which the individual is seeking to get or retain government subsidized health insurance. This quarter we received 305 calls from individuals with a primary issue of eligibility, but we received a whopping 676 calls from individuals for whom eligibility was either a primary or secondary issue.

We received 123 eligibility calls from current DVHA beneficiaries, compared to 103 last quarter, which were coded as a primary issue:

- 30 involved Medicaid eligibility, compared to 28 last quarter;
- 29 involved VHAP, compared to 15;
- 11 involved the Buy In Programs, aka Medicare Savings Programs, compared to 7; and
- 13 involved Catamount Health and Premium Assistance, compared to 8. This count only includes callers who were already on DVHA plans when they called

us. Many callers who call about Catamount are either uninsured or on commercial plans.

VI. Outcomes

The HCO prevented 31 insurance terminations or reductions for DVHA beneficiaries and got two DVHA beneficiaries onto other plans. We provided advice or education to 101 callers, got claims covered or waived for 25 individuals. We estimated insurance eligibility for 26 callers and explained to 8 that they were not eligible. [See Outcome Summary for more detail on page 20 of the data report.]

VII. Table on All Calls by Month and Year

All Cases	2003	2004	2005	2006	2007	2008	2009	2010
January	241	252	178	313	280	309	240	218
February	187	188	160	209	172	232	255	228
March	177	257	188	192	219	229	256	250
April	161	203	173	192	190	235	213	222
May	234	210	200	235	195	207	213	206
June	252	176	191	236	254	245	276	251
July	221	208	190	183	211	205	225	271
August	189	236	214	216	250	152	173	234
September	222	191	172	181	167	147	218	310
October	241	172	191	225	229	237	216	300
November	227	146	168	216	195	192	170	300
December	226	170	175	185	198	214	161	289
Total	2578	2409	2200	2583	2560	2604	2616	3079

Investment Criteria #	Rationale	Attachment 6
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 to improve the health outcomes and the quality of life for Medicaid-eligible individuals in Vermont	
4	Encourage the formation and maintenance of public-private partnerships in health care.	

SFY10 Final MCO Investments

8/4/10

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