

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
July 1, 2011 – September 30, 2011

November 22, 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 (OVHA), the state's Medicaid organization, to a public Managed Care Entity (MCE). AHS will pay the MCE a lump sum premium payment for the provision of all Medicaid services in the state (with the exception of the Long-Term Care Waiver, managed separately). A Global Commitment to Health Waiver Amendment, approved October 31st 2007 by CMS, allows Vermont to implement the Catamount Health Premium Subsidy Program with the corresponding commercial Catamount Health Program (implemented by state statute October 1, 2007) up to 200 percent of the Federal Poverty Level. The Catamount Plan is a health insurance product offered in cooperation with Blue Cross Blue Shield of Vermont and MVP Health Care. It provides comprehensive, quality health coverage at a reasonable cost no matter how much an individual earns. The intent of this program is to reduce the number of uninsured citizens of Vermont. Subsidies are available to those who fall at or below 300 percent of the Federal Poverty Level (FPL). On December 23, 2009 a second amendment was approved that allowed Federal participation for subsidies up to 300 percent of the Federal Poverty Level. Additionally, this amendment also allowed for the inclusion of Vermont's supplemental pharmaceutical assistance programs in the Global Commitment to Health Waiver. Renewed January 1, 2011 the current waiver continues all of these goals.

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

One of the Terms and Conditions of the Global Commitment Waiver requires the State "to submit progress reports 60 days following the end of each quarter. ***This is the fourth quarterly report for waiver year six, covering the period from July 1, 2011 through September 30, 2011.***

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 9/30/2011	Previously Reported Enrollees Last Day of Qtr 6/30/2011	Variance 06/30/11 to 09/30/11
Demonstration Population 1:	46,711	46,272	0.95%
Demonstration Population 2:	43,586	43,638	-0.12%
Demonstration Population 3:	9,770	9,851	-0.82%
Demonstration Population 4:	N/A	N/A	N/A
Demonstration Population 5:	1071	1108	-3.34%
Demonstration Population 6:	3,244	3,208	1.12%
Demonstration Population 7:	35,407	36,042	-1.76%
Demonstration Population 8:	7,853	8,223	-4.50%
Demonstration Population 9:	2,525	2,537	-0.47%
Demonstration Population 10:	N/A	N/A	N/A
Demonstration Population 11:	11,132	10,952	1.64%

Green Mountain Care Outreach / Innovative Activities

Health care in Vermont is changing and so too is much of our web presence. DVHA is spearheading the creation of a web portal that will bring the nine health-related state websites under a health portal. The work started in this quarter and will continue over the year ahead.

Efforts continue to support the state's focus on primary care through the Blueprint for Health program. Marketing materials have been developed and tested with an eye on finalizing them in the next quarter.

A new program, known as '*Birth Control Plus Option*' will begin April 1, 2012. While not comprehensive coverage, it will be offered under Green Mountain Care. The Affordable Care Act established this new optional category (known as the Family Planning Option) and Vermont lawmakers included a provision in 2011 Act 63 (H.441) that directed the Department of Vermont Health Access to implement the program by April 1, 2012. The DVHA worked with Planned Parenthood to develop a name for the program and the two organizations will collaborate in outreach in the year ahead.

Green Mountain Care partnered with the Vermont Department of Labor to assist at four company layoffs affecting 60 people in order to inform them of their health insurance options.

Enrollment and legislative action: As of the end of September there were 12,104 individuals enrolled in the premium assistance program components of Green Mountain Care (Catamount Health and Employer-Sponsored Insurance).

As required by the Vermont Appropriations Act of State Fiscal Year 2011, Vermont requested 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. The legislature approved the request for one position and funds to implement this program. The Agency of Human Services submitted a waiver amendment request to CMS on April 4th and has formally submitted answers to questions raised by the Federal Review Team following a conference call on the waiver amendment request. Vermont is currently negotiating with CMS on the Standard Terms and Conditions.

A bill that would authorize Vermont's Health Benefits Exchange under the Affordable Care Act was passed by the legislature and signed into law by the Governor in May. DVHA is wrapping up its first year of planning for the Exchange, and details of its work during this past year can be found on the Exchange web page at: <http://dvha.vermont.gov/administration/health-benefits-exchange>. DVHA submitted its application on September 28 for a Level 1 Establishment grant for FFY 12 to continue its planning and implementation efforts.

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 September 30, 2011 are summarized below:

Initiative #1: Ensure Oral Health Exams for School-age Children - VDH, 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 - 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 - In February, 2008, DVHA began reimbursing 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 was developed to educate/train physicians on performing OHRAs, including online web

links. From February '08 – June'11, there were 4008 OHRAs claimed and approximately 3 of every 10 OHRAs claimed was from a physician.

Initiative #4: Place Dental Hygienists in Each of the 12 District Health Offices – Dental hygienists in district offices can be a valuable resource in providing fluoride varnish treatments, dental health education, early risk assessment and helping to connect children with a dental home. A successful pilot project resulted in the start of placement of 3 part-time dental hygienists in District Health Offices. This effort was scaled back due to budget constraints; current funding now covers one half-time dental hygienist in the Newport, Vermont district office. If resources improve and funding is allocated, this program remains well planned/tested and would be ready to expand.

Initiative #5: Selection/Assignment of a Dental Home for Children – Starting in May, 2008, 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 now select a dental home, emphasizing the importance of keeping oral health care on par with regular physicals and health checkups. If enrollees do not select a dental home, member services will assign one whenever possible, unless an enrollee formally declines this option. Through September, 2011, 73,963 eligible children (ages 0-17) have been identified since the program began in early 2008; of these, 72% voluntarily selected a dental home, approximately 14% were assigned dental homes by member services, and approximately 14% of enrollees declined.

Initiative #6: Enhance Outreach - 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. Also, a retired Vermont dentist, with grant assistance, is helping recruit and retain more dentists.

Initiative #7: Codes for Missed Appointments/Late Cancellations – In 2008, DVHA introduced a code to report missed appointments and late cancellations. The negative impact of missed appointments and late cancellations is three-fold: 1) the originally scheduled beneficiary does not receive care, 2) that appointment could have gone to another beneficiary, and 3) dental office productivity and income is reduced. The DVHA is collecting/evaluating 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 - DVHA introduced a system upgrade to allow enrolled dentists to access Medicaid cap information for adult benefits automatically. This system has proven to be a convenient and well-received tool for providers. Currently, the annual cap for adult benefits is set at \$495 and DVHA tracks 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 \$125,000 for both SFY 2010 and 2011. Fifteen awards were distributed in SFY 2010 and 14 awards were allocated for SFY 2011. No awards exceed \$20,000.

Initiative #10: Scholarships - Scholarships, administered through the Vermont Student Assistance Corporation, are awarded to encourage new dentists to practice in Vermont. A combined allocation of \$40,000 for SFY 2008/09 was distributed for the 2008-2009 academic year. There was \$20,000 available for 2010 and another \$20,000 for 2011.

Initiative #11: Access Grants - In SFY 2008, VDH awarded a total of \$70,000 as an incentive for dentists to expand access to Medicaid beneficiaries. In order to receive a grant, dentists must meet specific goals for increased access. In SFY 2008, seven grants ranged from \$5,000 to \$20,000. Funding remained at \$70,000 for SFY 2009 and for SFY 2010. In the current year, funding will be targeted to ensure adequate recruitment measures are in place to ensure and enhance access.

Initiative #12: Supplemental Payment Program – In SFY 2008, DVHA began distributing \$292,836 annually to recognize and reward dentists serving high volumes of Medicaid beneficiaries. 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, for an annual total of \$292,836. The program has continued on the same cycle and dollar amount for SFY 2010 and SFY 2011. Typically, 35-40 dentists qualify for semi-annual payouts.

Expenditure Containment Initiatives

Highlights of the Vermont Chronic Care Initiative for Quarter 4 of FFY 2011

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.

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). The staff is 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 VCCI staff is currently co-located in the following areas:

Rutland County	Franklin County
<ul style="list-style-type: none"> • Rutland Regional Medical Center (ED) • Rutland Primary Care • Community Health Centers of Rutland Region 	<ul style="list-style-type: none"> • Northwestern Medical Center (ED) • Cold Hollow Family Practice • Northern Tier Center for Health • Mousetrap Pediatrics • St. Albans Primary care

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

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

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

APS Contract

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

Vermont Advanced Improvement Program Overview

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

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

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

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

The DVHA Care Coordinators will automatically receive a daily list of high cost, high risk beneficiaries generated by the Percolator using data from a variety of sources (e.g., claims, pharmacy, self report, staff interactions, program goals, etc.). This listing will identify potential highest priority cases for that day and recommend evidence-based interventions to support Care Coordinator workflow. Care Coordinators will use Care Connection to document beneficiary assessments, interventions, and other aspects of the plan of care for each beneficiary.

APS Clinical Practice Specialists will collaborate with Care Coordinators to work with providers of highest priority beneficiaries by delivering *Patient Health Briefs* to identify urgent concerns with care and *Patient Registries* to identify patients with chronic disease and gaps in care. In consultation with the Clinical Pharmacist, they will also identify gaps in medication adherence and issues with poly-pharmacy, as well as promote best prescribing practices. In addition, Clinical Practice Specialists will provide a limited amount of care management with high risk beneficiaries. APS Social Workers will support interventions with high risk beneficiaries to increase post-discharge follow up appointments and medication adherence in order to reduce hospital readmissions and ER utilization. The VCCI highlights indicate the following:

- DVHA is transitioning away from traditional disease management and expanding its care coordination services provided by DVHA Nurse Case Managers and Medical Social Workers, Licensed Clinical Social Worker and Licensed Drug and Alcohol Counselor.

