State of Vermont
Agency of Human Services

Global Commitment to Health
11-W-00194/1

Section 1115
Demonstration Year: 5
(10/1/2009 – 9/30/2010)

Quarterly Report for the period
July 1, 2010 to September 30, 2010

November 16, 2010

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. 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 fourth quarterly report for waiver year five, covering the period from July 1, 2010 through September 30, 2010.***

Enrollment Information and Counts

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

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

Enrollment counts are person counts, not member months.

Demonstation Population	Current Enrollees Last Day of Qtr 9/30/2010	Previously Reported Enrollees Last Day of Qtr 6/30/2010	Variance 09/30/10 to 06/30/10
Demonstration Population 1:	45,006	44,058	2.15%
Demonstration Population 2:	43,576	43,733	-0.36%
Demonstration Population 3:	9,885	10,048	-1.62%
Demonstration Population 4:	N/A	N/A	N/A
Demonstration Population 5:	1123	1226	-8.40%
Demonstration Population 6:	3,030	3,020	0.33%
Demonstration Population 7:	34,889	34,142	2.19%
Demonstration Population 8:	7,757	7,614	1.88%
Demonstration Population 9:	2,631	2,642	-0.42%
Demonstration Population 10:	N/A	N/A	N/A
Demonstration Population 11:	10,364	10,423	-0.57%

Green Mountain Care Outreach / Innovative Activities

Green Mountain Care Update: The Department of Vermont Health Access took advantage of the back-to-school shopping week to promote Green Mountain Care on two radio stations (WDEV and WLVB) that have reach into the county with the highest rate of uninsured in the state (Lamoille at 11.4%). A week of 78 spots featured individuals on Green Mountain Care plans and culminated in an event at the Berlin Wal-Mart which services that region. Live interviews included outreach personnel from CMS's Boston office carrying a message from the Secretary of Health and Human Services. Also partnering in this effort were Bi-State Primary Care and DVHA's two Catamount Health partners, Blue Cross Blue Shield of Vermont and MVP Health Care.

A television program on Green Mountain Care was taped on public access Channel 17. It featured a panel of three self-employed entrepreneurs who shared their experience enrolling into Green Mountain Care. The show was posted the Channel 17 site as well as the Green Mountain Care site and picked up by over 10 additional public access stations, thereby giving us reach at no cost statewide. Some stations aired the show for a week, while others will air it for two months.

Given the significant role that small community papers play in Vermont, they are becoming an important

part of our outreach strategy. Several consumers have volunteered to write articles which have been published or will be in the next quarter.

This quarter Vermont's two United States Senators and Congressman posted the Green Mountain Care web button link on their websites. Not only do these sites give Green Mountain Care important exposure, they enhance our Google rating given the high rating that Google gives them as a trusted source.

During this quarter, the DVHA was involved in one lay off coordinated by the Vermont Department of Labor, which have informed 15 people about health insurance under Green Mountain Care. This compares to three lays offs impacting 251 employees during the same quarter last year.

Enrollment and legislative action: Enrollment in the premium assistance program components of Green Mountain Care (Catamount Health and Employer-Sponsored Insurance) has grown very slowly over the quarter. As of the end of September there were 11,722 individuals enrolled.

Vermont submitted a waiver amendment request to CMS in late August of 2009 to implement two minor changes to eligibility required by Act 61, an omnibus health care reform bill passed during the 2009 legislative session. The two changes to the VHAP and premium assistance eligibility determination process were as follows:

- Depreciation would be allowed as a business expense for self-employed applicants
- Self-employed people who lose their non-group insurance coverage due to no longer being self-employed would not have a 12-month waiting period to enroll in premium assistance.

In the amendment request, Vermont noted that an August 18, 2009, Joint Fiscal Committee decision rescinded the allocated funding to implement these changes. OVHA submitted a report to the legislature in January 2010 on the estimated cost of implementing the depreciation change. The Budget Adjustment bill which was passed by the General Assembly deferred the implementation of these provisions to July 1, 2011. These issues will be revisited during the 2011 legislative session.

As required by the Vermont appropriations act for State Fiscal Year 2011, pending approval by Vermont's new Governor, Vermont will be seeking CMS approval to implement a palliative care program that would allow Medicaid children with life-limiting illnesses to receive concurrent curative and palliative care. We will determine with CMS if a waiver request is necessary in the winter of 2011-2012.

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

To ensure the solvency of the Catamount Fund, the legislature passed a change to the Catamount Health benefit structure that would increase the deductible from $250 to $500 and increase co-pays for brand-name and non-preferred drugs by $5. The two Catamount Health carriers filed rates and forms to reflect this change, in addition to the changes required by the Affordable Care Act (ACA). The higher deductible and co-pays, as well as the ACA changes, were effective on October 1.

Beginning January 1, 2011, the two Catamount Health carriers, Blue Cross Blue Shield of Vermont (BCBS) and MVP Health Care (MVP), will have very different monthly premiums. For unknown reasons, MVP's claims experience has resulted in a premium that will be significantly higher than BCBS's premium. Since enrollees are by law required to pay the difference in price between the higher-

and lower-cost plans, we expect to see many of MVP's customers migrate to BCBS.

