

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
January 1, 2011 – March 31, 2011

May 19, 2011

Background and Introduction

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

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

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

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

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

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

One of the Terms and Conditions of the Global Commitment Waiver requires the State "to submit progress reports 60 days following the end of each quarter. ***This is the second quarterly report for waiver year six, covering the period from January 1, 2011 through March 31, 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 3/31/2011	Previously Reported Enrollees Last Day of Qtr 12/31/2010	Variance 12/31/10 to 03/31/11
Demonstration Population 1:	46,062	45,247	1.80%
Demonstration Population 2:	43,785	43,594	0.44%
Demonstration Population 3:	9,840	9,862	-0.22%
Demonstration Population 4:	N/A	N/A	N/A
Demonstration Population 5:	1074	1129	-4.87%
Demonstration Population 6:	3,300	3,047	8.30%
Demonstration Population 7:	36,089	35,165	2.63%
Demonstration Population 8:	7,956	7,756	2.58%
Demonstration Population 9:	2,558	2,629	-2.70%
Demonstration Population 10:	N/A	N/A	N/A
Demonstration Population 11:	10,534	10,355	1.73%

Green Mountain Care Outreach / Innovative Activities

This quarter, the Director of Outreach and Enrollment continued to work with military personnel to prepare for outreach events in order to ensure that returning soldiers, who do not have access to TRICARE, have access to health insurance under Green Mountain Care.

The DVHA also began to look at systems that cause churn. During the month of March we tracked 127 premium checks that were mailed to incorrect addresses, which is a significant number for our small state and ultimately result in delays that cause a drop in coverage. We have included payment information on the Green Mountain Care website, and are considering other measures to ensure that payment occurs correctly.

Green Mountain Care partnered with the Vermont Department of Labor to assist four company lay offs effecting 160 people to inform them of their health insurance options.

Since the DHVA is focused on bolstering primary care while expanding access to coverage, the Director of Outreach and Enrollment has gotten involved in supporting the development of a marketing plan for the Blueprint for Health, which is dedicated to achieving well coordinated and seamless health

services in the primary care setting. Focus groups have been conducted in three regions in the state, and a writer has been secured to develop core messages and collateral material that will support significant growth of the program in the year ahead.

Enrollment and legislative action: As of the end of March there were 11,919 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 SFY 12 budget bill has been passed by the House and is now in the Senate, and so far it appears that funding will be approved to implement this program. The Agency of Human Services submitted a waiver amendment request to CMS on April 4th.

To reduce the cost to the State in Catamount Health premiums, the legislature (in cooperation with the administration and the Catamount Health carriers) is working on language in the budget bill that would reduce the carriers' administration costs and provider payment rates, which in turn would lower Catamount premiums. These changes would not affect the beneficiaries' coverage or cost sharing.

A bill that would authorize Vermont's Health Benefits Exchange under the Affordable Care Act has passed both Houses and will now go to conference committee.

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 OVHA, 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 March 31, 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 '10, there were 2565 OHRAs claimed and approximately 1 of every 4 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 January, 2011, 62,828 eligible children (ages 0-17) have been identified since the program began in early 2008; of these, dental homes have been selected for 52,422 Vermont children and 10,406 enrollees have 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 into SFY 2011. Typically, 35-40 dentists qualify for semi-annual payouts.

Expenditure Containment Initiatives

Vermont Chronic Care Initiative

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

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

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

The VCCI focuses on beneficiaries identified as having a specified chronic health condition and are enrolled in Medicaid, VHAP, PCPlus or Dr. Dynasaur under the Vermont Health Access Program with approval by the Centers for Medicaid and Medicare; beneficiaries are not eligible for the VCCI if they receive Medicare or other third party insurance. Those targeted for enrollment in VCCI programs have at least one chronic condition including, but not limited to: Arthritis, Asthma, Chronic Obstructive Pulmonary Disease (COPD), Chronic Renal Failure, Congestive Heart Failure (CHF), Depression,

Diabetes, Hyperlipidemia, Hypertension, Ischemic Heart Disease, and Low Back Pain. Eligible beneficiaries are identified and risk stratified by the DVHA's disease management vendor, APS Healthcare, using a proprietary disease identification and stratification system based on Adjusted Clinical Group predictive modeling. Referrals from physicians, hospitals, and other community agencies also are accepted. Beneficiaries at highest risk are referred to DVHA care coordinators for intensive face-to-face case management services and those considered at lower risk for complications are assigned to APS Healthcare for telephonic disease management provided by a RN health coach. Service level needs are ultimately determined through both predictive modeling and clinical assessment, in accordance with national evidence-based, disease-specific clinical guidelines. The VCCI is designed to enable seamless transition between service tiers as a beneficiary's needs change.

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

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

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

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

Effective July 1, 2010, DVHA expanded its direct care coordination capacity in two areas of the state through the Challenges for Change initiative. The two trial areas were selected based on, among other factors, high disease prevalence and high health system utilization. The initiative adds three additional

DVHA care coordination staff (two RNs and 1 Licensed Clinical Social Worker) in each of the two areas (Rutland and Franklin Counties). These staff are 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 • Pediatric Associates 	<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.

Highlights of the Vermont Chronic Care Initiative for Quarter 2 of FFY 2011

- A clinical performance improvement project (PIP) is currently being developed targeting congestive heart failure (CHF). The PIP will be implemented during 2nd quarter FFY 2011.
- DVHA care coordinators expanded meetings and electronic data exchange systems with hospital emergency departments (EDs) for increased collaboration regarding emergency room utilization among VCCI beneficiaries.
- 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.

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 both quarters (October 2010- March 31st 2011) is \$106,454.44 (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
Grand Total	\$106,454.44

Mental Health – Vermont Futures Planning

Community System Development

Vermont Psychiatric Survivors, Vermont's state-wide mental health consumer organization, is working with the board of directors of the peer-run crisis alternative program (Alyssum, Inc.) to complete the final stages of hiring an executive director. Once hired, the executive director will oversee the final stages of development and the ongoing operations of the Alyssum program. The board of directors is also in the process of selecting a facility to house the program. The new program is scheduled to open in the summer of 2011.

DMH has received responses to an RFP to develop a “bed board” to identify inpatient and crisis bed availability state-wide for use by the emergency and inpatient providers. Proposals are currently under review. DMH plans to select the vendor most responsive to the RFP requirements within the next quarter. The Department of Mental Health has been unable to finalize a contract with Deerfield Health

Systems to secure access to the LOCUS (Level of Care Utilization System) for all admissions to acute care (crisis beds) and residential beds. Several provisions of the proposed contract remain under discussion with the vendor. If these outstanding issues cannot be satisfactorily resolved, DMH will need to explore alternative options in partnership with its Designated Agencies to implement the web-based application statewide as part of the care management system.

Secure Residential Recovery Treatment Program

The 15-bed secure adult psychiatric treatment and recovery residential program proposed on the grounds of the state office complex in Waterbury and approved for a Certificate of Need (CON) in December 2010 has been placed on hold for the foreseeable future. The ongoing physical space needs for quality patient care, as well as, the less than optimal inpatient service milieu resulting from such environmental limitations compels a different direction in the short-term for the hospital and its staff and patients. The Department of Mental Health, with the support of the current administration and stakeholder groups, is prioritizing the replacement of the Vermont State Hospital inpatient services prior to further development of the secure recovery residential program.

Acute Psychiatric Inpatient Care

During this past quarter, DMH has been moving at an accelerated pace to identify a suitable alternative location and construction plan that will result in a new state hospital. At this time, the planning is focused on building a replacement facility possibly on the expanded campus of the Central Vermont Medical Center in Berlin. For preliminary planning purposes, DMH is estimating 40-54 beds will be necessary at a state built facility. DMH has had preliminary meetings with the leadership of CVMC to discuss this concept. No decisions have been made, but this is the option seriously being explored at this time. DMH staff are actively exploring model facility construction in other states to further inform this conversation. Although DMH believes that it remains very important to co-locate a new state hospital with a general hospital, the Department acknowledges its obligation to meet current inpatient needs as quickly as possible. This is achievable in the near term through a plan to build, own and operate the new facility.

At this same time, DMH is also working with the Brattleboro Retreat to determine if there are some number of VSH replacement beds that they can develop (in the range of 16-24 inpatient beds). The number of beds developed at the Brattleboro Retreat will undoubtedly impact the actual number of beds in any new state hospital construction, but it is unlikely to be a 1:1 ratio.

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 CMS-64 filing on April 30, 2011, AHS will true up the Federal claims from the estimated monthly PMPM payments to the underlying actual Global Commitment expenditures incurred.