- DVHA has an enhanced information technology and sophisticated decision-support system through its contract with APS which targets the most costly and complex beneficiaries, adjusted with new information as frequently as daily.
- DVHA has enhanced its specialty services by adding a Licensed Clinical Social Worker and a Licensed Alcohol and Drug Counselor to the VCCI team.
- DVHA care coordinators expanded meetings and electronic data exchange systems with hospital emergency departments (EDs) for increased collaboration regarding emergency room utilization among VCCI beneficiaries.
- DVHA care coordinators in the Challenges for Change Pilot for both Rutland and St. Albans have established high penetration in EDs and in various Primary Care Physician locations in those counties.

The data indicates that from July 1, 2011 through June 30, 2011 VCCI maintained an average monthly caseload of 747 beneficiaries and from October 1, 2010 through September 30th, 2011 a total of 2,189 beneficiaries received either face to face or telephonic case coordination/intervention support services.

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			Final Capitated Rate (depends on the number of patients per level, per provider)
III.	Induction	\$366.42	+	BONUS	=
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 all four quarters (October 2010- September 30, 2011) is \$215,741.62 **(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
Total	\$ 55,709.12

SECOND QUARTER	
Jan-11	\$13,263.03
Feb-11	\$20,099.69
Mar-11	\$17,382.60
Total	\$50,745.32
THIRD QUARTER	
April-11	\$27,828.34
May-11	\$23,079.54
June-11	\$14,258.14
Total	\$65,166.02
FOURTH QUARTER	
July-11	\$23,135.76
Aug-11	\$16,117.24
Sept-11	4,868.16
Total	\$44,121.16
Grand Total	\$215,741.62

Mental Health – Vermont Futures Planning

Vermont State Hospital – Replacement Planning

In June, the Joint Commission surveyed the existing Vermont State Hospital facility. The hospital was complimented on the number of sustained improvements over the past three years, although there remained areas for improvement principally in facilities maintenance and clinical documentation. Subsequent to approving the hospital's plan to address report findings, the hospital was successfully re-accredited for another three years. On August 28, 2011, Vermont was severely impacted by Hurricane Irene. The State Office Complex in Waterbury, Vermont, where VSH is located on its campus, was inundated by flood waters. The extent of damage to all below ground and first floor areas forced the evacuation of the fifty-one inpatients of VSH and nearly fifteen hundred state employees. At the time of this quarterly report, patients who were hospitalized at VSH at the time of the flood, remain displaced and are receiving care and treatment services in other acute care hospital, residential care, and secure facilities throughout Vermont. VSH personnel, as well, are geographically dispersed to these alternate sites to provide ongoing patient care and treatment.

In the weeks following the displacement of the patients and staff of VSH, the Agency of Administration, the Agency of Human Services, and the Department of Mental Health have been actively exploring alternative acute and sub-acute care options to address the ongoing need for inpatient mental health treatment services for individuals who would have been served at the VSH facility. Designated Hospitals and Designated mental health agency providers have also been actively engaged with the state in proposing planning and development considerations for new facility construction or renovation and new treatment service capacities, both traditional and alternative, at the community level.

At this time, it is too early to identify a proposed plan among the several promising options being discussed. It is clear, however, that this natural disaster has compelled Vermont to be on a rapid trajectory for VSH replacement. It is also understood that this emergency, and any administrative or policy decision made in the weeks and months following this event, provides an immediate opportunity to move the current system of care from a slowly evolving change process to one of expedited transformation planning and action.

Community System Development

Alyssum, Vermont's first peer-run crisis alternative program, completed the final phase of development activities during this quarter, which included leasing and renovating a facility to house the program, hiring and training staff, and finalizing program policies and procedures. The program will be holding an open house in October and begin accepting referrals in November.

Both the electronic bed board, which will identify inpatient and crisis bed availability state-wide for use by the emergency and inpatient providers, and the LOCUS (Level of Care Utilization System), for all admissions to acute care (crisis beds) and residential beds, experienced further set-back during this quarter as the Department of Mental Health was relocated. Vendor selection and contract development have been delayed given the emergent planning needs focusing on VSH and the development of new community services capacity.

Through its participation in its five-year SAMHSA-funded *Mental Health Transformation Grants*, Vermont is moving forward in the development of a new credentialed peer workforce that will provide outreach and support services for young adults (ages 18-34) with or at risk of serious mental illness. Many of the individuals in this target population chose not to access professional mental health services, and those who are at risk for serious mental illness are not even eligible for the more comprehensive community mental health services (e.g. Community Rehabilitation and Treatment) that might prevent long-term disability. Peer services funded through the Mental Health Transformation grant will provide prevention and early intervention services that are not currently available in our system. Long-term sustainability planning post grant funding is in its early stages and looking towards global commitment flexibility to fund these non-traditional support services as a cost-effective alternative to higher cost services. DMH expects that these services will achieve the following outcomes for a population that is not receiving adequate support from our current service system:

- Improved engagement rates and referrals to other social services
- Increased employment rates
- Improved educational status
- Decreased homeless rates
- Decreased interactions with law enforcement
- Reduced drug use
- Reduced emergency room use
- Increased social connectedness and support.

Although in its early stages, this work will be occurring in tandem with the development of new and alternative services in the community.

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. Effective with the QE0311 and QE0611 CMS-64 filings, AHS reconciled the Federal claims from the estimated monthly PMPM payments to the underlying actual Global Commitment expenditures incurred via the usual reconciliation draw process.

AHS began working with its actuarial consultant in April 2011 (Aon), to develop actuarially sound capitation rate ranges for the FFY12 period, and delivered the selected FFY12 rates to CMS on August 23, 2011 (one week prior to the required September 1 due date). AHS posted an actuarial consultant RFP in July, 2011, in accordance with State contracting guidelines that require this contract to be rebid. The existing agreement with Aon is set to expire on March 31, 2012, and AHS anticipates entering into a new contractual agreement with an actuarial consulting vendor for the FFY13 and FFY14 period, effective April 1, 2012. Bids for this arrangement are due to be received by the State on or before November 1, 2011; the State plans to select a contractor prior to January 2012.

The ARRA enhanced funding period for Medicaid expenditures ended on June 30, 2011; the State has ceased claiming ARRA funding for Global Commitment effective July 1, 2011 (with the exception of allowable prior quarter adjustments).

Member Month Reporting

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

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

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

Demonstration Population	Month 1 7/30/2011	Month 2 8/31/2011	Month 3 9/30/2011	Total for Quarter Ending 4th Qtr FFY '11	Total for Quarter Ending 3rd Qtr FFY '11	Total for Quarter Ending 2nd Qtr FFY '11	Total for Quarter Ending 1st Qtr FFY '11	Total for Quarter Ending 4th Qtr FFY '10	Total for Quarter Ending 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
Demo Pop 1:	46,378	46,502	46,711	139,591	138,493	137,968	136,144	134,256	132,168	131,930	131,513	129,656	128,203	125,825	123,997
Demo Pop 2:	43,520	43,609	43,586	130,715	130,868	131,340	131,167	131,402	131,865	130,746	129,075	128,698	128,590	122,210	121,981
Demo Pop 3:	9,854	9,772	9,770	29,396	29,431	29,787	29,874	30,068	30,244	29,567	29,352	29,428	28,628	26,555	26,452
Demo 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
Demo Pop 5:	1,087	1,088	1,071	3,246	3,310	3,237	3,423	3,444	3,701	3,614	3,546	3,410	3,568	3,832	3,850
Demo Pop 6:	3,338	3,306	3,244	9,888	9,795	9,769	9,226	9,073	8,972	8,495	8,218	8,088	7,480	8,208	7,428
Demo Pop 7:	35,503	35,022	35,407	105,932	108,184	107,915	105,131	103,915	103,194	98,576	92,217	89,158	87,116	75,277	74,301
Demo Pop 8:	7,668	7,766	7,853	23,287	24,639	23,499	23,180	23,155	22,707	22,462	22,254	21,905	23,165	22,032	21,715
Demo Pop 9:	2,475	2,512	2,525	7,512	7,634	7,722	7,887	7,848	7,914	7,770	7,673	7,634	7,665	7,649	7,626
Demo 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
Demo Pop 11:	11,018	11,057	11,132	33,207	32,732	31,046	31,397	30,986	31,445	29,728	28,278	26,444	24,717	19,465	16,136

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

Consumer Issues

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

helping beneficiaries to understand the benefits and responsibilities of their particular programs. The complaints received by Member Services are based on anecdotal weekly reports that the contractor provides to DVHA (see Attachment 3). Member services works to resolve the issues raised by beneficiaries, and their data helps DVHA look for any significant trends. The weekly reports are seen by several management staff at DVHA and staff asks for further information on complaints that may appear to need follow-up to ensure that the issue is addressed. When a caller is dissatisfied with the resolution that Member Services offers, the member services representative explains the option of filing a grievance and assists the caller with that process. It is noteworthy that Member Services receives an average approximately 25,000 calls a month. We believe that the low volume of complaints and grievances is an indicator that our system is working well.

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

The third mechanism to track consumer issues is the report for the Office of Health Care Ombudsman (HCO) is a comprehensive report of all contacts with beneficiaries (see Attachment 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 Quality Improvement Manager continued to work with DVHA staff as they prepare for this year's External Quality Review Organization (EQRO) Performance Improvement Project (PIP) validation activities. Toward the end of the quarter, DVHA completed and submitted the validation tool. The new project will be validated up to and including step seven (i.e., Analyze and Interpret Study Results). Prior to submission, the Quality Improvement Manager reviewed the documents associated with the review and provided feedback. The EQRO will score the initial submission by the beginning of next quarter. If necessary, the AHS will initiate a technical assistance call with the EQRO to discuss any preliminary findings. Also during this quarter, the AHS Quality Improvement Manager continued to review a list of performance improvement reference documents to be used to help support performance improvement activities throughout the Agency. It is anticipated that this list will be available to staff by the end of next quarter. During this quarter, the AHS Quality Improvement Manager and Managed Care Entity representatives decided on a final list of measures that will be subject to EQRO review during the next quarter. It was agreed that the measures from last year will be required again this year and thus subject to review (less Prenatal/Postpartum Care & Lead Screening). While no longer a Managed Care Entity requirement; both of the aforementioned measures will still be available to AHS via alternative mechanisms. It is anticipated that initial measures and rates for the nine HEDIS measures subject to validation will be ready for EQRO review by the beginning of next quarter. The AHS provided technical assistance and feedback as needed in preparation of the EQRO review. All documents were posted to the EQRO FTP site by the due date. The EQRO confirmed that all requested documents were received and that the on-site visit is

scheduled for early next quarter.