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

The 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 September 30, 2010 are summarized below:

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

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

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

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

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

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

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

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

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

Initiative #10: Scholarships - Scholarships, administered through the Vermont Student Assistance Corporation, are awarded to encourage new dentists to practice in Vermont. The combined allocation of $40,000 for SFY 2008/09 was distributed for the 2008-2009 academic year. The program is scheduled to continue in SFY 2010.

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

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

Expenditure Containment Initiatives

Vermont Chronic Care Initiative

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

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

The VCCI supports and aligns with other State health care reform efforts, including the Blueprint for Health and the Capitated Office-Based Medically Assisted Treatment (COBMAT) for Opioid

Dependence initiative (see below). VCCI staff partner with providers, hospitals, community agencies and other Agency of Human Services (AHS) departments to support a patient-focused model of care committed to enhanced self-management skills, healthcare systems improvement, and efficient coordination of services in a climate of increasingly complex health care needs and scarce resources.

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

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

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

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

Vermont's state budget rescission for State Fiscal Year 2009 included elimination of approximately 25%

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

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

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

Highlights of the Vermont Chronic Care Initiative for Quarter 4 of FFY 2010

- All analyses from UVM's VCCI evaluation have been completed and a clinical performance improvement project (PIP) is being developed targeting congestive heart failure. The PIP will be implemented during 1st quarter FFY 2011.
- DVHA care coordinators expanded meetings and electronic data exchange systems with hospital emergency departments (EDs) for increased collaboration regarding emergency room utilization among VCCI beneficiaries.
- During FFY 2010, 51 buprenorphine patients who were part of the Capitated Program for the Treatment of opiate Dependency (CPTOD) program received case management services from DVHA care coordinators.
- During the fourth quarter of FFY 2010, the average monthly program caseload was 1,744. Monthly caseload includes beneficiaries in active outreach by VCCI staff, as well as those successfully engaged and receiving care coordination or health coaching services.

3,226 unique beneficiaries were served by either DVHA care coordinators or APS disease management health coaches during FFY 2010 (10/01/2009 through 09/30/2010). This number includes the 51 buprenorphine patients who received case management services from DVHA care coordinators.

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				
III.	Induction	$366.42	+	**BONUS**	=	**Final Capitated Rate (depends on the number of patients per level, per provider)**
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 quarters (October 2009-September 2010) is $422,225.88 **(Figure 2)**.

(Figure 2)

Buprenorphine Program Payment Summary FFY '10	
FIRST QUARTER	
Oct-09	$ 54,512.45
Nov-09	$ 51,177.27
Dec-09	$ 53,567.75
Quarter Total	**$ 159,257.47**
SECOND QUARTER	
Jan-10	$ 32,801.15
Feb-10	$ 31,634.36
Mar-10	$ 30,784.87
Quarter Total	**$ 95,220.38**
THIRD QUARTER	
April -10	$28,865.08
May-10	$29,446.11
June-10	$28,527.56
Quarter Total	**$86,838.75**
FOURTH QUARTER	
July-10	$40,516
Aug-10	$24,767.34
Sept-10	$15,625.94
Quarter Total	**$80,909.28**
GRAND TOTAL	**$422,225.88**

Mental Health – Vermont Futures Planning

Community System Development

The six-bed Meadowview community residential recovery program is operating at capacity, has successfully transitioned residents from Vermont State Hospital, and even discharged some to community care. The individuals referred to and served at Meadowview would otherwise remain at VSH due to the complexity and intensity of their treatment needs. This clinically targeted and cost effective alternative to hospitalization nearly completes the development of community-based programs designed to reduce the need for State Hospital Services. Meadowview is licensed as a Level Three Residential Care Facility, and is the newest program in the Community Rehabilitation and Treatment (CRT) system.

Vermont Psychiatric Survivors, Inc., Vermont's adult mental health consumer organization has entered into a contract with a program developer to create a peer-run alternative to traditional crisis stabilization services. A board of directors has been created and the project has been named Alyssum, which is a common Vermont flower and means "a place without madness". Progress has been made on the 501 C-3 organization application and the Department of Mental Health is negotiating a start up budget and contract for the program.

The care management system design work included the development of a consensus medical screening protocols for all hospital emergency departments to use when referring individuals for psychiatric inpatient care. This consensus document has been approved by the five psychiatric inpatient programs. Work to develop a "bed board" to identify inpatient and crisis bed availability state-wide for use by the emergency and inpatient providers has been delayed due to lack of IT capacity to customize and administer the program in Vermont. The Minnesota Hospital Association has software and a system that Vermont would like to import. The Department of Mental Health is developing a contract with Deerfield Health Systems to secure access to the LOCUS (Level of Care Utilization System) for all admissions to acute care (crisis beds) and residential beds. Vermont plans to begin statewide implementation of the web-based application in March 2011 as part of the care management system.

Secure Residential Recovery Treatment Program

Vermont intends to enhance the continuum of services available to CRT participants and fulfill the objectives of the Vermont Futures Project by creating a 15-bed, secure residential recovery treatment program. This 15-bed secure adult psychiatric treatment and recovery residential program is proposed on the grounds of the state office complex in Waterbury as described in the FFY 08 annual report and the last quarterly report. The residential recovery treatment program will provide comprehensive, patient-centered care in a newly constructed facility. The residential treatment program will fill a gap in the current delivery system, providing treatment at a level of care not currently available in the community while offering a lower-cost option to hospital-level care.