Member Month Reporting

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

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

Demonstration Population	Month 1	Month 2	Month 3	Total for Quarter Ending 2nd Qtr	Total for Quarter Ending 1st Qtr	Total for Quarter Ending 4th Qtr	Total for Quarter Ending 3 rd Qtr	Total for Quarter Ending 2 nd Qtr	Total for Quarter Ending 1st Qtr	Total for Quarter Ending 4th Qtr	Total for Quarter Ending 3rd Qtr	Total for Quarter Ending 1st Qtr	Total for Quarter Ending 4th Qtr	Total for Quarter Ending 3rd Qtr	Total for Quarter Ending 2nd Qtr
	1/31/2011	2/28/2011	3/31/2011	FFY '11	FFY '11	FFY '10	FFY '10	FFY '10	FFY '10	FFY '09	FFY '09	FFY '09	FFY '08	FFY '08	FFY '08
Dem. Population 1:	45,884	46,022	46,062	137,968	136,144	134,256	132,168	131,930	131,513	129,656	128,203	125,825	123,997	122,281	121,926
Dem. Population 2:	43,729	43,826	43,785	131,340	131,167	131,402	131,865	130,746	129,075	128,698	128,590	122,210	121,981	123,283	122,118
Dem. Population 3:	10,059	9,888	9,840	29,787	29,874	30,068	30,244	29,567	29,352	29,428	28,628	26,555	26,452	25,723	24,676
Dem. Population 4:	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Dem. Population 5:	1,103	1,060	1,074	3,237	3,423	3,444	3,701	3,614	3,546	3,410	3,568	3,832	3,850	3,767	3,542
Dem. Population 6:	3,158	3,311	3,300	9,769	9,226	9,073	8,972	8,495	8,218	8,088	7,480	8,208	7,428	7,357	6,208
Dem. Population 7:	35,880	35,946	36,089	107,915	105,131	103,915	103,194	98,576	92,217	89,158	87,116	75,277	74,301	73,966	72,336
Dem. Population 8:	7,710	7,833	7,956	23,499	23,180	23,155	22,707	22,462	22,254	21,905	23,165	22,032	21,715	23,100	22,697
Dem. Population 9:	2,588	2,576	2,558	7,722	7,887	7,848	7,914	7,770	7,673	7,634	7,665	7,649	7,626	7,838	7,919
Dem. Population 10:	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Dem. Population 11:	10,139	10,373	10,534	31,046	31,397	30,986	31,445	29,728	28,278	26,444	24,717	19,465	16,136	12,525	7,997

Data reported in the following table is NOT used in Budget Neutrality Calculations or Capitation Payments as information will change at the end of quarter; information in this table cannot be summed across the quarters. All payments are adjusted at the end of the year to reconcile expected population movement between eligibility groups.

Consumer Issues

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

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

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

Quality Assurance/Monitoring Activity

External Quality Review Organization

During this quarter, the AHS Quality Improvement Manager reviewed all EQRO documents associated with this year's Performance Improvement Project validation activities. Feedback was given and modifications were made to the appropriate documents. DVHA is scheduled to receive the documents during next quarter. The AHS Quality Improvement Manager also worked with the EQRO to develop a list of performance improvement reference documents to be used to help support performance improvement activities. It is anticipated that this list will be available to staff by the end of next quarter. The AHS Quality Improvement Manager also discussed the Managed Care Entity generated performance measures that will be subject to this year's validation. Meetings have been scheduled with Managed Care Entity representatives to discuss the applicability of current measures as well as the need for additional measures. It is expected that a final list of measures will be developed by the end of next quarter. Finally, during this quarter, the AHS Quality Improvement Manager reviewed/approved all EQRO documents associated with this year's Compliance review. These documents included the tool that will be used to assess the Managed Care Entity's ability to comply with the Federal Medicaid Managed Care Structure & Operations standards. This and other documents will be sent to the Managed Care Entity during the next quarter.

Quality Assurance Performance Improvement Committee (QAPI)

During this quarter, the Quality Assurance and Performance Improvement Committee (Committee) held two meetings. New members were oriented to the Committee. The Committee approved a revised purpose statement that included a description of the committee's structure and responsibilities as well as the revised *Toolkit for Monitoring Delegated Administrative Activities*. The DVHA and IGA Partners continued their ongoing compliance activities with the Committee members reporting back on these activities as scheduled. In addition, the Committee members continued to communicate between meetings.

Also during this quarter, the AHS Quality Improvement Manager met with newly revised QAPI Committee to review the following activities: health information systems, enrollee's experience of care, and performance measures. This was the first meeting since the group restructured. The first two items were addressed during the quarterly meeting, while the third was addressed in separate ad hoc meetings. The health information systems (HIS) review focused on compliance with maintaining a health information system that collects, analyzes, integrates, and reports data and provides information on areas including, but not limited to, utilization, grievances and appeals, and disenrollments for other than loss of Medicaid eligibility. During, this meeting, it was noted that an updated HIS (i.e., MMIS) is planned. The contract is currently out to bid and the AHS Quality Improvement Manager will be part of the review committee to ensure that the Medicaid Managed Care HIS requirements are addressed during the review/selection process. During the experience of care presentation, it was noted that the DVHA and each of the IGA partners perform regular satisfaction surveys of beneficiaries and utilize the data to assess compliance with quality standards. While each targets a different subset of Medicaid beneficiaries, the idea of a single survey was discussed. It was suggested that a single instrument could have subpopulation specific questions, but it could also have a set of common questions that attempt to assess quality, access, and timeliness of care received by beneficiaries. It was agreed that this discussion would continue during subsequent Committee meetings.

Finally, the AHS Quality Improvement Manager met with staff to review current performance measures. During these discussions, suggestions to improve the validity of certain measures were identified as well as additional measures that might be added to allow AHS to further assess performance. It is anticipated that the current list of measures and any additional measures for this year will be identified by the end of next quarter.

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. Any necessary or agreed upon modifications will be finalized by the AHS Quality Improvement Manager.

Demonstration Evaluation

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

Reported Purposes for Capitated Revenue Expenditures

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

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

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

Enclosures/Attachments

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

Attachment 1: Catamount Health Enrollment Report

Attachment 2: Budget Neutrality Workbook

Attachment 3: Complaints Received by Health Access Member Services

Attachment 4: Medicaid Managed Care Entity Grievance and Appeal Reports

Attachment 5: Office of VT Health Access Ombudsman Report

Attachment 6: DVHA Managed Care Entity Investment Summary

State Contact(s)

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

Date Submitted to CMS: May 19, 2011

ATTACHMENTS


 Department of Vermont Health Access
 SFY 11 Catamount Health Actual Revenue and Expense Tracking
 Monday, April 18, 2011

	SFY '11 BAA			Consensus Estimates for SFY to Date			Actuals thru 3/31/11			
	<=200%	>200%	Total	<=200%	>200%	Total	<=200%	>200%	Total	% of SFY to-Date
TOTAL PROGRAM EXPENDITURES										
Catamount Health	41,787,258	15,432,576	57,219,834	30,586,678	11,282,709	41,869,386	27,062,602	12,924,688	39,987,290	95.50%
Catamount Eligible Employer-Sponsored Insurance	1,557,244	802,257	2,359,501	1,139,803	581,040	1,720,843	828,188	360,775	1,188,964	69.09%
Subtotal New Program Spending	43,344,502	16,234,833	59,579,335	31,726,480	11,863,749	43,590,229	27,890,790	13,285,464	41,176,254	94.46%
Catamount and ESI Administrative Costs	1,554,749	1,142,276	2,697,025	1,166,062	856,707	2,022,769	1,166,062	856,707	2,022,769	100.00%
TOTAL GROSS PROGRAM SPENDING	44,899,251	17,377,109	62,276,360	32,892,542	12,720,456	45,612,998	29,056,852	14,142,171	43,199,022	94.71%
TOTAL STATE PROGRAM SPENDING	17,616,897	7,316,623	24,933,521	12,703,055	5,357,468	18,060,522	11,995,589	5,837,377	17,832,966	98.74%
TOTAL OTHER EXPENDITURES										
Immunizations Program	-	2,500,000	2,500,000	-	1,875,000	1,875,000	-	1,875,000	1,875,000	100.00%
VT Dept. of Labor Admin Costs Assoc. With Employer Assess.	-	394,072	394,072	-	295,554	295,554	-	295,554	295,554	100.00%
Marketing and Outreach	500,000	-	500,000	375,000	-	375,000	375,000	-	375,000	100.00%
Blueprint	-	1,846,713	1,846,713	-	1,385,035	1,385,035	-	1,385,035	1,385,035	100.00%
TOTAL OTHER SPENDING	500,000	4,740,785	5,240,785	375,000	3,555,589	3,930,589	375,000	3,555,589	3,930,589	100.00%
TOTAL STATE OTHER SPENDING	206,350	4,740,785	4,947,135	154,763	3,555,589	3,710,351	154,763	3,555,589	3,710,351	100.00%
TOTAL ALL STATE SPENDING	17,823,247	12,057,408	29,880,656	12,857,817	8,913,057	21,770,874	12,150,351	9,392,966	21,543,317	98.95%
TOTAL REVENUES										
Catamount Health Premiums	5,775,190	4,653,264	10,428,454	4,250,109	3,436,231	7,686,341	3,924,940	3,521,530	7,446,470	96.88%
Catamount Eligible Employer-Sponsored Insurance Premiums	411,090	355,978	767,068	297,996	259,158	557,153	252,640	189,756	442,396	79.40%
Subtotal Premiums	6,186,279	5,009,242	11,195,522	4,548,105	3,695,389	8,243,494	4,177,580	3,711,286	7,888,866	95.70%
Federal Share of Premiums	(3,632,255)	(2,941,928)	(6,574,183)	(2,670,483)	(2,170,302)	(4,840,785)	(2,452,930)	(2,179,638)	(4,632,569)	95.70%
TOTAL STATE PREMIUM SHARE	2,554,024	2,067,314	4,621,339	1,877,622	1,525,087	3,402,709	1,724,650	1,531,648	3,256,297	95.70%
Cigarette Tax Increase (\$.60 / \$.80)			9,408,500			7,056,375			7,728,319	109.52%
Employer Assessment			7,600,000			5,700,000			6,989,000	122.61%
Interest			-			-			2,163	0.00%
TOTAL OTHER REVENUE			17,008,500			12,756,375			14,719,482	115.39%
TOTAL STATE REVENUE	2,554,024	2,067,314	21,629,839	1,877,622		16,159,084	1,724,650		17,975,780	111.24%
State-Only Balance			(8,250,817)			(5,611,789)			(3,567,537)	
Carryforward			793,641			793,641			793,641	
CATAMOUNT FUND (DEFICIT)/SURPLUS			(7,457,176)			(4,818,148)			(2,773,896)	
General Fund BAA to GC on Behalf of Catamount			7,822,019			5,866,514			5,866,514	100.00%
ALL FUNDS THAT SUPPORT CATAMOUNT (DEFICIT)/SURPLUS			364,843			1,048,366			3,092,618	