Quality Assurance Performance Improvement Committee (QAPI)

During this quarter, the AHS continued to work with DVHA staff as they prepare for this year's External Quality Review Organization (EQRO) Performance Improvement Project (PIP) validation activities. Toward the end of the quarter, DVHA completed and submitted the validation tool. The EQRO will score the initial submission by the beginning of next quarter. Also during this quarter, the AHS continued to work with MCE staff to prepare for the EQRO performance measure validation and helped them prepare for this year's compliance review. All documents were posted to the EQRO FTP site by the due date. The EQRO confirmed that all requested documents were received and that the on-site visit is scheduled for early next quarter. During this quarter, the Quality Assurance and Performance Improvement Committee held their quarterly meeting. The Committee reviewed the compliance activities of the MCE in three areas: confidentiality, availability of services and performance improvement projects. The Committee reviewed the annual report from the AHS Privacy and Security Officer on all possible HIPAA violations reported throughout the MCE during SFY 2011. The Committee also reviewed the provider mapping generated from DVHA to assess the availability of services throughout Vermont. The provider mapping is one mechanism the MCE utilizes to assess the adequacy of the provider network. Other mechanisms include grievances & appeals, member complaint logs, satisfaction surveys, and the Ombudsman report. Other activities specific to individual AHS departments include tracking penetration rates, annual services and performing satisfaction surveys. For the third compliance activity, performance improvement projects (PIP), the Committee reviewed the annual evaluation of the PIP by Health Services Advisory Group. This was the first year of the new MCE PIP, Increasing Adherence to Evidenced-Based Pharmacy Guidelines in Member with Congestive Heart Failure. Also during this quarter, the AHS met with representatives of the MCE QAPI Committee to discuss the following activities: availability of services, confidentiality, and utilization management.

Quality Strategy

Now that the monitoring/oversight structure has been revised, 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. During this quarter, no action was taken on the strategy.

Demonstration Evaluation

During the first quarter of FFY11, CMS approved the State's formal waiver extension request through 2013. During the next quarter, the AHS will continue to work with the Pacific Health Policy Group (PHPG) project manager to modify the current evaluation work plan to be in sync with the new waiver extension time period.

Reported Purposes for Capitated Revenue Expenditures

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

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

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

Please see Attachment 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	802-871-3005 (P) 802-871-3001 (F) jim.giffin@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	802-871-3265 (P) 802-871-3001 (F) suzanne.santarcangelo@state.vt.us
Managed Care Entity:	Mark Larson, Commissioner Department of VT Health Access 312 Hurricane Lane, Suite 201 Williston, VT 05495	802-879-5901 (P) 802-879-5952 (F) mark.larson@state.vt.us

Date Submitted to CMS: November 22, 2011

ATTACHMENTS



Department of Vermont Health Access
SFY 12 Catamount Health Actual Revenue and Expense Tracking
Tuesday, October 18, 2011

	SFY '12 Appropriation			Consensus Estimates for SFY to Date			Actuals thru 9/30/11			
	<=200%	>200%	Total	<=200%	>200%	Total	<=200%	>200%	Total	% of SFY to-Date
TOTAL PROGRAM EXPENDITURES										
Catamount Health	37,583,124	14,894,418	52,477,542	9,211,649	3,650,632	12,862,281	8,607,295	4,207,266	12,814,562	99.63%
Catamount Eligible Employer-Sponsored Insurance	1,549,861	1,093,183	2,643,044	380,155	268,139	648,294	272,547	128,092	400,639	61.80%
Subtotal Program Spending	39,132,985	15,987,601	55,120,586	9,591,804	3,918,771	13,510,575	8,879,842	4,335,358	13,215,200	97.81%
DVHA Administration	1,296,865	529,828	1,826,693	324,216	132,457	456,673	324,216	132,457	456,673	100.00%
DCF Administration	875,023	357,487	1,232,510	218,756	89,372	308,128	218,756	89,372	308,128	100.00%
Subtotal Administration Spending	2,171,888	887,315	3,059,203	542,972	221,829	764,801	542,972	221,829	764,801	100.00%
TOTAL GROSS PROGRAM SPENDING	41,304,873	16,874,916	58,179,789	10,134,776	4,140,600	14,275,376	12,307,294	5,981,358	18,288,653	128.11%
TOTAL STATE PROGRAM SPENDING	17,407,059	7,111,573	24,518,631	4,189,264	1,711,539	5,900,804	2,685,530	1,286,643	3,972,173	67.32%
TOTAL OTHER EXPENDITURES										
Immunizations Program	2,500,000	-	2,500,000	625,000	-	625,000	625,000	-	625,000	100.00%
VT Dept. of Labor	-	401,993	401,993	-	100,498	100,498	-	100,498	100,498	100.00%
Marketing and Outreach	500,000	-	500,000	125,000	-	125,000	125,000	-	125,000	100.00%
Blueprint	1,846,713	-	1,846,713	461,678	-	461,678	461,678	-	461,678	100.00%
TOTAL OTHER SPENDING	4,846,713	401,993	5,248,706	1,211,678	100,498	1,312,177	1,211,678	100,498	1,312,177	100.00%
TOTAL STATE OTHER SPENDING	2,042,405	401,993	2,444,398	510,601	100,498	611,099	500,302	100,498	600,800	98.31%
TOTAL ALL STATE SPENDING	19,449,463	7,513,566	26,963,029	4,699,866	1,812,038	6,511,903	3,185,832	1,387,141	4,572,973	70.22%
TOTAL REVENUES										
Catamount Health Premiums	5,118,571	4,933,526	10,052,097	1,254,565	1,209,211	2,463,776	1,322,252	1,262,187	2,584,439	104.90%
Catamount Eligible Employer-Sponsored Insurance Premiums	356,157	441,156	797,314	87,359	107,258	194,617	83,032	67,673	150,705	77.44%
Subtotal Premiums	5,474,728	5,374,682	10,849,411	1,341,925	1,316,468	2,658,393	1,405,284	1,329,860	2,735,144	102.89%
Federal Share of Premiums	(3,167,512)	(3,109,618)	(6,277,130)	(787,844)	(772,899)	(1,560,743)	(825,042)	(781,027)	(1,606,069)	102.90%
TOTAL STATE PREMIUM SHARE	2,307,216	2,265,064	4,572,280	554,081	543,570	1,097,650	580,242	548,833	1,129,075	102.86%
Cigarette Tax & Floor Stock			10,048,500			2,512,125			3,599,160	143.27%
Employer Assessment			9,800,000			2,450,000			2,482,000	101.31%
Interest			-			-			463	0.00%
Shared Savings by > 300%			1,277,100			232,200			-	-
TOTAL OTHER REVENUE			21,125,600			5,194,325			6,081,623	117.08%
TOTAL STATE REVENUE			25,697,880			6,291,975			7,210,698	114.60%
State-Only Balance			(1,265,149)			(219,928)			134,068	
Carryforward			-			-			-	
CATAMOUNT FUND (DEFICIT)/SURPLUS			(1,265,149)			(219,928)			134,068	
General Fund BAA to GC on Behalf of Catamount			2,612,336			653,084			435,389	66.67%
ALL FUNDS THAT SUPPORT CATAMOUNT (DEFICIT)/SURPLUS			1,347,187			433,156			569,458	

**Green Mountain Care Enrollment Report
 SEPTEMBER 2011**

TOTAL ENROLLMENT BY MONTH

	Jul-07	Nov-07	Jul-08	Aug 10	Sept 10	Oct 10	Nov 10	Dec 10	Jan 11	Feb 11	Mar 11	Apr 11	May 11	June 11	July 11	Aug 11	Sept 11
Adults:																	
VHAP-ESIA	-	35	672	921	906	873	871	899	899	905	918	890	876	850	818	825	807
ESIA	-	21	336	731	729	768	760	764	783	785	801	801	804	782	782	759	755
CHAP	-	320	4,608	9,839	10,087	9,891	9,898	9,898	9,820	9,967	10,200	10,375	10,477	10,434	10,461	10,669	10,542
Catamount Health	-	120	697	2,474	2,491	2,483	2,552	2,498	2,545	2,718	2,810	2,622	2,852	2,386	2,921	2,964	2,960
Total	-	496	6,313	13,965	14,213	14,015	14,081	14,059	14,047	14,375	14,729	14,688	15,009	14,452	14,982	15,217	15,064
Adults:																	
VHAP	23,725	24,849	26,441	35,408	35,852	36,019	35,730	36,669	37,093	37,194	37,820	37,383	36,988	37,412	36,569	35,953	36,886
Other Medicaid	69,764	69,969	70,947	39,590	38,663	39,913	39,777	39,414	40,384	40,462	40,799	40,794	40,094	39,962	39,897	39,773	40,530
Children:																	
Dr Dynasaur	19,738	19,733	19,960	19,608	19,891	20,051	20,141	21,120	21,113	21,080	21,064	21,171	20,821	20,027	20,077	20,029	22,069
SCHIP	3,097	3,428	3,396	3,500	3,508	3,613	3,587	3,539	3,499	3,657	3,605	3,622	3,612	3,721	3,789	3,790	3,843
Other Medicaid*	Included	Included	Included	38,015	39,142	39,349	38,942	38,265	38,355	38,460	38,675	38,523	37,666	38,103	37,948	37,841	38,394
Total	116,324	117,979	120,744	136,121	137,056	138,945	138,177	139,007	140,444	140,853	141,963	141,493	139,181	139,225	138,280	137,386	141,722
TOTAL ALL	116,324	118,355	127,057	150,086	151,269	152,960	152,258	153,066	154,491	155,228	156,692	156,181	154,190	153,677	153,262	152,603	156,786