The Certificate of Need (CON) application that DMH submitted March 17, 2010 was ruled complete in early October and the Public Oversight Commission has completed its hearing on the application. It is expected that the program will be state licensed as a Level III Community Care Home and seek accreditation from the Commission of the Accreditation of Rehabilitation Programs. The program will be state-run, operate independently from other state programs (including Vermont State Hospital) and have its own governance, management team, medical director, clinical team, operating policies and procedures, and business office.

The clinical services provided as part of the 24-hour care will include evidence-based psychiatric rehabilitation services and psychosocial treatment delivered in a positive behavioral support framework to

assist individuals to engage in their own recovery and to develop the necessary skills to move to less intensive services and achieve a higher level of independent living. The anticipated length of stay in the program ranges from approximately three months to two years or more. This level of care is unique and not currently available in the Vermont system of care.

As required by the Capital Bill passed by the General Assembly in May 2010, the commissioners of Mental Health and Buildings and General Services (BGS) are conferring with the village and town officials in Waterbury about alternative sites for the proposed program on the Waterbury State Office Complex. The BGS commissioner reported the final site to the Chairs of the House and Senate Institutions committees on July 1, 2010.

DMH and OVHA have sought concurrence from the Centers for Medicaid and Medicare that the SRR program will be eligible as a covered benefit of Vermont's Managed Care Organization via the Community Rehabilitation and Treatment[1] (CRT) program under the Global Commitment Waiver. Vermont's Section 1115 Demonstration Waiver, amended in 1999 to include the CRT program, provides federal authority to include residential treatment and alternative to hospital services as covered services for CRT program participants. Further, under the terms of the Global Commitment Waiver Managed Care model, DVHA has the authority to reimburse for cost effective alternatives. Should either of these types of Demonstration authority terminate or be revised at some indefinite point in the future, Vermont would need to modify our programs to comply with traditional state Medicaid rules.

Acute Psychiatric Inpatient Care

DMH presented a Master Plan to replace the Vermont State Hospital to the General Assembly in February, 2010. The plan reflects the broad consensus reached by state policy makers, providers, consumers and advocates that the physical plant of Vermont State Hospital in Waterbury should be closed. The nearly unanimous recommendation of the Futures Advisory Group[2] was that the State Hospital should be replaced with a different model of care rather than simply replacing the old building with a new, fifty bed facility. This group further recommended that the new model of care should address the concepts of integration of mental health with general health care, be based on the best practices, and reflect Vermont's longstanding commitment to community-based care. It called for the development of community programs to decrease the need for inpatient care and to create new inpatient programs in collaboration with general hospitals.

The consensus framework - that Vermont would move away from institutional care; develop new community resources and create new psychiatric inpatient programs in integrated health care settings – guides the Master Plan.

The Futures Master Plan confirms that new construction will be necessary for the completion of VSH successor beds. The most recent new construction for an inpatient facility currently used for psychiatric care in Vermont was in 1968 at Central Vermont Hospital – although the initial use of the space was not planned for psychiatric inpatient care. Vermont's general hospital psychiatric inpatient services operate in buildings that are over forty years old. These programs and facilities are designed for less acute patients than are served at VSH. Despite downsizing VSH by some 250 beds since the early eighties there has been relatively little development of psychiatric inpatient services at Vermont's general

[1] The Community Rehabilitation and Treatment program (CRT) is Vermont's program for treating adults with severe and persistent mental illness. Under the Vermont's 1115 Waiver, the CRT program includes mental health treatment and rehabilitation services, residential services, employment services, crisis services and acute psychiatric inpatient care.
[2] No. 22 An Act Making Appropriations for the Support of Government Fiscal Year 2005 Sec. 141 (a) created the State Hospital Future Planning Advisory Group.

hospitals (the State has invested in the community system of care). Any new, intensive inpatient services will require significant capital investments. Developing new inpatient programs with general hospital partners will also require creating new operational frameworks to support long term partnerships. The State and hospitals together are challenged to develop new approaches to raising the capital necessary for new facilities both to replace VSH and to improve general psychiatric care.

DMH continues to explore inpatient development options with the Rutland Regional Medical Center, the Brattleboro Retreat, and the Veteran's Administration Hospital in White River Junction, Vermont.

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

Financial/Budget Neutrality Development/Issues

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

On October 1, 2010, AHS began paying DVHA the monthly capitation payment rate for FFY11 per our existing process, under the GC waiver extension. AHS will continue making PMPM payments per our usual process while final waiver renewal issues are being resolved.

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 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.