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

Green Mountain Care Enrollment Report March 2011

TOTAL ENROLLMENT BY MONTH

Adults:	Jul-07	Nov-07	Jul-08	Nov-08	Dec 09	Mar 10	Apr 10	May 10	June 10	July 10	Aug 10	Sept 10	Oct 10	Nov 10	Dec 10	Jan 11	Feb 11	Mar 11
VHAP-ESIA	-	35	672	759	968	952	942	923	926	926	921	906	873	871	899	899	905	918
ESIA	-	21	336	499	698	749	745	759	729	702	731	729	768	760	764	783	785	801
CHAP	-	320	4,608	6,120	9,138	9,755	10,163	9,902	9,943	9,823	9,839	10,087	9,891	9,898	9,898	9,820	9,967	10,200
Catamount Health	-	120	697	932	2,088	2,267	2,277	2,307	2,349	2,463	2,474	2,491	2,483	2,552	2,498	2,545	2,718	2,810
Total	-	496	6,313	8,310	12,892	13,723	14,127	13,891	13,947	13,914	13,965	14,213	14,015	14,081	14,059	14,047	14,375	14,729

Adults:	Jul-07	Nov-07	Jul-08	Nov-08	Dec 09	Mar 10	Apr 10	May 10	June 10	July 10	Aug 10	Sept 10	Oct 10	Nov 10	Dec 10	Jan 11	Feb 11	Mar 11
VHAP	23,725	24,849	26,441	26,860	33,067	35,010	36,010	34,801	34,570	35,329	35,408	35,852	36,019	35,730	36,669	37,093	37,194	37,820
Other Medicaid	69,764	69,969	70,947	35,601	38,411	39,181	39,483	39,266	39,368	39,481	39,590	38,663	39,913	39,777	39,414	40,384	40,462	40,799
Children:																		
Dr Dynasaur	19,738	19,733	19,960	20,511	20,472	20,602	20,707	20,262	19,882	19,898	19,608	19,891	20,051	20,141	21,120	21,113	21,080	21,064
SCHIP	3,097	3,428	3,396	3,527	3,451	3,514	3,564	3,513	3,478	3,478	3,500	3,508	3,613	3,587	3,539	3,499	3,657	3,605
Other Medicaid*	Included	Included	Included	34,015	38,116	38,531	38,862	39,325	39,157	39,846	38,015	39,142	39,349	38,942	38,265	38,355	38,460	38,675
Total	116,324	117,979	120,744	120,514	133,517	136,838	138,626	137,167	136,455	138,032	136,121	137,056	138,945	138,177	139,007	140,444	140,853	141,963
TOTAL ALL	116,324	118,355	127,057	128,824	146,409	150,561	152,753	151,058	150,402	151,946	150,086	151,269	152,960	152,258	153,066	154,491	155,228	156,692

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

March 2011 Demographics

Income	VHAP-ESIA*	ESIA*	CHAP*	TOTAL
0-50%	23	-	550	573
50-75%	32	-	103	135
75-100%	107	3	100	210
100-150%	439	5	313	757
150-185%	301	226	3718	4,245
185-200%	6	287	2506	2,799
200-225%	2	138	1374	1,514
225-250%	3	84	919	1,006
250-275%	-	52	463	515
275-300%	5	6	154	165
Total	918	801	10,200	11,919

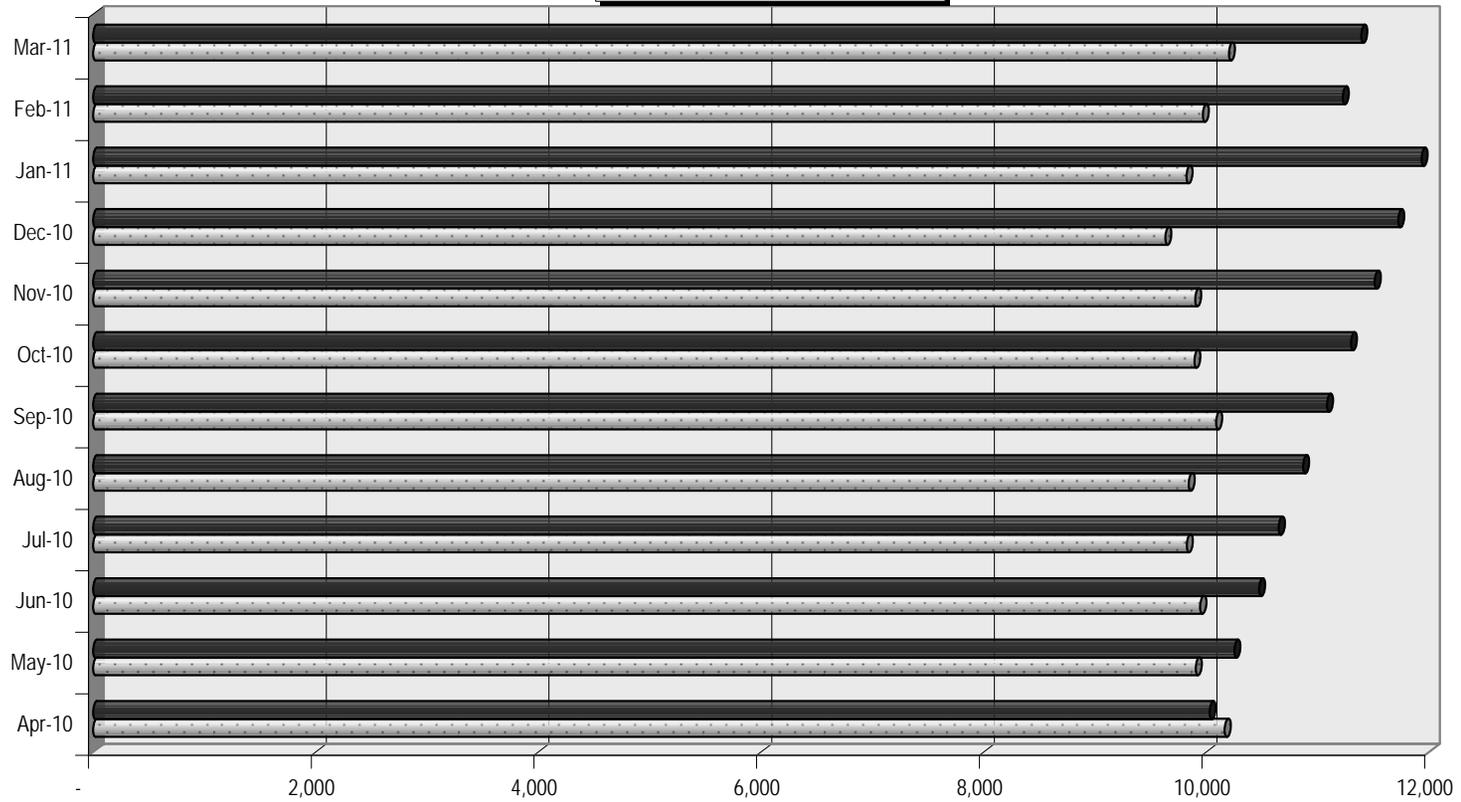
Age	VHAP-ESIA	ESIA	CHAP	TOTAL
18-24	45	72	1905	2,022
25-35	268	202	1890	2,360
36-45	319	232	1594	2,145
46-55	234	206	2126	2,566
56-64	51	89	2670	2,810
65+	1	-	15	16
Total	918	801	10,200	11,919

Green Mountain Care Enrollment Report (continued)
March 2011 Demographics

Gender	VHAP-ESIA	ESIA	CHAP	TOTAL
Male	335	284	4398	
Female	583	517	5802	
Total	918	801	10,200	11,919