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

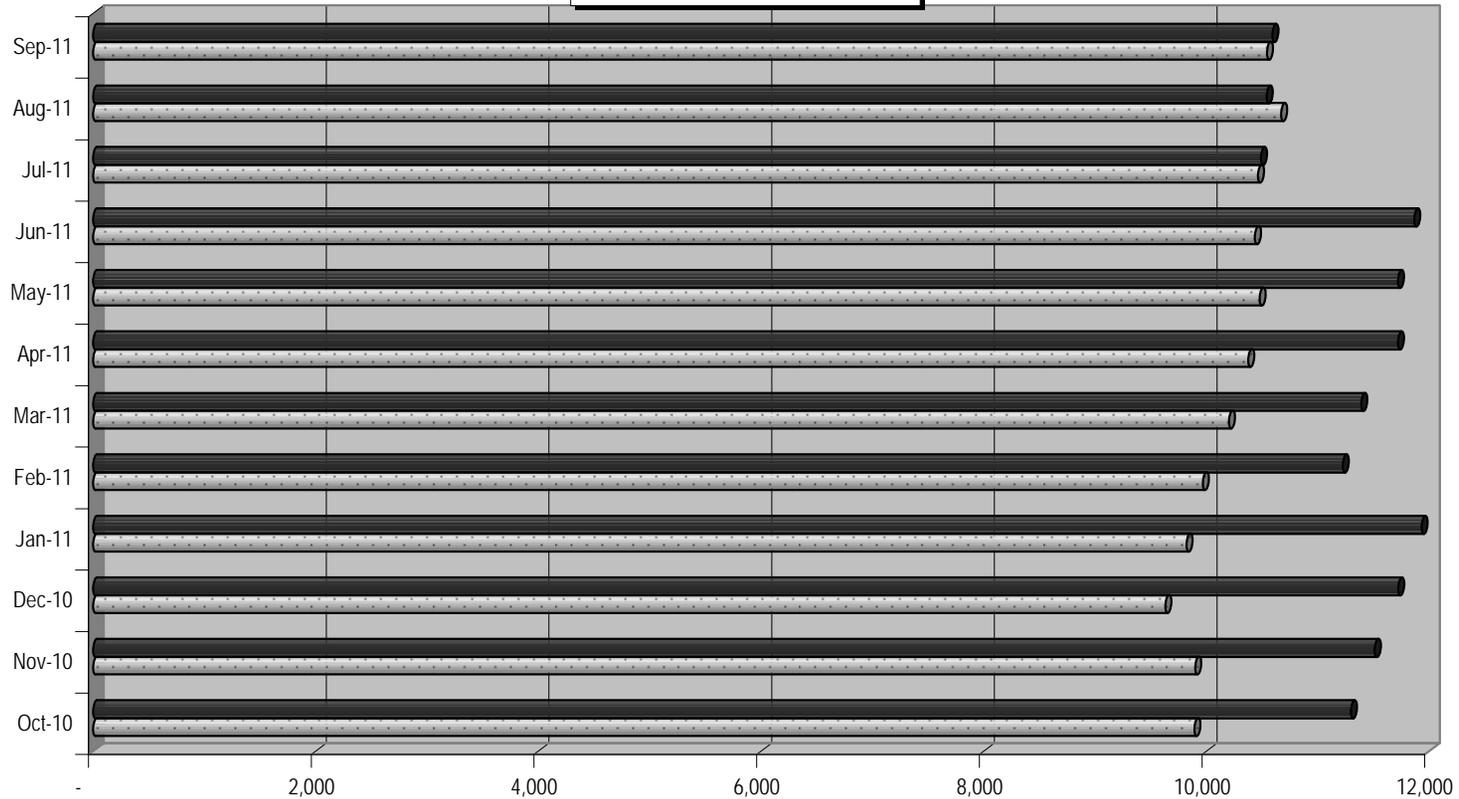
Data on the range and types of ESI plans has not been included in this report, but will be included as soon as the data is available.

Green Mountain Care Enrollment Report				
SEPTEMBER 2011 Demographics				
Income	VHAP-ESIA*	ESIA*	CHAP*	TOTAL
0-50%	32	3	524	559
50-75%	29	2	95	126
75-100%	76	-	114	190
100-150%	389	15	337	741
150-185%	275	211	3757	4,243
185-200%	3	259	2563	2,825
200-225%	2	124	1432	1,558
225-250%	0	97	1005	1,102
250-275%	1	41	520	562
275-300%	-	3	195	198
Total	807	755	10,542	12,104

Age	VHAP-ESIA	ESIA	CHAP	TOTAL
18-24	29	61	1,876	1,966
25-35	262	194	2,016	2,472
36-45	288	227	1,629	2,144
46-55	190	194	2,348	2,732
56-64	37	78	2,666	2,781
65+	1	1	7	9
Total	807	755	10,542	12,104

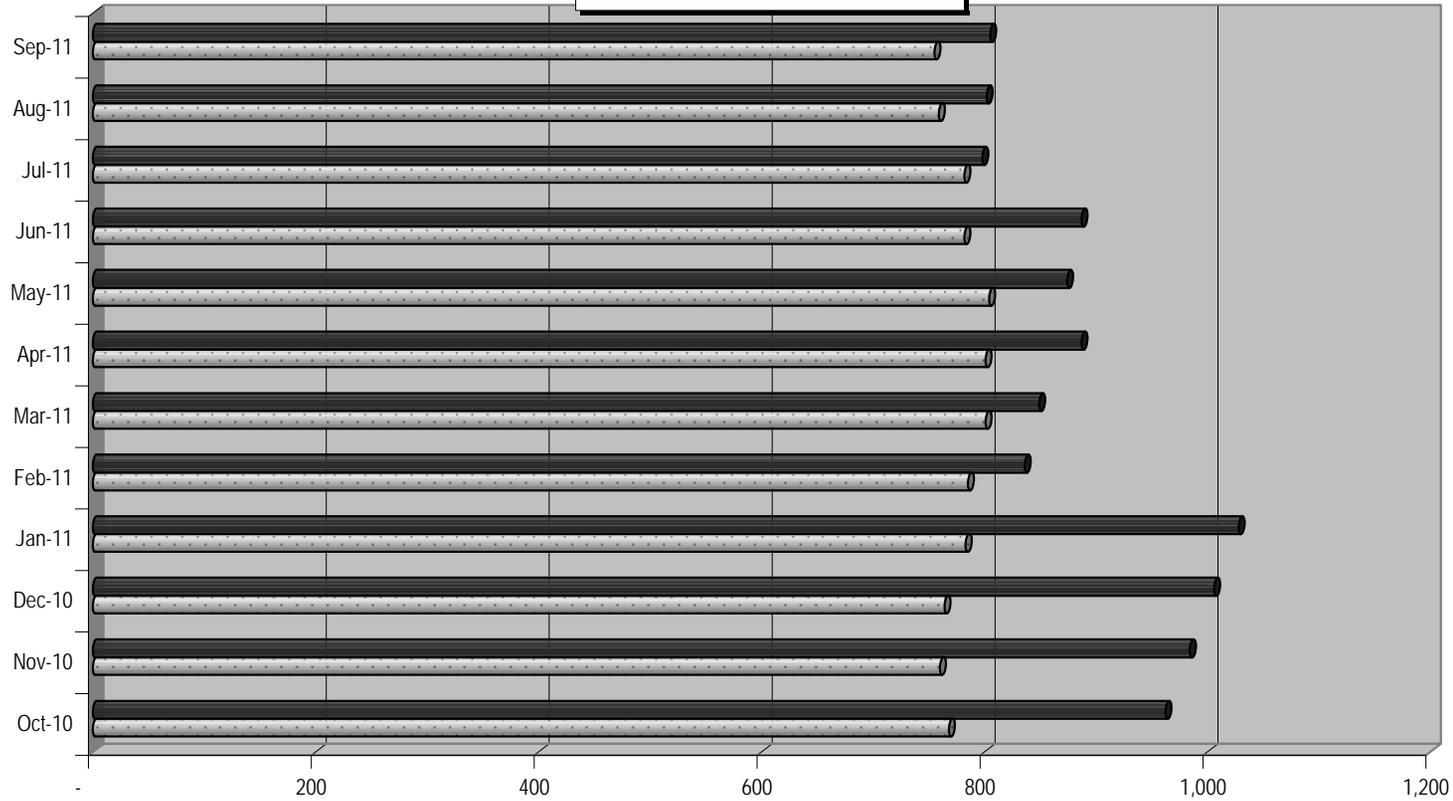
Green Mountain Care Enrollment Report (continued)				
SEPTEMBER 2011 Demographics				
Gender	VHAP-ESIA	ESIA	CHAP	TOTAL
Male	278	274	4586	
Female	529	481	5956	
Total	807	755	10,542	12,104
County	VHAP-ESIA	ESIA	CHAP	TOTAL
Addison	46	40	614	700
Bennington	77	74	636	787
Caledonia	26	21	664	711
Chittenden	189	181	1971	2,341
Essex	4	4	144	152
Franklin	70	51	688	809
Grand Isle	13	6	112	131
Lamoille	48	64	523	635
Orange	40	35	543	618
Orleans	33	45	597	675
Other	1	-	7	8
Rutland	95	76	1109	1,280
Washington	66	65	994	1,125
Windham	39	41	911	991
Windsor	60	52	1029	1,141
Total	807	755	10,542	12,104