Demonstation Population	Month 1	Month 2	Month 3	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 3nd 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	Total for Quarter Ending 1st Qtr
	7/31/2010	8/31/2010	9/30/2010	FFY '10	FFY '10	FFY '10	FFY '10	FFY '09	FFY '09	FFY '09	FFY '08	FFY '08	FFY '08	FFY '08
Demonstration Population 1:	44,470	44,780	45,006	134,256	132,168	131,930	131,513	129,656	128,203	125,825	123,997	122,281	121,926	120,113
Demonstration Population 2:	43,960	43,866	43,576	131,402	131,865	130,746	129,075	128,698	128,590	122,210	121,981	123,283	122,118	120,309
Demonstration Population 3:	10,133	10,050	9,885	30,068	30,244	29,567	29,352	29,428	28,628	26,555	26,452	25,723	24,676	24,821
Demonstration 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
Demonstration Population 5:	1,190	1,131	1,123	3,444	3,701	3,614	3,546	3,410	3,568	3,832	3,850	3,767	3,542	3,767
Demonstration Population 6:	2,989	3,054	3,030	9,073	8,972	8,495	8,218	8,088	7,480	8,208	7,428	7,357	6,208	6,084
Demonstration Population 7:	34,289	34,737	34,889	103,915	103,194	98,576	92,217	89,158	87,116	75,277	74,301	73,966	72,336	65,803
Demonstration Population 8:	7,683	7,715	7,757	23,155	22,707	22,462	22,254	21,905	23,165	22,032	21,715	23,100	22,697	22,445
Demonstration Population 9:	2,613	2,604	2,631	7,848	7,914	7,770	7,673	7,634	7,665	7,649	7,626	7,838	7,919	7,929
Demonstration 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
Demonstration Population 11:	10,401	10,221	10,364	30,986	31,445	29,728	28,278	26,444	24,717	19,465	16,136	12,525	7,997	1,641

Consumer Issues

The AHS and OVHA 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 OVHA (see Attachment 2). Member services works to resolve the issues raised by beneficiaries, and their data helps OVHA look for any significant trends. The weekly reports are seen by several management staff at OVHA 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 OVHA 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 Managed Care Entity's (MCE) Performance Improvement Project (PIP) work group submitted the initial PIP summary form to the External Quality Review Organization (EQRO) for review. This year's document included information associated with Activities I through VIII of the protocol and focused on analysis of baseline data and interpretation of results. After an initial review, the EQRO provided the group with three points of clarification. The PIP work group decided to address these points of clarification, modify their initial submission, and resubmit the modified document to the EQRO for final review. After reviewing this document, the EQRO conducted their validation consistent with the CMS protocol, *Validating Performance Improvement Projects: A Protocol for Use in Conducting Medicaid External Quality Review Activities*, final protocol, Version 1.0, May 1, 2002. The validation finding for DVHA's PIP showed an overall score of 96 percent, a critical element score of 100 percent, and a *Met* validation status indicating high confidence in the results of the PIP for steps I-VIII.

Also during this quarter, the MCE submitted Performance Measure (PM) source code and supporting documentation to help inform the EQRO PM Validation activities. After reviewing the documents, the EQRO conducted an on-site review of the MCE. During their visit, the EQRO completed the following: opening meeting, evaluation of system compliance, review of ISCAT and supporting documentation, overview of data integration and control procedures, primary source verification, and a closing conference. During their review, the EQRO validated a set of 11 performance measures calculated by the MCE as outlined in the CMS publication, *Validating Performance Measures: A Protocol for Use in Conducting External Quality Review Activities*, final protocol, Version 1.0, May 1, 2002. The performance measures were reported and validated for the measurement period of calendar year 2009

(i.e., January 1, 2009 through December 31, 2009). All 11 measures were assigned a validation finding of fully compliant with AHS specifications.

Finally, during this quarter, the MCE submitted documents demonstrating its ability to comply with Federal Medicaid Managed Care Access standards. After reviewing the document, the EQRO conducted an on-site review of the MCE. During the visit, the EQRO conducted the following activities: opening conference, review of documents, interviews with key staff, and a closing conference. The EQRO followed the guidelines in the February 11, 2003, CMS protocol, *Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs): A Protocol for Determining Compliance With Medicaid Managed Care Proposed Regulations* at 42 CFR Parts 400, 430, et al, for the pre-on-site and on-site review activities. The MCE received an overall compliance score of 97 percent.

During the next quarter, the AHS Quality Improvement Manager will work the EQRO to develop the Annual Technical Report. This document combines the results of all three external quality review activities and identifies strengths and challenges associated with the three activities as well as making recommendations to improve the timeliness, access, and quality of services provided by the MCE. It is anticipated that this document will be produced by the EQRO by the end of next quarter.

Quality Assurance Performance Improvement Committee (QAPI): During this quarter, the Quality Assessment and Performance Improvement (QAPI) Committee continued their monitoring/oversight function of the MCE QAPI activities using the newly developed reporting/review format. The following MCE QAPI activity was reviewed/discussed during this quarter: Confidentiality (including privacy and security). The group also continued to develop a list of sample measures to support an Agency-wide performance management system. In addition to developing a list of measures, the group began the process of identifying Key Concepts of Quality. This approach remains in line with a broader State-wide support for the use of performance measures and establishing a performance management system. During this quarter, the group also discussed the committee structure and format. It was agreed that the current structure/format of the committee needed to be modified to best address the monitoring/oversight needs of the Agency, as well as, the quality assessment and performance improvement needs of the MCE. It was decided that DVHA would convene MCE staff four times per year to discuss specific delegated QAPI activities while the broader group would meet four times per year to review the MCE performance on all QAPI activities. The impact of this change will be evaluated at the quarterly AHS meetings.