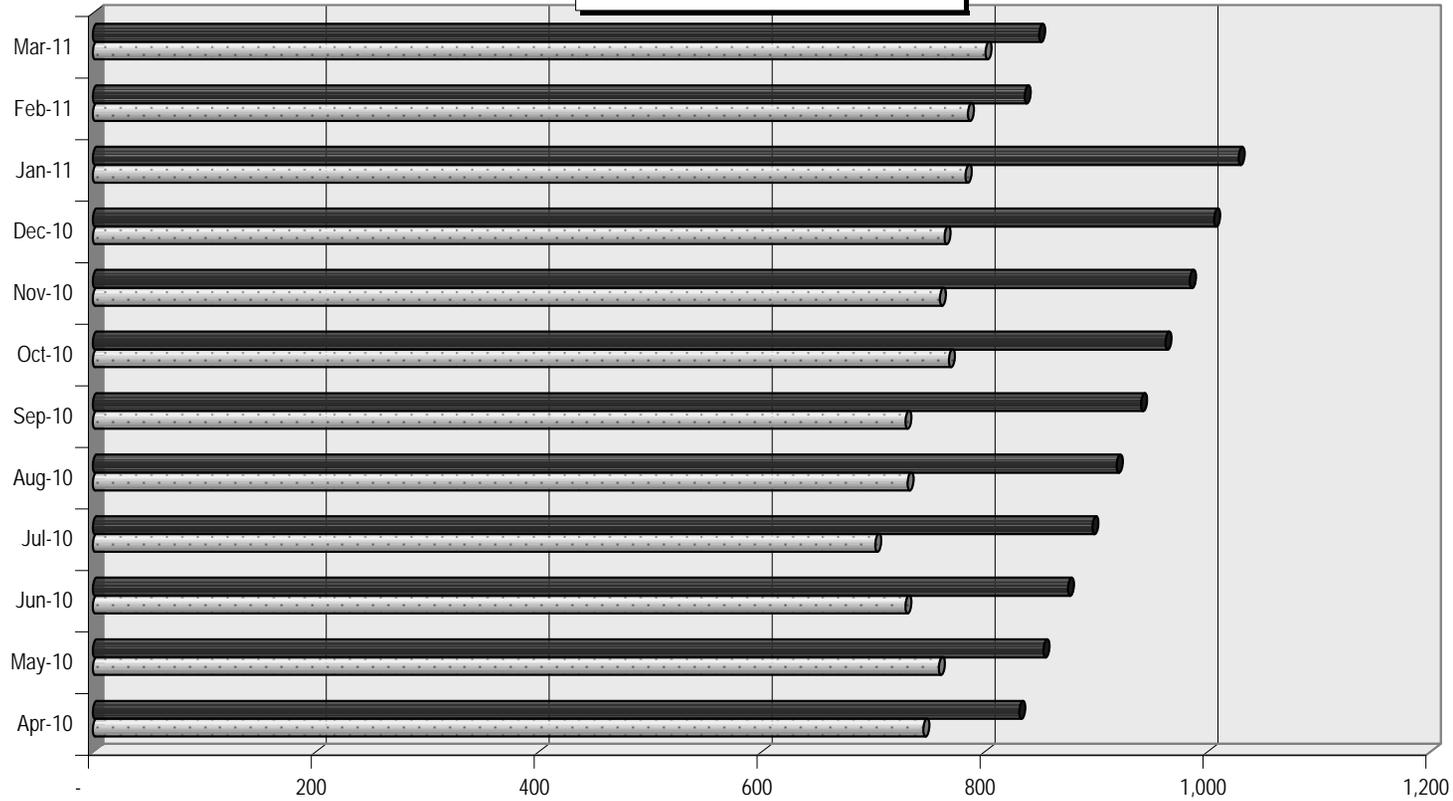
County	VHAP-ESIA	ESIA	CHAP	TOTAL
Addison	60	38	595	693
Bennington	83	85	657	825
Caledonia	26	37	634	697
Chittenden	189	188	1983	2,360
Essex	5	3	138	146
Franklin	80	53	646	779
Grand Isle	12	3	118	133
Lamoille	55	58	503	616
Orange	49	30	495	574
Orleans	60	48	551	659
Other	-	-	4	4
Rutland	106	89	1082	1,277
Washington	71	64	957	1,092
Windham	51	49	871	971
Windsor	71	56	966	1,093
Total	918	801	10,200	11,919

Catamount Health Assistance Program
 Enrollment



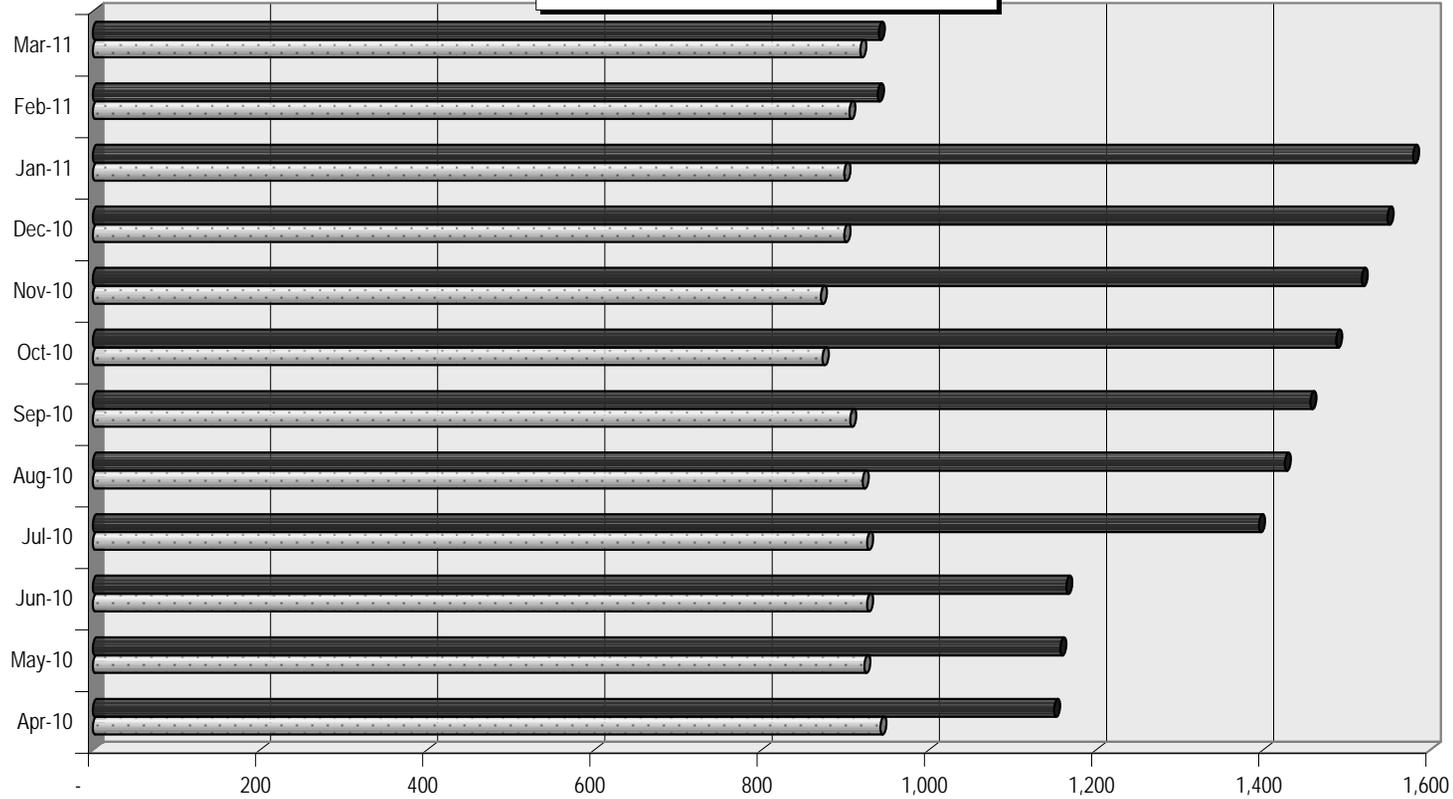
	Apr-10	May-10	Jun-10	Jul-10	Aug-10	Sep-10	Oct-10	Nov-10	Dec-10	Jan-11	Feb-11	Mar-11
■ Projected	10,028	10,250	10,472	10,649	10,867	11,083	11,297	11,510	11,722	11,932	11,224	11,389
□ Actual	10,163	9,902	9,943	9,823	9,839	10,087	9,891	9,898	9,630	9,820	9,967	10,200