Catamount Health Assistance Program
 Enrollment



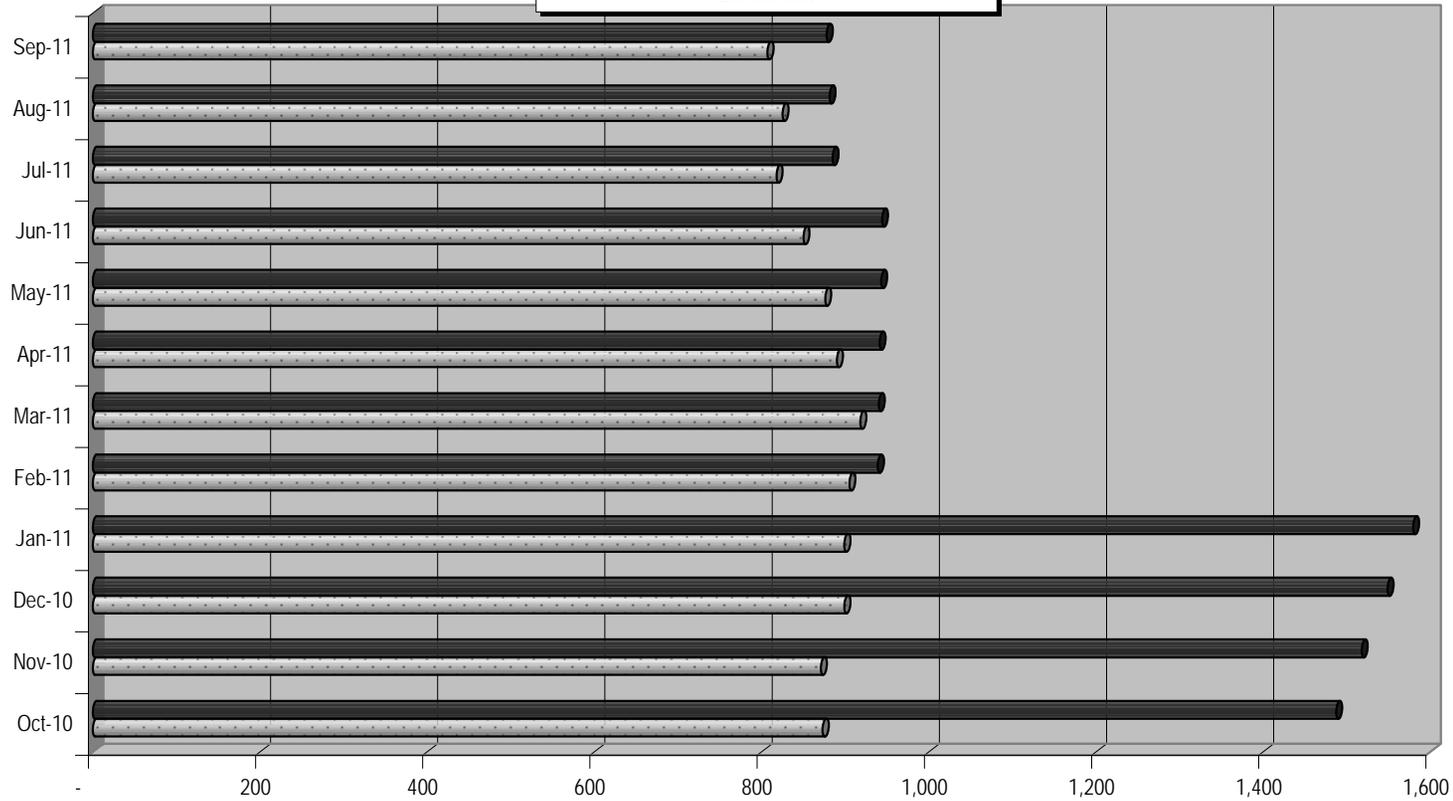
	Oct-10	Nov-10	Dec-10	Jan-11	Feb-11	Mar-11	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11
■ Projected	11,297	11,510	11,722	11,932	11,224	11,389	11,720	11,720	11,866	10,490	10,541	10,591
□ Actual	9,891	9,898	9,630	9,820	9,967	10,200	10,375	10,477	10,434	10,461	10,669	10,542

Employer Sponsored Insurance Assistance Enrollment



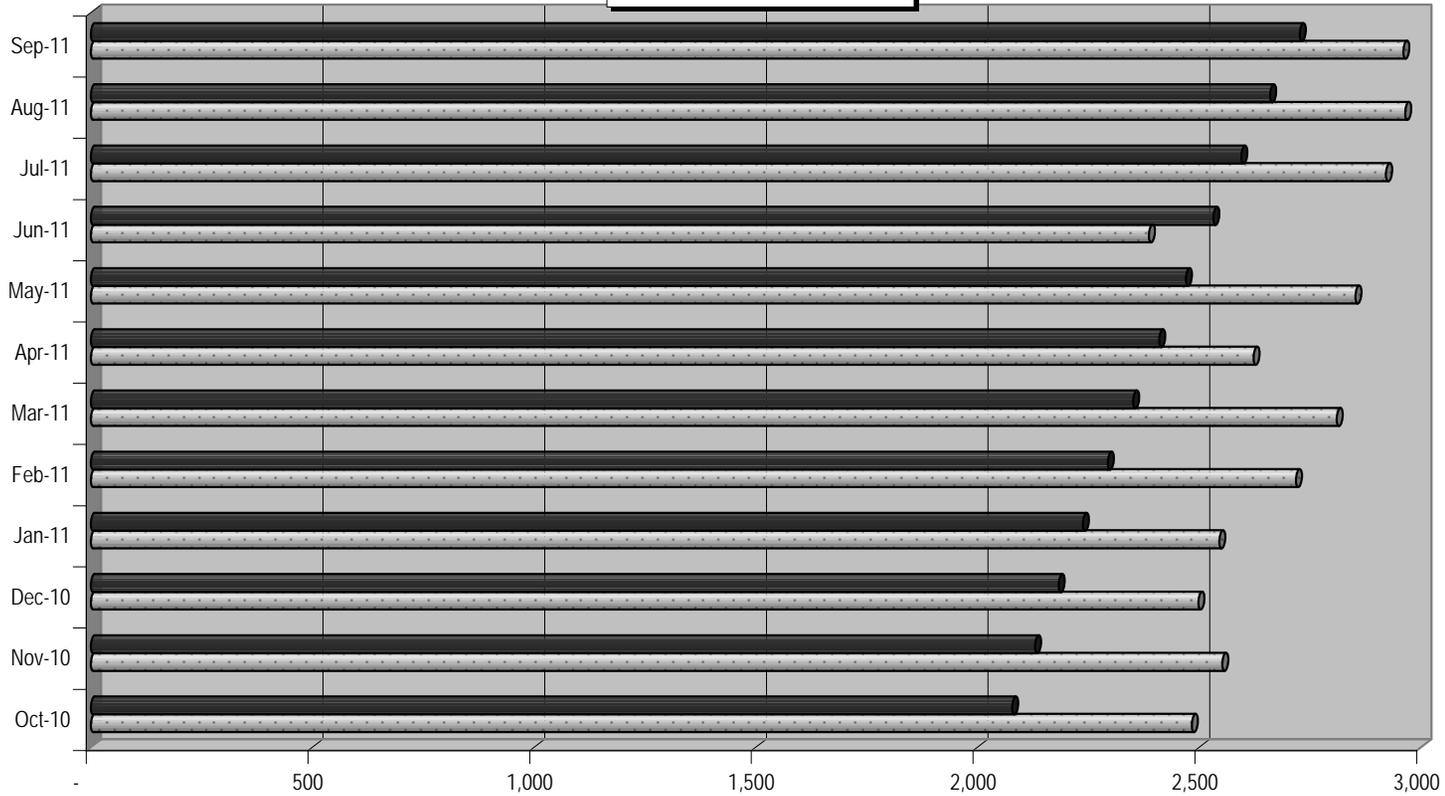
	Oct-10	Nov-10	Dec-10	Jan-11	Feb-11	Mar-11	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11
■ Projected	962	984	1,006	1,028	836	849	887	874	887	798	802	805
▨ Actual	768	760	764	783	785	801	801	804	782	782	759	755

VHAP - Employer Sponsored Insurance Assistance
 Enrollment



	Oct-10	Nov-10	Dec-10	Jan-11	Feb-11	Mar-11	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11
■ Projected	1,487	1,518	1,549	1,579	939	940	941	943	944	885	881	878
□ Actual	873	871	899	899	905	918	890	876	850	818	825	807

Catamount Health - Unsubsidized Enrollment



	Oct-10	Nov-10	Dec-10	Jan-11	Feb-11	Mar-11	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11
■ Projected	2,078	2,130	2,183	2,238	2,293	2,351	2,410	2,470	2,532	2,595	2,660	2,726
▨ Actual	2,483	2,552	2,498	2,545	2,718	2,810	2,622	2,852	2,386	2,921	2,964	2,960

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	\$ 3,606,430,571	\$ 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	\$ 4,700,022,174	\$ 255,901,196
Cumulative																	
1210	\$ 262,106,988	\$ -	\$ 6,444,984									\$ 6,444,984	\$ 268,551,972				
0311	\$ 257,140,611	\$ -	\$ -	\$ 257,140,611								\$ -	\$ 257,140,611				
0611	\$ 277,748,680	\$ (121,416)	\$ -	\$ 277,627,264								\$ (121,416)	\$ 277,627,264				
0911	\$ 243,508,248	\$ -	\$ 5,528,143	\$ 249,036,391								\$ 5,528,143	\$ 249,036,391				
WY6 SUM	\$ 1,040,504,528	\$ -	\$ -	\$ 6,444,984	\$ 5,406,727							\$ 11,851,711	\$ 1,045,911,255	\$ 5,950,020	\$ 1,051,861,274	\$ 5,865,213,737	\$ 369,231,485
Cumulative																	
1211	\$ -	\$ -	\$ -	\$ -								\$ -	\$ -				
0312	\$ -	\$ -	\$ -	\$ -								\$ -	\$ -				
0612	\$ -	\$ -	\$ -	\$ -								\$ -	\$ -				
0912	\$ -	\$ -	\$ -	\$ -								\$ -	\$ -				
WY7 SUM	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Cumulative																	
1212	\$ -	\$ -	\$ -	\$ -								\$ -	\$ -				
0313	\$ -	\$ -	\$ -	\$ -								\$ -	\$ -				
0613	\$ -	\$ -	\$ -	\$ -								\$ -	\$ -				
0913	\$ -	\$ -	\$ -	\$ -								\$ -	\$ -				
WY8 SUM	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Cumulative																	
1213	\$ -	\$ -	\$ -	\$ -								\$ -	\$ -				
WY9 SUM	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Cumulative																	
	\$ 5,321,030,165	\$ 10,166,327	\$ (16,042,281)	\$ 79,876,130	\$ 41,153,315	\$ 19,453,990	\$ 5,406,727	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 5,461,044,373	\$ 34,937,880	\$ 5,495,982,252	\$ 8,955,886,798	\$ 3,459,904,546