Quality Strategy: The AHS Quality Improvement Manager and the members of the QAPI committee review the Quality Strategy on a regular basis and recommend any necessary modifications. There were no changes made to the Quality Strategy during this quarter.

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. Once the renewal is final, the AHS Quality Improvement Manager will meet with the PHPG project manager to modify the current evaluation work plan to correspond with the time period agreed upon in the final STC's.

Reported Purposes for Capitated Revenue Expenditures

Provided that OVHA'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: OVHA Managed Care Entity Investment Summary

State Contact(s)

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

Date Submitted to CMS: November 16, 2010

ATTACHMENTS

VERMONT

State of Vermont
Agency of Human Services
Office of Vermont Health Access

Office of Vermont Health Access
SFY 11 Catamount Health Actual Revenue and Expense Tracking
Tuesday, October 19, 2010

	SFY '11 Appropriated			Consensus Estimates for SFY to Date			Actuals thru 9/30/10			
	<=200%	*>200%*	*Total*	*<=200%*	*>200%*	*Total*	*<=200%*	*>200%*	*Total*	*% of SFY to-Date*
TOTAL PROGRAM EXPENDITURES										
Catamount Health	45,091,811	16,621,443	61,713,254	10,125,042	3,713,868	13,838,911	9,284,924	4,448,246	13,733,170	99.24%
Catamount Eligible Employer-Sponsored Insurance	2,076,890	863,710	2,940,600	449,529	189,596	639,125	252,872	121,756	374,628	58.62%
Subtotal New Program Spending	47,168,701	17,485,153	64,653,854	10,574,571	3,903,465	14,478,036	9,537,796	4,570,002	14,107,798	97.44%
Catamount and ESI Administrative Costs	1,554,749	1,142,276	2,697,025	388,687	285,569	674,256	388,687	285,569	674,256	100.00%
TOTAL GROSS PROGRAM SPENDING	48,723,450	18,627,429	67,350,879	10,963,258	4,189,034	15,152,292	9,926,483	4,855,571	14,782,055	97.56%
TOTAL STATE PROGRAM SPENDING	**17,463,400**	**7,832,788**	**25,296,188**	**3,293,363**	**1,764,447**	**5,057,810**	**2,981,916**	**2,003,894**	**4,985,810**	**98.58%**
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 Admin Costs Assoc. With Employer Assess.	-	394,072	394,072	-	98,518	98,518	-	98,518	98,518	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	500,000	4,740,785	5,240,785	125,000	1,185,196	1,310,196	125,000	1,185,196	1,310,196	100.00%
TOTAL STATE OTHER SPENDING	**206,350**	**4,740,785**	**4,947,135**	**51,588**	**1,185,196**	**1,236,784**	**37,550**	**1,185,196**	**1,222,746**	**98.86%**
TOTAL ALL STATE SPENDING	**17,669,750**	**12,573,573**	**30,243,323**	**3,344,950**	**2,949,643**	**6,294,594**	**3,019,466**	**3,189,091**	**6,208,556**	**98.63%**
TOTAL REVENUES										
Catamount Health Premiums	6,230,445	5,009,960	11,240,405	1,430,993	1,160,864	2,591,857	1,284,186	1,116,687	2,400,873	92.63%
Catamount Eligible Employer-Sponsored Insurance Premiums	517,094	447,771	964,865	116,290	102,099	218,389	81,523	64,309	145,832	66.78%
Subtotal Premiums	6,747,539	5,457,732	12,205,270	1,547,283	1,262,963	2,810,246	1,365,709	1,180,996	2,546,705	90.62%
Federal Share of Premiums	(4,320,029)	(3,204,487)	(7,524,516)	(1,082,479)	(741,738)	(1,824,217)	(955,450)	(693,599)	(1,649,049)	90.40%
TOTAL STATE PREMIUM SHARE	2,427,510	2,253,245	4,680,755	464,804	521,225	986,029	410,259	487,397	897,656	91.04%
Cigarette Tax Increase ($.60 / $.80)			9,408,500			2,352,125			2,774,539	117.96%
Employer Assessment			7,600,000			1,900,000			2,217,000	116.68%
Interest			-			-			155	0.00%
TOTAL OTHER REVENUE			17,008,500			4,252,125			4,991,694	117.39%
TOTAL STATE REVENUE	**2,427,510**	**2,253,245**	**21,689,255**	**464,804**		**5,238,154**	**410,259**		**5,889,350**	**112.43%**
State-Only Balance			(8,554,068)			(1,056,440)			(319,206)	
Carryforward			732,049			732,049			793,641	
CATAMOUNT FUND (DEFICIT)/SURPLUS			**(7,822,019)**			**(324,391)**			**474,435**	
General Fund Appropriated to GC on Behalf of Catamount			7,822,019			1,955,505			1,955,505	100.00%
ALL FUNDS THAT SUPPORT CATAMOUNT (DEFICIT)/SURPLUS			**(0)**			**1,631,114**			**2,429,940**	