Employer Sponsored Insurance Assistance Enrollment



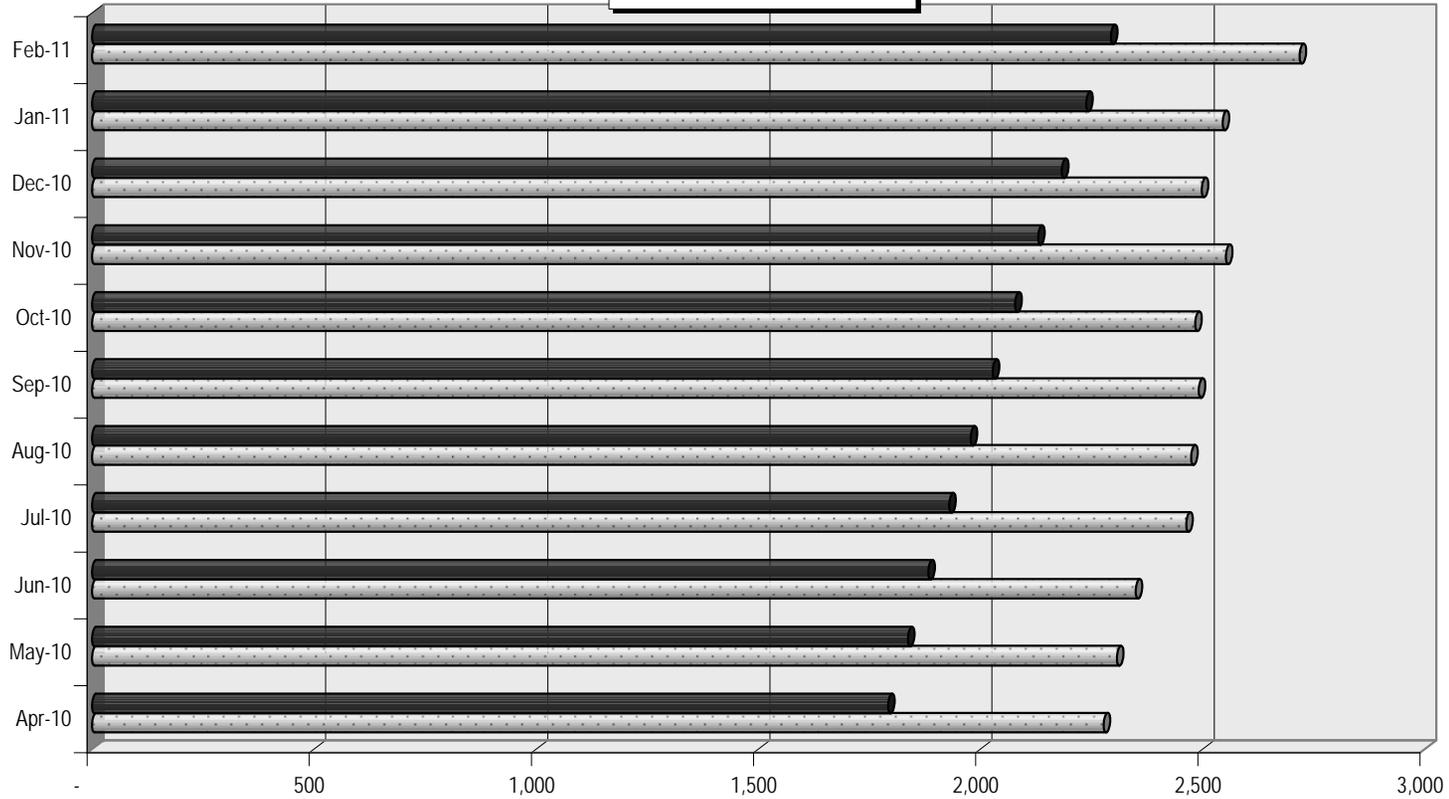
	Apr-10	May-10	Jun-10	Jul-10	Aug-10	Sep-10	Oct-10	Nov-10	Dec-10	Jan-11	Feb-11	Mar-11
■ Projected	831	853	875	897	919	940	962	984	1,006	1,028	836	849
□ Actual	745	759	729	702	731	729	768	760	764	783	785	801

VHAP - Employer Sponsored Insurance Assistance Enrollment



	Apr-10	May-10	Jun-10	Jul-10	Aug-10	Sep-10	Oct-10	Nov-10	Dec-10	Jan-11	Feb-11	Mar-11
■ Projected	1,150	1,157	1,164	1,395	1,426	1,456	1,487	1,518	1,549	1,579	939	940
□ Actual	942	923	926	926	921	906	873	871	899	899	905	918

Catamount Health - Unsubsidized Enrollment



	Apr-10	May-10	Jun-10	Jul-10	Aug-10	Sep-10	Oct-10	Nov-10	Dec-10	Jan-11	Feb-11	Mar-11
■ Projected	1,792	1,836	1,882	1,929	1,978	2,027	2,078	2,130	2,183	2,238	2,293	2,351
▨ Actual	2,277	2,307	2,349	2,463	2,474	2,491	2,483	2,552	2,498	2,545	2,718	2,810

Global Commitment Expenditure Tracking

ATTACHMENT 2

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			
	PQA: WY1	PQA: WY2	PQA: WY3	PQA: WY4	PQA: WY5	PQA: WY6	PQA: WY7	PQA: WY8	PQA: WY9	Cumulative per 1/1/11 STCs				Waiver Cap	Variance to Cap under/(over)		
1205	\$ 178,493,793											\$ 178,493,793					
0306	\$ 189,414,365	\$ 14,472,838										\$ 14,472,838	\$ 203,887,203				
0606	\$ 209,647,618	\$ (14,172,165)										\$ (14,172,165)	\$ 195,475,453				
0906	\$ 194,437,742	\$ 133,350										\$ 133,350	\$ 194,571,092				
WY1 SUM	\$ 771,993,518	\$ 434,023										\$ 434,023	\$ 782,159,845	\$ 4,620,302	\$ 786,780,147	\$ 841,266,663	\$ 54,486,516
1206	\$ 203,444,640	\$ 8,903										\$ 8,903	\$ 203,453,543				
0307	\$ 203,804,330	\$ 8,894,097										\$ 8,894,097	\$ 212,698,427				
0607	\$ 186,458,403	\$ 814,587	\$ (68,408)									\$ 746,179	\$ 187,204,582				
0907	\$ 225,219,267	\$ -	\$ -									\$ -	\$ 225,219,267				
WY2 SUM	\$ 818,926,640	\$ 9,717,587	\$ (68,408)									\$ 9,649,179	\$ 802,884,359	\$ 6,464,439	\$ 809,348,797	\$ 1,684,861,317	\$ 88,732,372
Cumulative															\$ 1,596,128,945	\$ 2,604,109,308	\$ 119,793,211
1207	\$ 213,871,059	\$ -	\$ 1,010,348									\$ 1,010,348	\$ 214,881,406				
0308	\$ 162,921,830	\$ -	\$ -									\$ -	\$ 162,921,830				
0608	\$ 196,466,768	\$ 14,717	\$ -	\$ 40,276,433								\$ 40,291,150	\$ 236,757,918				
0908	\$ 228,593,470	\$ -	\$ -	\$ -								\$ -	\$ 228,593,470				
WY3 SUM	\$ 801,853,126	\$ 14,717	\$ 1,010,348	\$ 40,276,433								\$ 41,301,498	\$ 881,729,256	\$ 6,457,896	\$ 888,187,152	\$ 2,604,109,308	\$ 119,793,211
Cumulative															\$ 2,484,316,097	\$ 4,700,022,174	\$ 255,901,196
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	\$ 4,700,022,174	\$ 181,250,037
Cumulative															\$ 3,425,180,534	\$ 7,113,290,903	\$ 2,147,022,828
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	\$ 7,113,290,903	\$ 2,147,022,828
Cumulative															\$ 4,444,120,978	\$ 9,855,886,798	\$ 3,989,618,723
1210	\$ 262,106,988	\$ -	\$ 6,444,984									\$ 6,444,984	\$ 268,551,972				
0311	\$ 257,140,611	\$ -	\$ -									\$ -	\$ 257,140,611				
0611	\$ -	\$ -	\$ -									\$ -	\$ -				
0911	\$ -	\$ -	\$ -									\$ -	\$ -				
WY6 SUM	\$ 519,247,599	\$ -	\$ 6,444,984	\$ -	\$ -							\$ 6,444,984	\$ 519,247,599	\$ 2,899,498	\$ 522,147,097	\$ 9,855,886,798	\$ 3,989,618,723
Cumulative															\$ 4,966,268,075	\$ 11,811,777,701	\$ 7,828,166,978
1211	\$ -	\$ -	\$ -									\$ -	\$ -				
0312	\$ -	\$ -	\$ -									\$ -	\$ -				
0612	\$ -	\$ -	\$ -									\$ -	\$ -				
0912	\$ -	\$ -	\$ -									\$ -	\$ -				
WY7 SUM	\$ -	\$ -	\$ -	\$ -	\$ -							\$ -	\$ -	\$ -	\$ -	\$ 11,811,777,701	\$ 9,855,886,798
Cumulative															\$ 4,966,268,075	\$ 21,667,664,402	\$ 13,847,777,600
1212	\$ -	\$ -	\$ -									\$ -	\$ -				
0313	\$ -	\$ -	\$ -									\$ -	\$ -				
0613	\$ -	\$ -	\$ -									\$ -	\$ -				
0913	\$ -	\$ -	\$ -									\$ -	\$ -				
WY8 SUM	\$ -	\$ -	\$ -	\$ -	\$ -							\$ -	\$ -	\$ -	\$ -	\$ 11,811,777,701	\$ 9,855,886,798
Cumulative															\$ 4,966,268,075	\$ 31,479,442,103	\$ 23,703,663,806
1213	\$ -	\$ -	\$ -									\$ -	\$ -				
WY9 SUM	\$ -	\$ -	\$ -	\$ -	\$ -							\$ -	\$ -	\$ -	\$ -	\$ 11,811,777,701	\$ 9,855,886,798
Cumulative															\$ 4,966,268,075	\$ 43,331,319,804	\$ 33,559,550,604
Grand Total	\$ 4,799,773,237	\$ 10,166,327	\$ (16,042,281)	\$ 79,876,130	\$ 41,153,315	\$ 19,453,990	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 4,934,380,717	\$ 31,887,358	\$ 4,966,268,075	\$ 8,955,886,798	\$ 3,989,618,723

**Complaints Received by Health Access Member Services
January 1, 2011 – March 31, 2011**

Eligibility forms, notices, or process	18
ESD Call-center complaints (IVR, rudeness, hold times)	3
Use of social security number as identifiers	0
General premium complaints	12
Catamount Health Assistance Program premiums, process, ads, plans	2
Coverage rules	4
Member services	2
Eligibility rules	2
Eligibility local office	3
Prescription drug plan complaint	3
Copays/service limit	1
Pharmacy coverage	0
Provider issues (perceived rudeness, refusal to provide service, prices) (variety of provider types)	7
Provider enrollment issues	0
Chiropractic coverage change	0
Shortage of enrolled dentists	0
Green Mountain Care Website	0
DVHA	2
Total	59

**Grievance and Appeal Quarterly Report
Medicaid MCO All Departments Combined Data
January 1, 2011 – March 31, 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 April 22, 2011, from the centralized database for grievances and appeals that were filed from January 1, 2011 through March 31, 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 10 grievances filed with the MCO; 4 were addressed during the quarter, none were withdrawn and six were still pending at the end of the quarter. Grievances must be addressed within 90 days of filing, so having pending cases at the end of the quarter is to be expected. The grievances were addressed in an average of 12 days. Acknowledgement letters of the receipt of a grievance must be sent within five days; the average was 2 days, although one letter was sent late. Of the grievances filed, 80% were filed by beneficiaries, none were filed by a representative of the beneficiary and 20% were filed by another source. Of the 10 grievances filed, DMH had 80%, DVHA had 30%, DAIL had 10%, and VDH had 10%. There were no grievances filed for DCF during this quarter.