Office of Vermont Health Access
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Agency of Human Services

**Complaints Received by Health Access Member Services
 July 1, 2011 – September 30, 2011**

Eligibility forms, notices, or process	13
ESD Call-center complaints (IVR, rudeness, hold times)	2
Use of social security number as identifiers	0
General premium complaints	9
Catamount Health Assistance Program premiums, process, ads, plans	5
Coverage rules	2
Member services	1
Eligibility rules	2
Eligibility local office	3
Prescription drug plan complaint	1
Copays/service limit	0
Pharmacy coverage	1
Provider issues (perceived rudeness, refusal to provide service, prices) (variety of provider types)	0
Provider enrollment issues	0
Chiropractic coverage change	0
Shortage of enrolled dentists	0
Green Mountain Care Website	0
DVHA	0
<hr/> Total	<hr/> 39

**Grievance and Appeal Quarterly Report
Medicaid MCO All Departments Combined Data
July 1, 2011 – September 30, 2011**

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 July 22, 2011, from the centralized database for grievances and appeals that were filed from April 1, 2011 through June 30, 2011.

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 7 grievances filed with the MCO; 4 were addressed during the quarter, none were withdrawn and two were filed to late. Grievances must be addressed within 90 days of filing. The grievances were addressed in an average of 14 days. Acknowledgement letters of the receipt of a grievance must be sent within five days; the average was 3 days. Of the grievances filed, 57% were filed by beneficiaries, 29% were filed by a representative of the beneficiary and 14% were filed by another source. Of the 7 grievances filed, DMH had 57%, DVHA had 29%, and DCF had 14%. There were no grievances filed for DAIL or VDH during this quarter.

There is one case that is pending from previous quarters; four cases from the previous quarters 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.

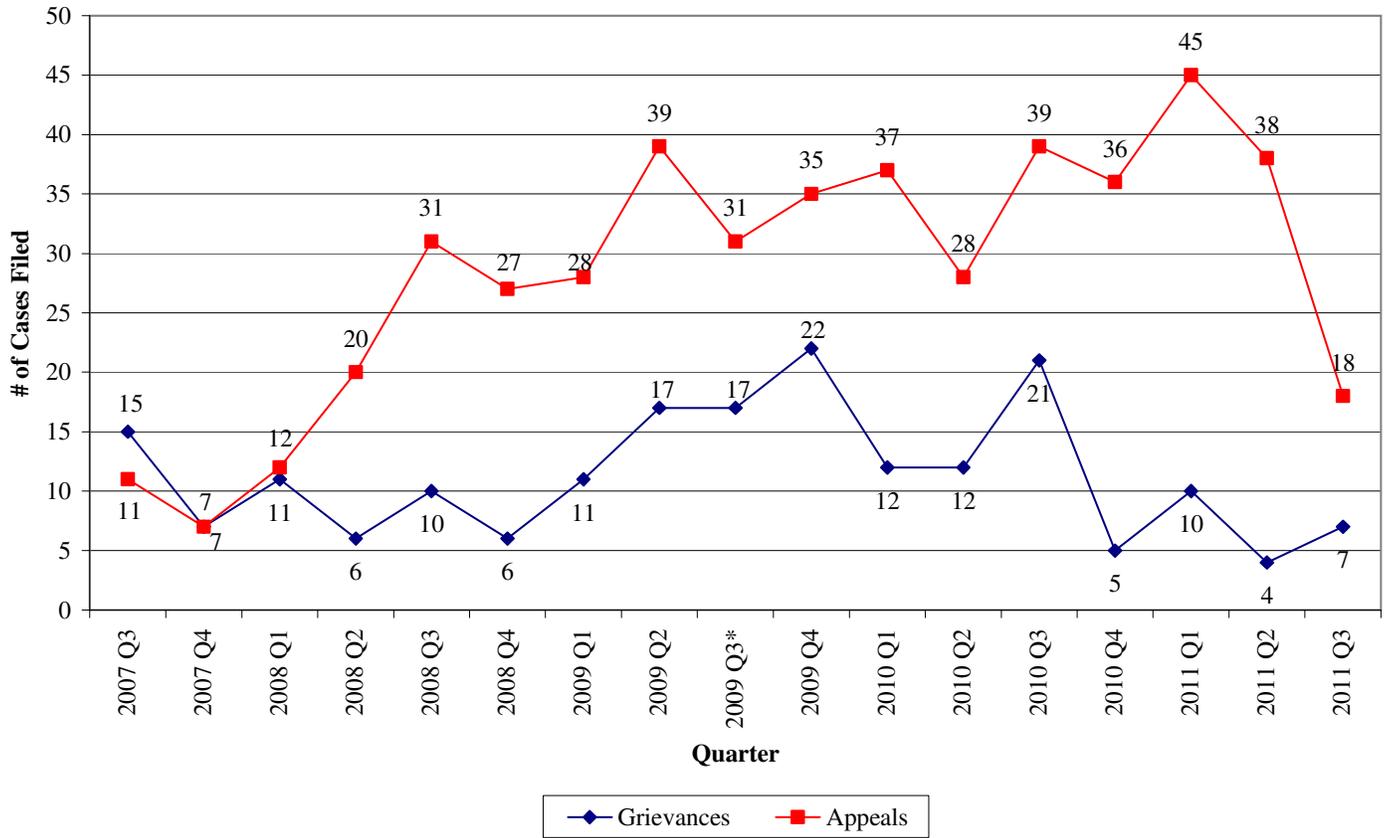
During this quarter, there were 18 appeals filed with the MCO; 5 requested an expedited decision of which 5 met the criteria. Of these 18 appeals, 15 were resolved (83% of filed appeals), 0 were withdrawn, and 3 were still pending (16%). In 6 cases (40% of those resolved), the original decision was upheld by the person hearing the appeal, one case (6% of those resolved) was reversed, one case was approved with modifications and seven cases (48% of those resolved) were approved by the applicable department/DA/SSA before the appeal meeting.

Of the 15 appeals that were resolved this quarter, 100% were resolved within the statutory time frame of 45 days; 60% were resolved within 30 days. The average number of days it took to resolve these cases was 21 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.

Of the 18 appeals filed, 9 were filed by beneficiaries (50%), 8 were filed by a representative of the beneficiary (44%). Of the 18 appeals filed, DVHA had 83%, DAIL had 6%, and DMH had 11%.

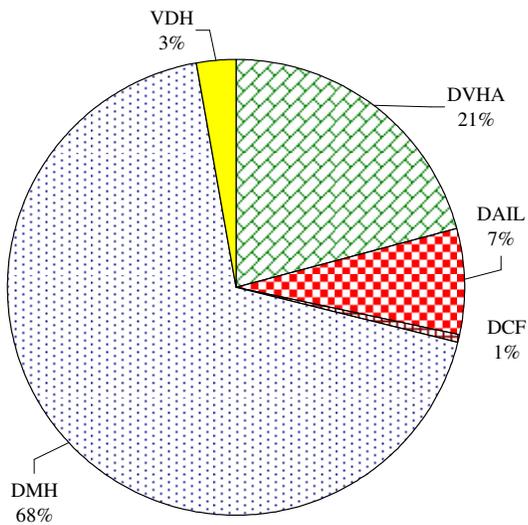
Beneficiaries can file an appeal and a fair hearing at the same time, and they can file a fair hearing if their appeal is not decided in their favor. There was one fair hearing for DVHA filed this quarter.

Medicaid MCO Grievances & Appeals

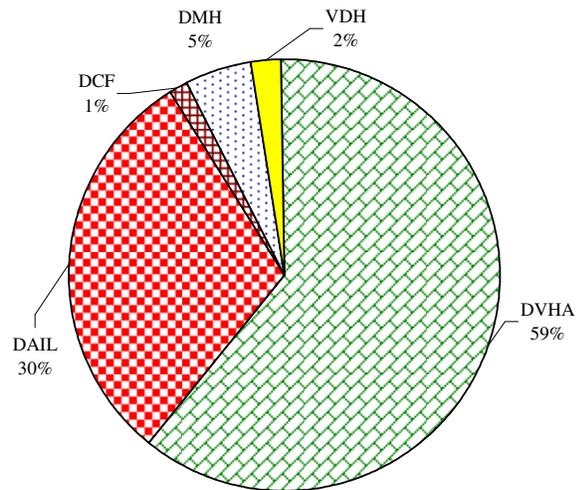


MCO Grievance & Appeals by Department From July 1, 2007 through September 30, 2011

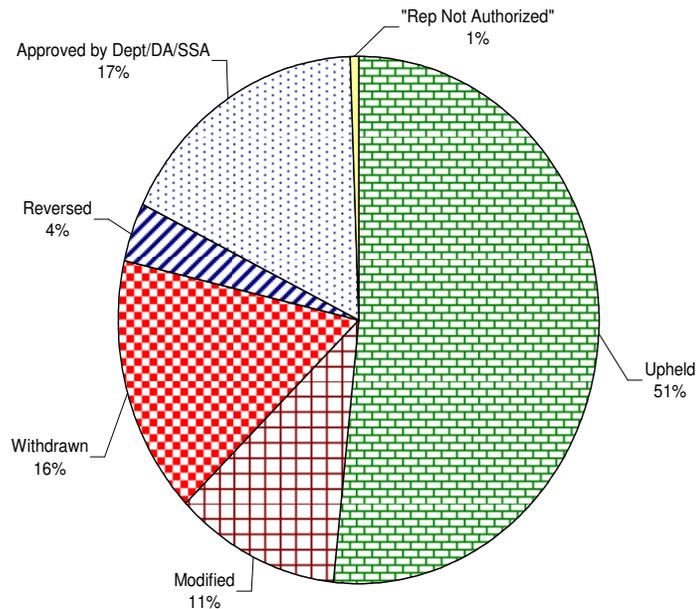
Grievances



Appeals



MCO Appeal Resolutions from July 1, 2007 through September 30, 2011



Grievance and Appeal Quarterly Report
Medicaid MCO All Departments Combined Data
for the period: 07/01/11 – 9/30/11