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

Green Mountain Care Enrollment Report

September 2010

TOTAL ENROLLMENT BY MONTH

	Jul-07	Nov-07	Jul-08	Nov-08	Sep 09	Oct 09	Nov 09	Dec 09	Jan 10	Feb 10	Mar 10	Apr 10	May 10	June 10	July 10	Aug 10	Sept 10
Adults:																	
VHAP-ESIA	-	35	672	759	953	962	959	968	958	954	952	942	923	926	926	921	906
ESIA	-	21	336	499	633	706	692	698	708	744	749	745	759	729	702	731	729
CHAP	-	320	4,608	6,120	8,477	8,802	8,954	9,138	9,339	9,503	9,755	10,163	9,902	9,943	9,823	9,839	10,087
Catamount Health	-	120	697	932	1,832	1,895	2,001	2,088	2,186	2,217	2,267	2,277	2,307	2,349	2,463	2,474	2,491
Total	-	376	6,313	8,310	11,895	12,365	12,606	12,892	13,191	13,418	13,723	14,127	13,891	13,947	13,914	13,965	14,213

	Jul-07	Nov-07	Jul-08	Nov-08	Sep 09	Oct 09	Nov 09	Dec 09	Jan 10	Feb 10	Mar 10	Apr 10	May 10	June 10	July 10	Aug 10	Sept 10
Adults:																	
VHAP	23,725	24,849	26,441	26,860	31,629	32,469	32,429	33,067	33,469	33,965	35,010	36,010	34,801	34,570	35,329	35,408	35,852
Other Medicaid	69,764	69,969	70,947	35,601	38,207	37,689	37,689	38,411	37,852	39,053	39,181	39,483	39,266	39,368	39,481	39,590	38,663
Children:																	
Dr Dynasaur	19,738	19,733	19,960	20,511	20,525	20,434	20,418	20,472	20,503	20,489	20,602	20,707	20,262	19,882	19,898	19,608	19,891
SCHIP	3,097	3,428	3,396	3,527	3,430	3,412	3,446	3,451	3,405	3,432	3,514	3,564	3,513	3,478	3,478	3,500	3,508
Other Medicaid*	Included	Included	Included	34,015	37,579	37,212	37,291	38,116	38,261	38,678	38,531	38,862	39,325	39,157	39,846	38,015	39,142
Total	116,324	117,979	120,744	120,514	131,370	131,216	131,273	133,517	133,490	135,617	136,838	138,626	137,167	136,455	138,032	136,121	137,056
TOTAL ALL	116,324	118,355	127,057	128,824	143,265	143,581	143,879	146,409	146,681	149,035	150,561	152,753	151,058	150,402	151,946	150,086	151,269

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.

Explanation of enrollment decrease in May 10 **column:**

Because of the late issuance of April premium bills, beneficiaries who did not pay their premiums in April had coverage extended through May 31st, rather than losing coverage on April 30th. Coverage terminations on May 31st therefore included beneficiaries who did not pay premiums in both April and May.

Green Mountain Care Enrollment Report

September 2010 Demographics

Income	VHAP-ESIA*	ESIA*	CHAP*	TOTAL
0-50%	26	3	580	
50-75%	46	-	109	
75-100%	112	2	147	
100-150%	424	7	427	
150-185%	269	228	3621	
185-200%	11	238	2353	
200-225%	12	137	1339	
225-250%	4	66	920	
250-275%	1	41	420	
275-300%	1	7	171	
Total	906	729	10,087	11,722

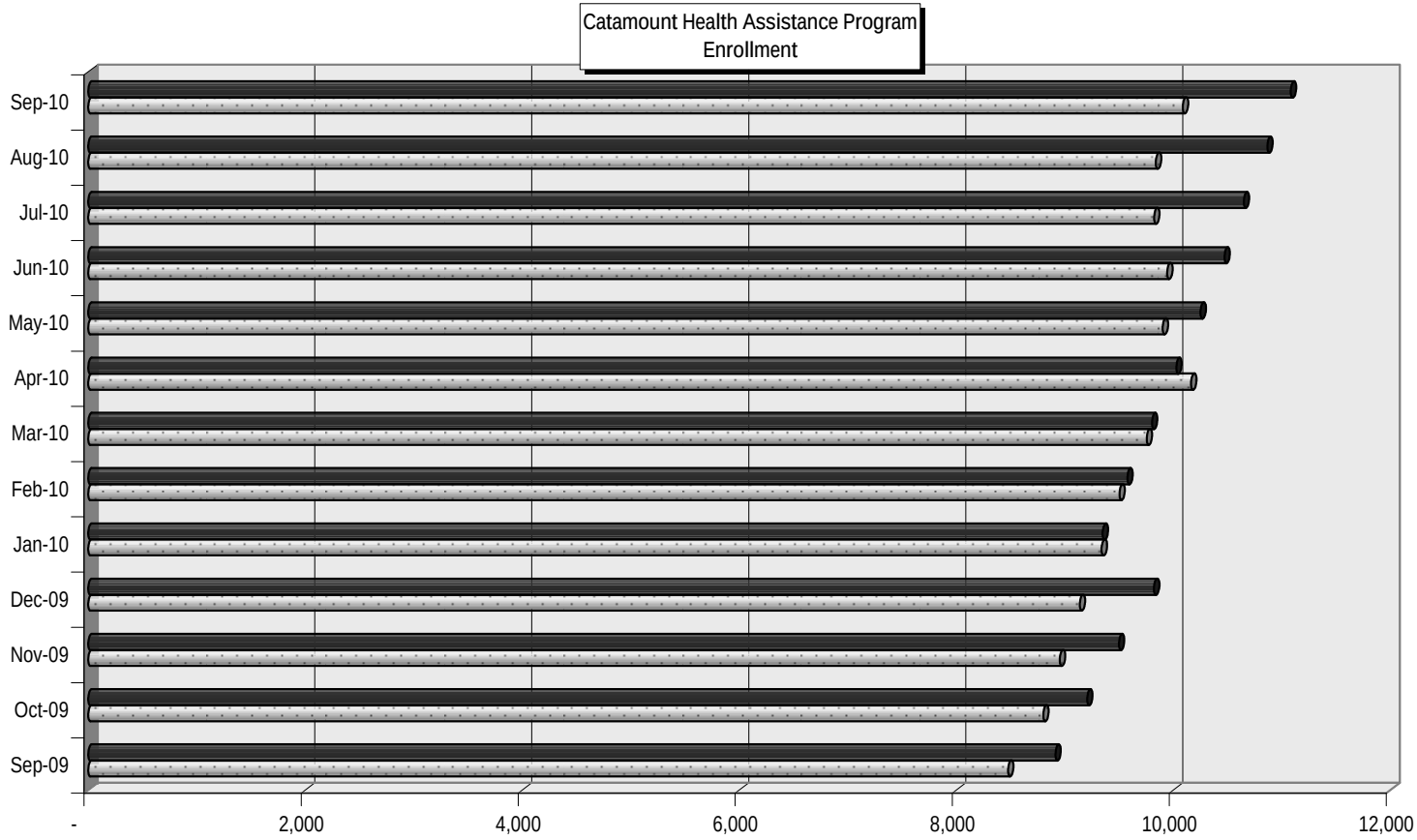
Age	VHAP-ESIA	ESIA	CHAP	TOTAL
18-24	59	81	2338	
25-35	285	176	1742	
36-45	322	215	1592	
46-55	194	184	2128	
56-64	46	73	2285	
65+	-	-	2	
Total	906	729	10,087	11,722