There were no cases that were pending from previous quarters; one case from the previous quarter was 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 45 appeals filed with the MCO; 11 requested an expedited decision of which 2 met the criteria. Of these 45 appeals, 37 were resolved (82% of filed appeals), five were withdrawn, and 3 were still pending (7%). In 21 cases (57% of those resolved), the original decision was upheld by the person hearing the appeal, eight cases (22% of those resolved) were reversed, and eight cases (22% of those resolved) were approved by the applicable department/DA/SSA before the appeal meeting.

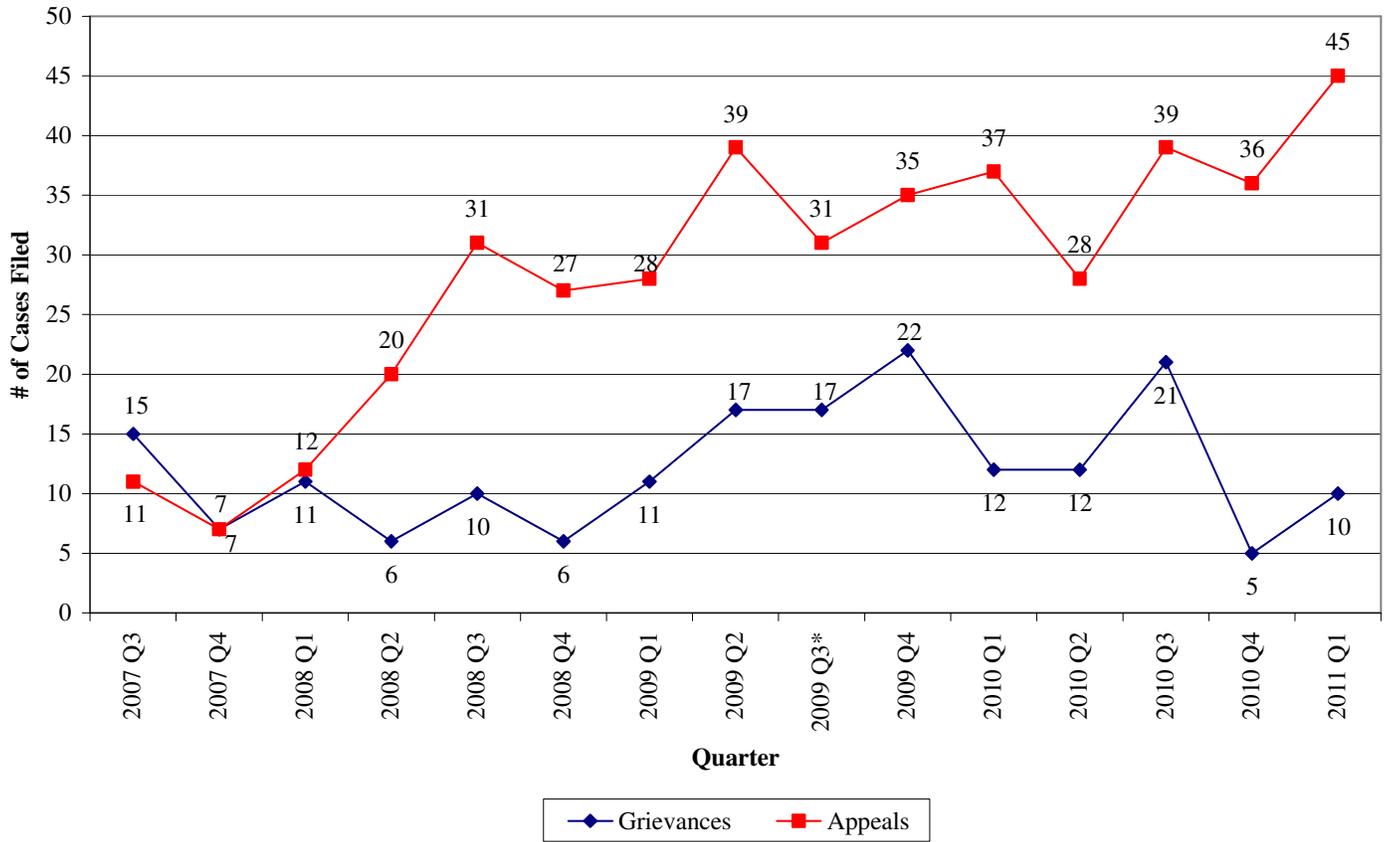
Of the 37 appeals that were resolved this quarter, 95% were resolved within the statutory time frame of 45 days; 78% were resolved within 30 days. The average number of days it took to resolve these cases was 21 days. 97% of appeals resolved this quarter were resolved within the maximum time frame of 59 days (the statutory time frame of 45 days plus an allowed 14 day extension). Acknowledgement letters of the receipt of an appeal must be sent within five days; the average was two days, although three letters were sent late.

Of the 45 appeals filed, 25 were filed by beneficiaries (55%), 18 were filed by a representative of the beneficiary (40%), 1 was filed by a provider (2%), and 1 was filed by another sources (2%). Of the 45 appeals filed, DVHA had 73%, DAIL had 18%, and DMH had 9%.

There were no cases filed between October 1, 2010, and December 31, 2010 that were still pending at the beginning of this quarter. There were four cases (three for DAIL and one for VDH) that were still pending from before October 1, 2010. There were nine pending cases that were resolved this quarter; 33% of these cases were upheld (two for DVHA and 1 for DAIL), two (both from DVHA) were reversed (22%), one case (for DAIL) was modified, 3 cases (2 for DAIL and 1 for DVHA) were withdrawn, and no cases were approved by the department/DA/SSA before the appeal meeting. 17% of these cases were resolved within 30 days, 67% in 45 days, and 100% within 59 days. On March 31, 2010 there were 7 cases still pending; four for DAIL, 2 for DVHA and one for VDH.

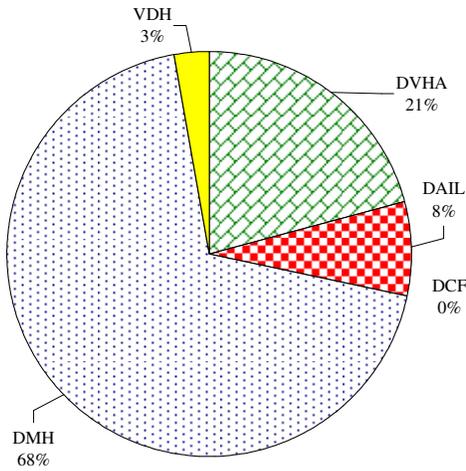
Beneficiaries can file an appeal and a fair hearing at the same time, and they can file a fair hearing if their appeal is not decided in their favor. There was one fair hearing for DVHA filed this quarter. There are a total of six fair hearings still pending as of the end of this quarter, five for DVHA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

Medicaid MCO Grievances & Appeals

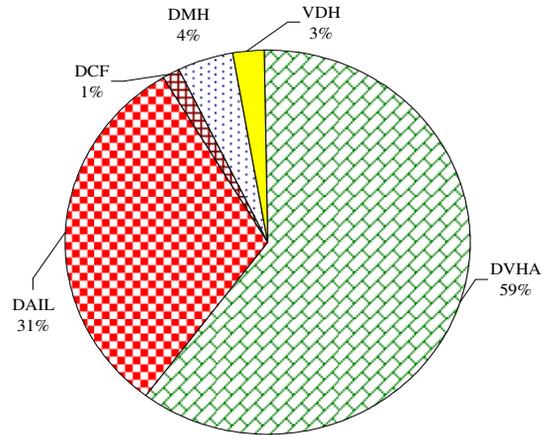


MCO Grievance & Appeals by Department From July 1, 2007 through March 31, 2011

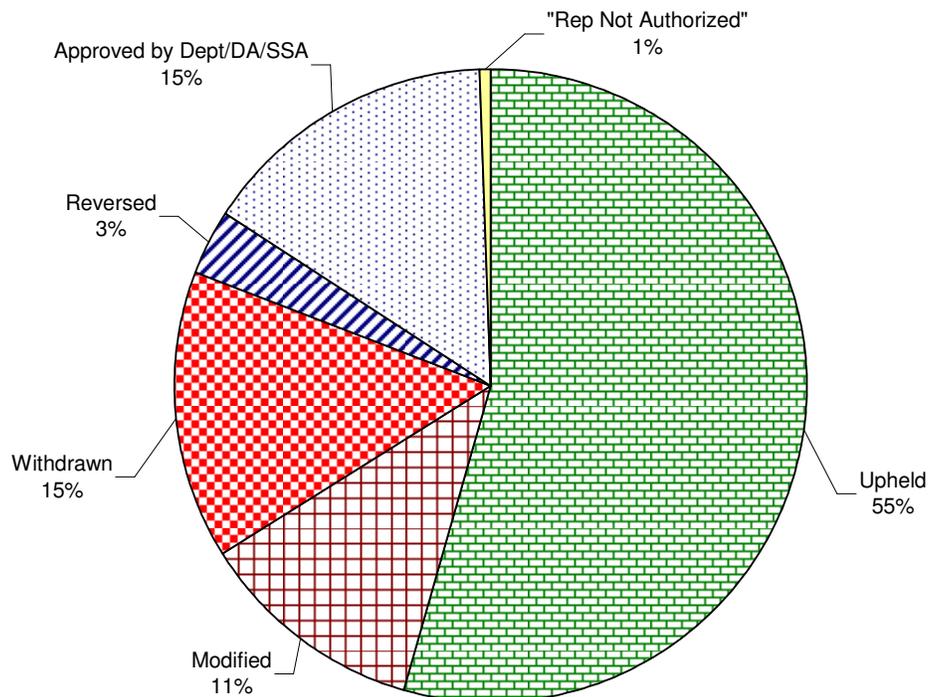
Grievances



Appeals



MCO Appeal Resolutions from July 1, 2007 through March 31, 2011



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QUARTERLY REPORT January 1, 2011 – March 31, 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 January 1, 2011 through March 31, 2011. We received 367 calls (43% of all calls) from DVHA program beneficiaries this quarter, compared to 377 (42%) 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 20 page data report specifically about DVHA beneficiaries who called us.