Grievances

Total number of grievances filed: 7

Number pending: 0

Number withdrawn: 0

Number addressed: 4 2-DVHA, 2-DMH
 Within 90 days: 100%
 Exceeding 90 days: 0%

Number of grievances filed too late: 2

Average number of days from "pertinent issue" to filing grievance: 28

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

Average number of days from filing to being addressed: 14

Average number of days to send acknowledgement letter: 3

Number of late acknowledgement letters: 0

Average number of days from filing to withdrawing: N/A

Number of grievance reviews requested: 0

Source of grievance request:

Beneficiary:	4	57%
Beneficiary Representative:	2	29%
Other:	1	14%

Number related to:

OVHA:	2	29%
DAIL:	0	0%
DCF:	1	14%
DMH:	4	57%
VDH:	0	0%

Top services Grieved:

Mental Health (2)
Case Management (2)

* * * * *

Number pending from all previous quarters: 1 1-DCF

Number that were pending in previous quarters and withdrawn this quarter: 0 0

Number that were pending in previous quarters and addressed this quarter: 4

 Within 90 days: 75% 1-DVHA, 2-DMH
 Exceeding 90 days: 25% DMH

Number of grievances still pending at the end of this quarter: 1

Data as of: 10/1/2011

Appeals

Number of appeals filed: 18

Number pending: 3 3-DVHA

Number withdrawn: 0

Number resolved: 15

Number upheld:	6	40%	6-DVHA
Number reversed:	1	6%	1-DMH
Number modified:	1	6%	1-DMH
Number approved by Dept/DA/SSA:	7	48%	7-DVHA

Number of cases extended: 0

Resolved time frames

Within 30 days:	60%	9-DVHA
Within 45 days:	40%	4-DVHA, 2-DMH
Within 59 days:	0%	
Extended (0) vs. Late (0)		
Over 59 days:	0%	

Number of appeals filed too late: 0

Average number of days from NOA to filing appeal: 24

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

Average number of days from filing to resolution: 21

Average number of days from filing to resolution when extended: N/A

Average number of days to send acknowledgement letter: 2

Number of late acknowledgement letters: 0

Average number of days from filing to withdrawing: N/A

Average number of days to send withdrawal letter: N/A

Number of late withdrawal letters: N/A

Source of appeal request:

Beneficiary:	9	50%
Beneficiary Representative:	8	44%
Provider:	0	0%
Other:	1	6%

Number related to:

OVHA:	15	83%
DAIL:	1	6%
DCF:	0	0%
DMH:	2	11%
VDH:	0	0%

Top services appealed:

MCO All Departments G&A Data

7/1/11 – 9/30/11

1. Prescriptions	4
2. Orthodontics	3
3. Transportation	3

Number of beneficiaries that requested that their services be continued: 1 5%

Of those that requested their services be continued:

Number that met criteria:	1	100%
Number that did not meet criteria:	0	

Expedited Appeals

Number of expedited appeals filed: 5 5-DVHA

Number of expedited appeals that:

Met criteria:	5
Did not meet criteria:	0

For those MEETING criteria

Number pending:0

Number of expedited appeals filed too late: 0

Number resolved: 5

Number upheld:0	0%
Number reversed:	3 60%
Number modified:	0 0%
Number approved by Dept/DA/SSA:	2 40%

Average number of days from Notice of Action to filing expedited appeal: 10

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

Average number of days from filing to resolution: 1

Number of late resolutions: 0 0%

Source of appeal:

Beneficiary:	3	60%
Beneficiary Representative:	2	40%
Provider:	0	0%
Other:	0	0%

Top Services Appealed:

Prescriptions:	4	90%
Transportation:	1	10%

Number related to:

OVHA:	5	100%
DAIL:	0	0%
DCF:	0	0%
DMH:	0	0%
VDH:	0	0%

* * * * *

Number pending from last quarter: 1

Number pending from previous quarters: 0

Total pending from ALL quarters: 1 0

Number of total pending that were resolved this quarter: 1

Number upheld: 1 100%

Number reversed: 0%

Number modified: 0%

Number approved by Dept/DA/SSA: 0%

Number withdrawn: 0%

Details: DVHA

Resolution time frames for resolving above cases:

Within 30 days: 0%

Within 45 days: 100%

Within 59 days: 0%

Extended (0) vs. Late (0)

Over 59 days: 0%

Number of appeals still pending from all previous quarters: 0

Fair Hearings

Total number of Fair Hearings filed: 0

* * * * *

Number of pending Fair Hearings from previous quarters resolved this quarter: 2

Number upheld: 1

Number reversed: 0

Number modified: 0

Number dismissed: 0

Number withdrawn: 1

Average number of days for resolution for pending Fair Hearings from previous quarters: 111

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QUARTERLY REPORT
July 1, 2011 – September 30, 2011
 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 July 1, 2011 through September 30, 2011. We received 369 calls (44% of all calls) from DVHA program beneficiaries this quarter, compared to 326 (41%) last quarter.

There are three parts to this report: this narrative section, which includes a table of all calls received, broken out by month and year; the Issue Summary page for Eligibility 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 19 page data report specifically about DVHA beneficiaries who called us.

A. Total call volume increased 6% over last quarter.

Overall call volume is staying consistently higher than the first nine months of last year. The total number of all cases/all coverages that we opened this quarter was 838, compared to 788 last quarter. It was 3% higher than the same quarter in 2010, when we received 815 calls. In August and September we had the highest call volumes ever for those particular months. [See the table at the end of this narrative for further detail.]

B. Statewide flooding from Tropical Storm Irene caused an increase in calls.

Tropical Storm Irene hit Vermont on Sunday August 28, 2011, causing massive flooding and destroying the state office complex in Waterbury. This wiped out much of the Department for Children and Family's (DCF's) infrastructure for processing applications and reviews for the state health care programs.

The HCO received 36 calls related to Irene. Twenty-three of those involved people who were on DVHA programs. We received three calls from individuals who could not get to their usual

pharmacy because the roads were washed out. We received one call from an individual who said he could not get into a psychiatric bed at a hospital because none was available due to the state hospital patients who had been transferred there as a result of the storm. Most of the other calls that we coded as Natural Disaster were from individuals who experienced delays in their applications or reviews for state programs due to the flooding.

The HCO worked with the Health Access Eligibility Unit (HAEU) to address eligibility concerns and with DVHA to address coverage concerns in the chaotic aftermath of the flood. Within just a couple of days of the storm we were able to re-establish contact with HAEU to resolve emergency cases. As DCF struggled with finding places for eligibility workers to physically work and a lack of email and phone access, HAEU made a serious effort to let the HCO know how to reach them by alternative means. It was a stressful time for state employees, and we appreciate their dedication to serving Vermonters.

C. The unaffordability of health care is rising to the top of the access problem list.

We have been tracking affordability as an access issue for several quarters now. This quarter we had 100 calls overall (as both a primary and a secondary issue) about the high cost of health care presenting a significant barrier to that care, compared to 61 last quarter, and 73 the previous quarter. A slight majority of these calls, 51, were from individuals who told us that they had insurance, but still could not afford the care they needed. This was usually due to the cost sharing requirements of their plans or because their plans did not cover the service and they could not afford it. Of these insureds, 27 were on DVHA programs. For seven DVHA beneficiaries it was the primary reason they could not access care. Lack of affordability jumped to the highest access issue this quarter for the first time for all calls, bumping access to prescription drugs to second place. For DVHA beneficiaries, it remained the second highest access issue, after prescriptions.

D. Access to pain management continued to be a problem.

The HCO continued to get a significant number of difficult calls from individuals who were having trouble getting adequate treatment for pain. We received 37 such calls (primary and secondary issue) this quarter. The majority of these calls, 23, were from state program beneficiaries.

Last quarter we received 36 pain calls, and the previous quarter, 26. Many of these callers have been discharged by their doctors for violations of “pain contracts,” and are unable to find another doctor to see them. Due to the shortage of primary care providers, and the reluctance of many providers to take on patients suffering from chronic pain, there is usually not much we can do for these individuals.

E. Calls about access to substance abuse treatment remained about the same as last quarter.

We received 16 calls regarding access to substance abuse treatment (primary and secondary issue) this quarter, compared to 19 last quarter. Of the 16, 12 of the calls were for substance

abuse treatment as the primary issue, compared to 13 last quarter. Eight of these callers were on state health care programs, and most of the calls involved access to buprenorphine.

F. Lack of transportation remains a barrier to access for state program beneficiaries.

Twenty-two callers, all on DVHA programs, complained about access to care due to problems getting transportation, same as last quarter.

G. The top ten issues for DVHA beneficiaries changed only slightly.

The issues, looking at both primary and secondary, with the highest call volumes for DVHA beneficiaries were as follows:

- Medicaid Eligibility 49 (compared to 40 last quarter);
- Communication problems or complaints about providers (in Other) 40 (51);
- VHAP Eligibility 39 (35);
- Prescription drug Access 34 (42),
- Affordability resulting in access problems (in Access) 27 (13);
- Natural Disaster (new code in Other) 23;
- Pain Management Access 23 (28);
- Medicaid or VHAP Billing 22 (34);
- Transportation Access 22 (22); and
- Info re applying for DVHA programs (Consumer Education) 20 (12).

II. Major Issues

A. Eligibility for state programs

Just when DCF was beginning to really have control of eligibility processing since the beginning of the Modernization effort over a year ago, Tropical Storm Irene hit and wiped out the document processing center and more.

Call volume related to eligibility for state programs increased this quarter from 218 to 226. For DVHA beneficiaries it increased from 87 to 98 calls. Last year for this quarter we received 103 eligibility calls from DVHA beneficiaries, which was when the problems related to Modernization began to rise. The increase in calls related to eligibility appeared to be due to the flood destruction of the DCF infrastructure.

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. For this reason we include the data page from the BISHCA report on eligibility on all calls, in addition to the page included in the DVHA data report.

The following statistics include both primary and secondary issues, meaning that some of the numbers may overlap; that is, some of the ten DCF mistake cases could also involve lost paperwork, for example. Here is a sampling of the 434 total calls raising eligibility issues this quarter:

- 6 involved application process delays (compared to 3 last quarter);
- 26 involved the Buy In (Medicare Savings) Programs (compared to 23);
- 10 involved DCF mistakes (compared to 19);
- 17 involved lost paperwork, meaning that callers said they submitted paperwork to DCF and were subsequently told there was no record of it (compared to 2);
- 8 involved problems with the mail (compared to 2);
- 30 involved Medicaid Spend Downs (compared to 21); and
- 2 involved an error by Member Services (Maximus) (compared to 4).

We continue to see a relatively large number of cases involving problems with the Medicare Buy In Programs and Medicaid Spend Downs. Elderly and disabled individuals near the income levels of 100% -135% of the Federal Poverty Level continue to struggle with Medicare cost sharing and the mechanics of the Medically Needy (Spend Down) Program.

B. Access to Care

Access to health care is a bigger issue than eligibility problems for everyone, but DVHA beneficiaries in particular. This quarter we had a total of 244 calls related to access issues or 29.12% of all calls. Of these, 139 (57%) were from DVHA beneficiaries. In the previous quarter we had 230 total access calls, with 135 (56%) coming from DVHA beneficiaries. Since about 44% of our total calls were from DVHA beneficiaries, this is a comparatively high percentage of calls regarding access issues, and remains a cause of some concern. Historically, the percentage of calls from DVHA beneficiaries related to access has run at about 30-35%, but lately it seems to have crept up a bit. Since the last quarter of 2010, the percentage has remained above 37%. For beneficiaries of commercial carriers access calls usually run about 20-25%. This quarter 33 (25.98%) individuals on commercial plans called us about access problems.

Thus, **139 individuals on state plans had access issues, while just 33 on commercial plans did.** Access is a bigger issue for DVHA beneficiaries.

Two issues related to access continue to be of particular concern this quarter:

1. Access to Pain Management

The number of calls from DVHA beneficiaries related to pain management as the primary issue again decreased slightly to 14 this quarter (compared to 16 last quarter). However, 23 DVHA calls involved pain management as a primary or secondary issue. We received a total of 37 calls overall related to pain management, so the percentage of pain calls from DVHA beneficiaries was 62% (compared to 78% of the pain calls last quarter). We had only five callers on commercial insurance with pain management complaints. Thus, this continues to be primarily a

state program problem. These are some of our most difficult calls, as we are generally not able to do much to help.

2. Access to Substance Abuse Treatment

We received 12 calls coded as access to substance abuse treatment as the primary issue this quarter. Of these, 7 were from DVHA beneficiaries. The previous quarter we also received 13 such calls, and 9 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 this is a growing problem. Access to substance abuse treatment, especially for opiate addiction, and specifically for methadone and buprenorphine treatment, is of increasing concern.

Recently we received a call from a state beneficiary who had been advised by a substance abuse clinic to drop her Medicaid in order to get substance abuse treatment. We have heard of this happening before, and some individuals do actually drop their only source of health insurance, Medicaid or VHAP, in order to get immediate treatment. This is because of the way the DVHA pays for treatment. Some providers cap the number of Medicaid patients they will accept, and start waiting lists. The only way for an individual to get immediate treatment is then to be accepted as a non-Medicaid patient. Some individuals are so desperate for treatment, that they do drop their insurance, and attempt to pay out of pocket.

It is very clear that the state needs more providers willing to provide substance abuse treatment.

III. Call volume by type of insurance:

The HCO received 838 total calls this quarter. Callers had the following insurance status:

- **DVHA programs** (Medicaid, VHAP, VHAP Pharmacy, Premium Assistance, VScript, VPharm, or both Medicaid and Medicare aka dual eligibles) insured **44%** (369 calls), compared to 41% (326) last quarter;
- **Medicare** (Medicare only, Medicare and a Medicare Supplemental Plan aka Medigap, Medicare and Medicaid aka dual eligibles, Medicare and Medicare Savings Program aka Buy-In program, Medicare and Part D, or Medicare and VPharm) insured **24%** (205), compared to 24% (189) last quarter;
 - **12%** of all callers (104) had **Medicare only**;
 - 11% (95) 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, and Catamount Health plans) insured **15%** (127), compared to 17% (139) last quarter;
- **8%** (66) identified themselves as **Uninsured**, compared to 10% (78) last quarter;
- **3%** (26) had a **Catamount Health** plan, or Catamount ESIA, either at full cost or with Premium Assistance (CHAP), compared to 5% (42) last quarter; and
- In the remainder of calls the insurance status was either unknown or not relevant.

III. Statistics on issues raised by DVHA beneficiaries

We opened 369 cases from DVHA beneficiaries, compared to 326 last quarter. Of these:

- 37.67% (139 calls) involved Access to Care, compared to 41.41% (135 calls) last quarter;
- 11.38% (42 calls) involved Billing/Coverage, compared to 15.34% (50 calls);
- 6.78% (25 calls) were coded as Consumer Education, compared to 4.29 % (14 calls);
- 26.56% (98 calls) involved Eligibility, compared to 26.69% (87 calls); and
- 17.62% (65 calls) involved Other issues, compared to 12.27% (40 calls), which includes Medicare Part D calls, coded as MMA.

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 139 DVHA Access to Care calls, compared to 135 last quarter. The top call volume primary issues within this category were:

- 21 Transportation, compared to 16 last quarter;
- 14 Prescription Drugs, compared to 16 last quarter;
- 14 Pain Management, compared to 16;
- 12 Dental, Dentists or Orthodontics, compared to 14;
- 11 Durable Medical Equipment (DME), Supplies and Wheelchairs, compared to 18;
- 8 Mental Health, compared to 6;
- 7 Substance Abuse, compared to 7; and
- 7 Affordability.

The top ten access issues for DVHA beneficiaries when both primary and secondary issues (243 calls) were considered were:

- 34 Prescription Drugs;
- 27 Affordability;
- 23 Pain Management;
- 22 Transportation;
- 19 Dental, Dentists or Orthodontia;
- 16 Primary Care Doctor/Routine Care/PCP;
- 14 DME, Supplies and Wheelchairs;
- 13 Mental Health;
- 8 Substance Abuse;
- 8 Specialty Care; and
- 8 Quality 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 42 DVHA primary issue calls in this category, compared to 51 last quarter:

- 10 Medicaid/VHAP Managed Care;
- 9 Hospital Billing;
- 5 Out of network problems;
- 4 Premiums; and
- 3 VHAP premiums.

C. Eligibility

Eligibility cases are those in which the individual is seeking to get or retain government subsidized health insurance. This quarter we received 226 calls from individuals with a primary issue of eligibility, but we received 434 calls from individuals for whom eligibility was either a primary or a secondary issue.

We received 98 eligibility calls from current DVHA beneficiaries, compared to 87 last quarter, which were coded as a primary issue:

- 28 Medicaid eligibility, compared to 26 last quarter;
- 20 VHAP, compared to 18;
- 10 Lost paperwork;
- 7 Buy In Programs, aka Medicare Savings Programs, compared to 6;
- 6 Medicaid Spend Down compared to 5; and
- 6 Catamount Health and Premium Assistance, compared to 5. This count only includes callers who were already on DVHA plans when they called us. Many callers who call about Catamount eligibility are either uninsured or on commercial plans.

IV. Disposition of DVHA cases

We closed 364 DVHA cases this quarter, compared to 339 last quarter:

- About 4% of calls (14) from DVHA beneficiaries were resolved in the initial call, compared to 1% (4 calls) last quarter;
- 65% (236 calls) were resolved by advice or referral, after an analysis of the problem. Last quarter 63% (212 calls) were resolved in this manner;
- 20% (72 calls) were resolved by direct intervention on the caller's behalf, including advocacy with DVHA and providers, writing letters, and gathering medical information. Last quarter 17% (58 calls) were resolved in this manner;
- About 6% (23 calls) were considered complex intervention, which involves complex analysis and more than two hours of an advocate's time, compared to 10% (35 calls) last quarter;
- In the remaining calls clients either withdrew or resolved the issue on their own.

V. Outcomes

The HCO prevented 21 insurance terminations or reductions in coverage for DVHA beneficiaries and got 3 DVHA beneficiaries onto other DVHA plans. We provided advice or education to 235 DVHA callers. We got claims written off or paid for 13 individuals. We estimated insurance eligibility for 18 callers, and explained to 2 more that they were not eligible. [See Outcome Summary for more detail on page 19 of the data report.]

VI. Table on All Calls by Month and Year

All Cases (as of 10/19/11)

	2003	2004	2005	2006	2007	2008	2009	2010	2011
January	241	252	178	313	280	309	240	218	329
February	187	188	160	209	172	232	255	228	246
March	177	257	188	192	219	229	256	250	281
April	161	203	173	192	190	235	213	222	249
May	234	210	200	235	195	207	213	205	253
June	252	176	191	236	254	245	276	250	286
July	221	208	190	183	211	205	225	271	239
August	189	236	214	216	250	152	173	234	276
September	222	191	172	181	167	147	218	310	323
October	241	172	191	225	229	237	216	300	151
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	3077	2633

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

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