A. Total call volume drops slightly but remains high.

Overall call volume is staying consistently higher than the first six months of last year. The total number of all cases/all coverages that we opened this quarter was 856, compared to 889 last quarter. It was 23% higher than the same quarter in 2010, when we received 696 calls. January was the busiest month ever (329), beating out January 2006, the previous all time high (313), which was when Medicare Part D began. February 2011 was the second busiest February, and March 2011 was the busiest March. [See the table at the end of this narrative for further detail.]

Calls from DVHA beneficiaries also dropped slightly, from 377 to 367.

B. Eligibility calls decrease 19%.

Much of the call volume increase in the last six months of 2010 was due to problems that the Department for Children and Families (DCF) was having with processing applications and reviews, as part of its Modernization effort. The Great Recession and its aftermath compounded these problems by increasing the number of applications for state programs. The number of eligibility calls decreased this quarter by 19%, from 305 to 246. In the same quarter in 2010 we received 235 eligibility related calls. Thus, eligibility calls seem to be going back to a more "normal" range. DCF appears to be making progress in approving its eligibility determinations.

C. Insured individuals continue to have problems affording care.

We have been tracking Affordability as an access issue for several quarters now. These calls are from individuals who tell us that they have insurance, but they cannot afford the health care they need due to high levels of cost sharing.

This quarter we had 73 (as both a primary and a secondary issue) calls about this, compared to 101 last quarter, and 64 the previous quarter. Of these 73 calls, 26 were from Medicare beneficiaries (compared to 35 last quarter), 19 were from DVHA beneficiaries (compared to 51), 31 were from commercially insured individuals (compared to 21), and nine callers were on Catamount plans, compared to five last quarter. Just five were from uninsured Vermonters (compared to 10).

D. Issues with highest call volumes remained about the same.

The issues (primary and secondary) with the highest call volumes for DVHA beneficiaries were: Medicaid eligibility (59), communication problems or complaints about providers (54), access to prescription drugs (44), VHAP eligibility (43), Premium Assistance eligibility (43), Medicaid or VHAP billing (30), Fair Hearings (26), and Transportation (22).

II. Issues

A. Eligibility

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 DHVA data report.

Call volume related to eligibility for state programs dropped this quarter from an all time high of 305 last quarter to 246. This may be because the problems that DCF was having processing applications and reviews seem to have abated somewhat.

During the summer quarter of 2010, the number of HCO callers who were uninsured jumped dramatically to 99 from 55, and remained high at 100 last quarter. This quarter calls from the uninsured dropped to 68. Most of these calls continue to be about eligibility (63%).

We continue to see problems related to state program eligibility determinations, but not on the same scale as last fall. A look at both primary and secondary issues, reveals that there are still problems in this area. Note that some of the numbers below overlap; that is, some of the 28 DCF Mistake cases could also involve lost paperwork, for example. Of the 545 total calls raising eligibility issues this quarter:

- 7 involved application processing delays (compared to 15 last quarter);

- 35 involved the Buy In (Medicare Savings) Programs (compared to 34);
- 28 involved DCF mistakes (compared to 38);
- 6 involved lost paperwork, meaning that callers said they submitted paperwork to DCF and were subsequently told there was no record of it (compared to 15);
- 9 involved problems with the mail (compared to 8);
- 27 involved the Medicaid Spend Downs (compared to 25);
- 2 involved an error by Member Services (Maximus) (compared to 3); and
- 12 involved specific DCF Modernization complaints, listed in the issue section “Other,” as these are not necessarily related to eligibility problems (compared to 15).

B. DCF Mistakes

At last quarter’s meeting, we agreed to provide more detail on what we’ve coded as DCF mistakes. There were 28 cases in which a DCF mistake was a primary or secondary issue, and five where it was coded as the primary issue. Below are excerpted summaries of the problems from the advocates’ casenotes.

Primary problem:

- C had repeated contact with his worker, submitted his review paperwork and was closed 12/31 with an explanation that their workload was too high and they didn't have time to process his application in time. They originally re-instated his benefits 1/16 (so he had a 2 week gap in coverage and received medical services during that time). He finally made contact with his worker's supervisor, who re-instated his benefits back to 1/1 and explained that his worker isn't trained in HC, so she didn't know how to handle his case.
- VHAP closed on October 31 for being deemed an ineligible student and she wasn't screened for CHAP, for which she was eligible. She tried to follow up to find out why and received no response at all from the state.
- C called saying that the BS Center had given him a number for his worker that was no longer in service.
- C was very confused. Very difficult to figure out if she had any health care issue at all. She is dual eligible, and while it sounds like she has had eligibility and coverage issues with Medicaid in the past, it doesn't sound like she is having any health care problems currently. It does sound like she has a food stamps problem (C kept talking about "medical expense deductions"). C's FS have been fluctuating since July, more down than up, and she thinks she is entitled to reimbursement. C can't get anywhere with DCF directly - she can't ever get through to the right person using IVR, her worker laughed in her face, she gets form after form after form and returns them all but they lose them.
- C's wife sent in both of their reviews to DCF /ESD. Her coverage continued, but his was terminated. This was due to her coverage not needing review because of her SSI, but he does not have SSI so he must undergo review. Worker @ ESD confirmed their paperwork was submitted on time, but someone there overlooked his review and he was subsequently terminated.

Secondary problem:

- State got client's name wrong on insurance card.
- Applied for health care before June, waited to hear for over a month, went directly to the office in St. J, they hadn't even begun to process her claim. Meanwhile, she had to go to the doctor's and now has bills that would have been covered had the paperwork been processed in time. She is trying to get retroactive coverage for the state's failure to process. She is low / single income and cannot afford these bills.
- Termination from CHAP for nonpayment, even though premium check mailed in timely manner. Additional confusion over review paperwork, including requirement for 2010 tax returns, which had not yet been completed. Given misinformation by worker that he was "all set."
- C's HH was incorrectly calculated, which caused him to be over income for Medicaid. When he was found over income for Medicaid he was not sent a proper NOD or screened for other healthcare programs and was subsequently uninsured for 4.5 months.
- C had VPharm & Cigna PDP. She says that VPharm was paying the Cigna premium, but suddenly C gets a letter stating that the premium hadn't been paid and that Cigna was terminated. C told by SHIP to call DCF ASAP. So C called DCF and then a few days later she called again and was told the C's VPharm was cancelled at C's request, which C says is completely untrue. Then C got letter saying that Cigna was reinstated, but now she doesn't have VPharm and no one will help get her back on.
- C was not given VHAP limited pending premium payment.
- C received NOD on 3/19 stating that he was ineligible for GMC bcz he has other insurance or did not meet an exception to the 12 month rule, which is not accurate. C did not have insurance and the last insurance that he had, he lost when his wife lost her job.
- C was sent closure notice for 3/31 because of non-review, but his review had actually been received by DCF on 2/22.
- DCF Mistake 1: C's worker deemed C an ineligible student for VHAP in error (C was not a part time student and thus not susceptible to student status restrictions). DCF Mistake 2: When C was deemed ineligible for VHAP, she was not screened for or granted Seamless Transition to CHAP, for which she was eligible. As a result of these two mistakes, C went uninsured for November & December.
- C had sent in yearly review on 1/28 and her food stamp eligibility had been updated, but her VHAP eligibility wasn't reviewed, she was sent a termination notice for 2/28.
- C was denied VHAP because DCF said she had other insurance within the last 12 months and was therefore ineligible, however the other insurance she had was VHAP, so she is eligible.
- C's family received reduction in food stamps, which she says is inappropriate. This may have to do with income fluctuating due to whether or not disabled daughter is counted in HH [coded as not health related].
- Husband was terminated from CFC for allegedly not complying with CFC rules, potentially also for clinical reasons. Family believes he should still be CFC eligible.

- C and husband have been terminated from MSP for being over income. They look to be under QI-1 limit, but only if disabled daughter's income is not counted. Also, even if they are not eligible because state made error putting them on MSP in first place, they are now being forced to pay a higher Part B premium as a result.
- C's minor daughter has been terminated from Katie Beckett. State says she is no longer disabled, but mother says she still is disabled.
- Issue is a premium bill. She has a \$50 premium bill due on January 15th, \$25 for her VHAP, \$25 for son's VHAP. She doesn't think that she should have to pay this because her son started college and has already signed up for the university insurance. (She talked about VHAP student rules for a while and how terrible and ridiculous they are). She has been calling MS to try to tell them that she shouldn't have to pay the premium because her son is no longer on VHAP. She says that someone at MS told her that she shouldn't pay her premium at all for February (due 1/15) and someone else told her to pay the whole thing. She says her premium is always changing and she has had it.
- C trying to apply for CHAP. State repeatedly lost paperwork (then would eventually find it at C's insistence), also had wrong address for C on file.
- DCF Mistake 1: C is 71 year old. He was on VHAP until last January when they deemed him ineligible for being over 65 year old. and thus eligible for Medicare. DCF Mistake 2: C was put on Medicaid in January 2010. C did not go on Medicare at this time because he couldn't afford the Part A and Part B premiums and was not informed of his eligibility for QMB. January 2011 C was deemed ineligible for Medicaid for being over resource. This was determined based on his January review paperwork. He was most likely over resource last January as well. C could have been put on QMB and Medicare last year had he been screened correctly. Now he is facing a gap in coverage between his VHAP benefits ending and the Medicare July 1 effective date.
DCF Mistake 3: C requested a FH on 1/28 before his Medicaid benefits ended on 1/31. C does not have Medicaid CB, but is now on VHAP (CB?), pending his FH decision.
- C denied Medicaid due to special needs trust.
- Even though C closed for nonpayment of premium, I am coding this as a DCF mistake as well because her income and premium were incorrectly calculated because of DCF mistake. DCF counted her former employment income AND her new unemployment income and gave her a very high premium. They should have only been looking at her unemployment income because she no longer had the other income.
- C has been unable to meet Medicaid spend down because (she says) there is no consistent policy for documentation. C has been told different things by every state worker she's talked to.
- I chose DCF mistake because C's problem started as a DCF/DVHA mistake. She was flagged as an "illegal immigrant" when she is not and was denied Medicaid transportation in January and again in February. She was denied transportation even though she is a Medicaid recipient at least until 2/28/11.

- This is coded secondary as DCF Mistake. I believe it is actually DVHA mistake, as C's LIS status wasn't updated in their computers causing the pharmacy not to be able to bill Medicaid.

C. Access to Care

This quarter we had a total of 251 calls related to Access issues or 29.32% of all calls. Of these, 136 (54%) were from DVHA beneficiaries. In the previous quarter we had 257 total Access calls, with 140 (55%) coming from DVHA beneficiaries. Since about 43% of our total calls were from DVHA callers, this is a comparatively high percentage of calls regarding Access issues, and remains a cause of some concern. The percentage of calls from DVHA beneficiaries about access consistently runs about 30-35%; this quarter it was to last quarter, at 37.06%. For beneficiaries of commercial carriers it usually runs about 20-25%. This quarter only 42 (22.70%) individuals on commercial plans called us about access issues.

Thus, 136 individuals on state plans had access issues, while just 42 on commercial plans did. Access is clearly 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 was slightly higher, 14, this quarter as compared to last quarter, at 12 calls. However, 16 calls involved pain management as a primary or secondary issue. We received a total of 26 calls overall related to pain management, so the DVHA calls made up 62% of these calls. We had only four callers on commercial insurance with pain management issues. 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 13 calls coded as access to substance abuse treatment as the primary issue this quarter. Of these, eight were from DVHA beneficiaries. The previous quarter we received seven such calls, and six 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 suboxone treatment, is of increasing concern.

II. Call volume by type of insurance:

- **DVHA programs** (Medicaid, VHAP, VHAP Pharmacy, Premium Assistance, VScript, VPharm, or both Medicaid and Medicare aka dual eligibles) insured **43%** (367 calls), compared to 42% (377) last quarter;
- **Medicare** (Medicare only, Medicare and a Medicare Supplemental Plan aka Medigap, Medicare and Medicaid aka dual eligibles, Medicare and Medicare Savings

- Program aka Buy-In program, Medicare and Part D, or Medicare and VPharm) insured **25%** (210), compared to 21% (188) last quarter;
- 8% (69) had Medicare only;
 - 14% (121) 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 **22%** (185), compared to 20% (176) last quarter;
 - **8%** (69) identified themselves as **Uninsured**, compared to 11% (100) last quarter;
 - **7%** (63) had a **Catamount Health** plan, either at full cost or with Premium Assistance, compared to 6% (49) last quarter; and
 - In the remainder of calls the insurance status was either unknown or not relevant.

IV. Disposition of DVHA cases

We closed 346 DVHA cases this quarter, compared to 379 last quarter:

- About 2% (7 calls) from DVHA beneficiaries were resolved in the initial call, compared to 5% (18 calls) last quarter;
- 59% (204 calls) were resolved by advice or referral, after an analysis of the problem. Last quarter 58% (220 calls) were resolved in this manner;
- 20% (69 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 21% (79 calls) were resolved in this manner;
- About 9% (31 calls) were considered complex intervention, which involves complex analysis and more than two hours of an advocate's time, compared to 8% (31 calls) last quarter.

V. Issues raised by DVHA beneficiaries

We opened 367 cases from DVHA beneficiaries, compared to 377 last quarter. Of these:

- 37.06% (136 calls) involved Access to Care, compared to 37.40% (141 calls) last quarter;
- 15.26% (56 calls) involved Billing/Coverage, compared to 11.67% (44 calls) last quarter;
- 1.91% (7 calls) were coded as Consumer Education, compared to 1.33% (5 calls) last quarter;
- 32.15% (118 calls) involved Eligibility, compared to 32.63% (123 calls) last quarter; and
- 13.62% (50 calls) involved Other issues, compared to 16.45% (62 calls) last quarter, which includes Medicare Part D calls.

A. Access to Care

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

We received 136 DVHA Access to Care calls, compared to 141 last quarter. The top call volume primary issues within this category were:

- 18 Prescription Drugs, compared to 31 last quarter;
- 16 Dental, Dentists or Orthodontics, compared to 17;
- 16 Transportation, compared to 14;
- 14 Pain Management, compared to 12;
- 9 Specialty Care,
- 8 Substance Abuse, compared to 6; and
- 6 Affordability, compared to 10.

The top access issues when both primary and secondary issues (274 calls) were considered were:

- 44 Prescription Drug;
- 19 Affordability;
- 22 Transportation;
- 21 Specialty Care;
- 21 Dental, Dentists or Orthodontia;
- 14 Transition/Continuity of Care;
- 13 Substance Abuse;
- 13 Primary Care Doctor;
- 12 Transition/Continuity of Care; and
- 11 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 56 DVHA primary issue calls in this category, compared to 44 last quarter:

- 20 Medicaid/VHAP Managed Care, compared to 20 last quarter;
- 12 Hospital Billing;
- 5 Premiums; and
- 5 Provider Problems.

C. Eligibility

Eligibility cases are those in which the individual is seeking to get or retain government subsidized health insurance. This quarter we received 246 calls from individuals with a primary issue of eligibility, but we received 545 calls from individuals for whom eligibility was either a primary or secondary issue.

We received 118 eligibility calls from current DVHA beneficiaries, compared to 123 last quarter, which were coded as a primary issue:

- 39 involved Medicaid eligibility, compared to 30 last quarter;
- 26 involved VHAP, compared to 29;

- 12 involved the Buy In Programs, aka Medicare Savings Programs, compared to 11; and
- 9 involved Catamount Health and Premium Assistance, compared to 13. This count only includes callers who were already on DVHA plans when they called us. Many callers who call about Catamount are either uninsured or on commercial plans.

In addition, we received a number of calls from individuals who were upset that the premiums for their CHAP through MVP were increasing by \$86. Each of these callers was given advice about the option of switching to Catamount Blue. It is not easy to determine how many of these calls we received because some advocates coded these calls as Changing Plans, and others coded them as Premium Too High. These also probably did not show up as DVHA cases because the database now records Catamount Health beneficiaries as BISHCA rather than DVHA. There were 16 cases that were coded as Changing Plans or Premium Too High as the primary issue.

VI. Outcomes

The HCO prevented 15 insurance terminations or reductions for DVHA beneficiaries and got six DVHA beneficiaries onto other plans. We provided advice or education to 166 DVHA callers, got claims covered or waived for 23 individuals. We estimated insurance eligibility for 19 callers and explained to 3 that they were not eligible. [See Outcome Summary for more detail on page 20 of the data report.]

VII. Table on All Calls by Month and Year

All Cases	2003	2004	2005	2006	2007	2008	2009	2010	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	
May	234	210	200	235	195	207	213	205	
June	252	176	191	236	254	245	276	250	
July	221	208	190	183	211	205	225	271	
August	189	236	214	216	250	152	173	234	
September	222	191	172	181	167	147	218	310	
October	241	172	191	225	229	237	216	300	
November	227	146	168	216	195	192	170	300	
December	226	170	175	185	198	214	161	289	
Total	2578	2409	2200	2583	2560	2604	2616	3077	856

Investment Criteria #	Rationale	Attachment 6
1	Reduce the rate of uninsured and/or underinsured in Vermont	
2	Increase the access of quality health care to uninsured, underinsured, and Medicaid beneficiaries	
3	Provide public health approaches to improve the health outcomes and the quality of life for Medicaid-eligible individuals in Vermont	
4	Encourage the formation and maintenance of public-private partnerships in health care.	

SFY10 Final MCO Investments

8/4/10

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