Green Mountain Care Enrollment Report (continued)

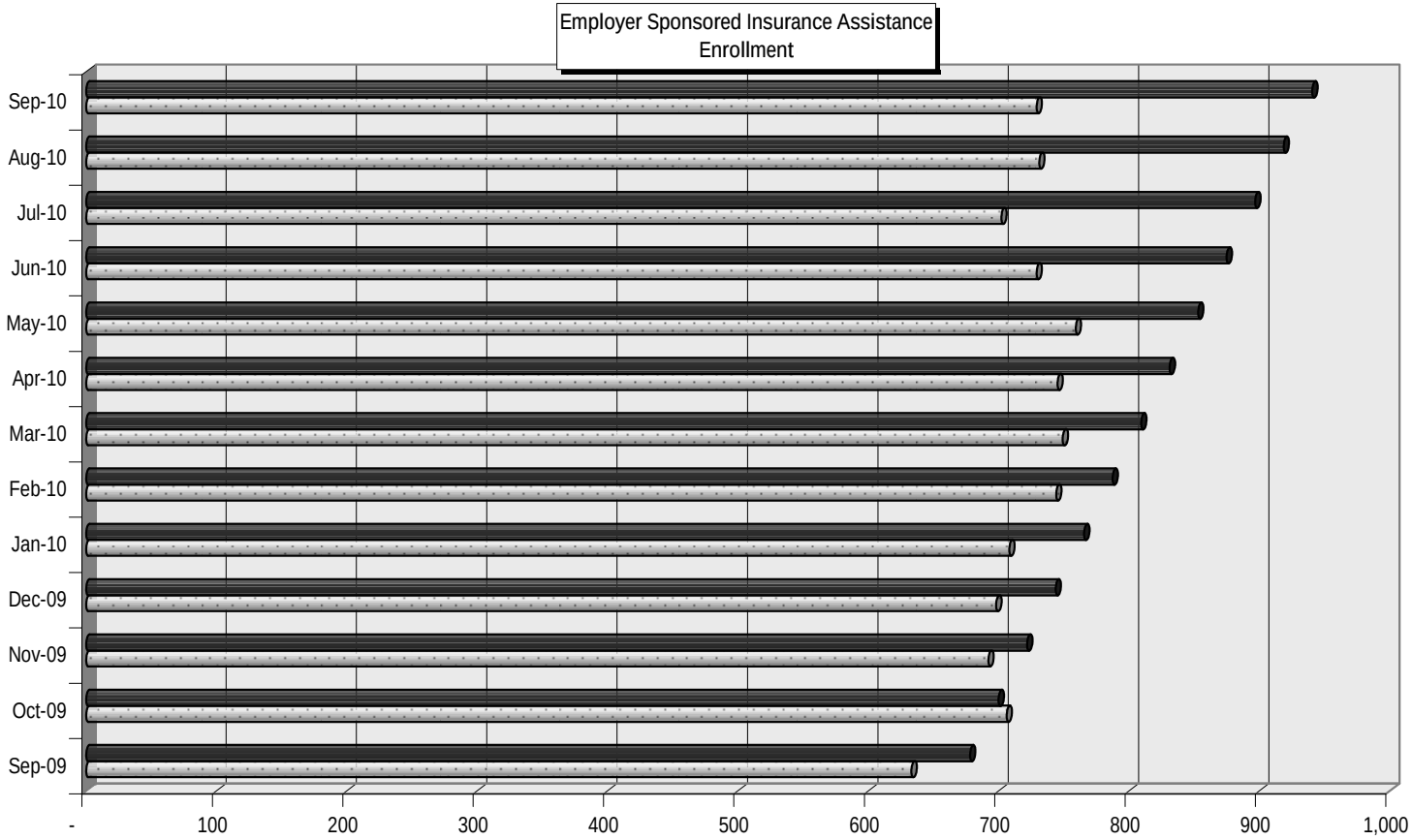
September 2010 Demographics

Gender	VHAP-ESIA	ESIA	CHAP	TOTAL
Male	323	277	4367	
Female	583	452	5720	
Total	906	729	10,087	11,722

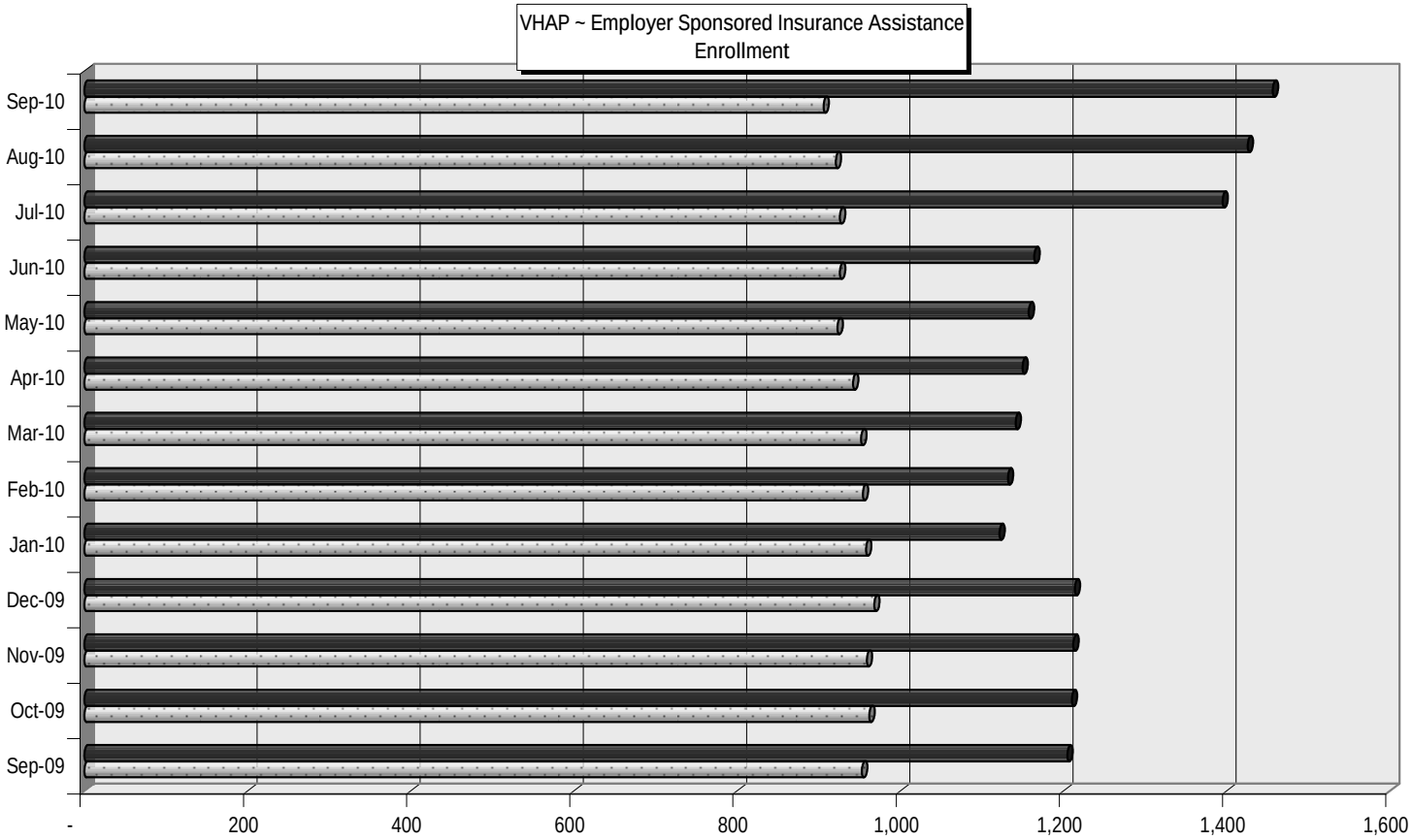
County	VHAP-ESIA	ESIA	CHAP	TOTAL
Addison	60	35	602	
Bennington	79	65	635	
Caledonia	31	36	658	
Chittenden	183	177	1923	
Essex	7	5	145	
Franklin	78	39	646	
Grand Isle	8	7	108	
Lamoille	60	49	554	
Orange	36	26	505	
Orleans	57	43	540	
Other -		-	4	
Rutland	115	90	1016	
Washington	64	54	993	
Windham	48	53	798	
Windsor	80	50	960	
Total	906	729	10,087	11,722



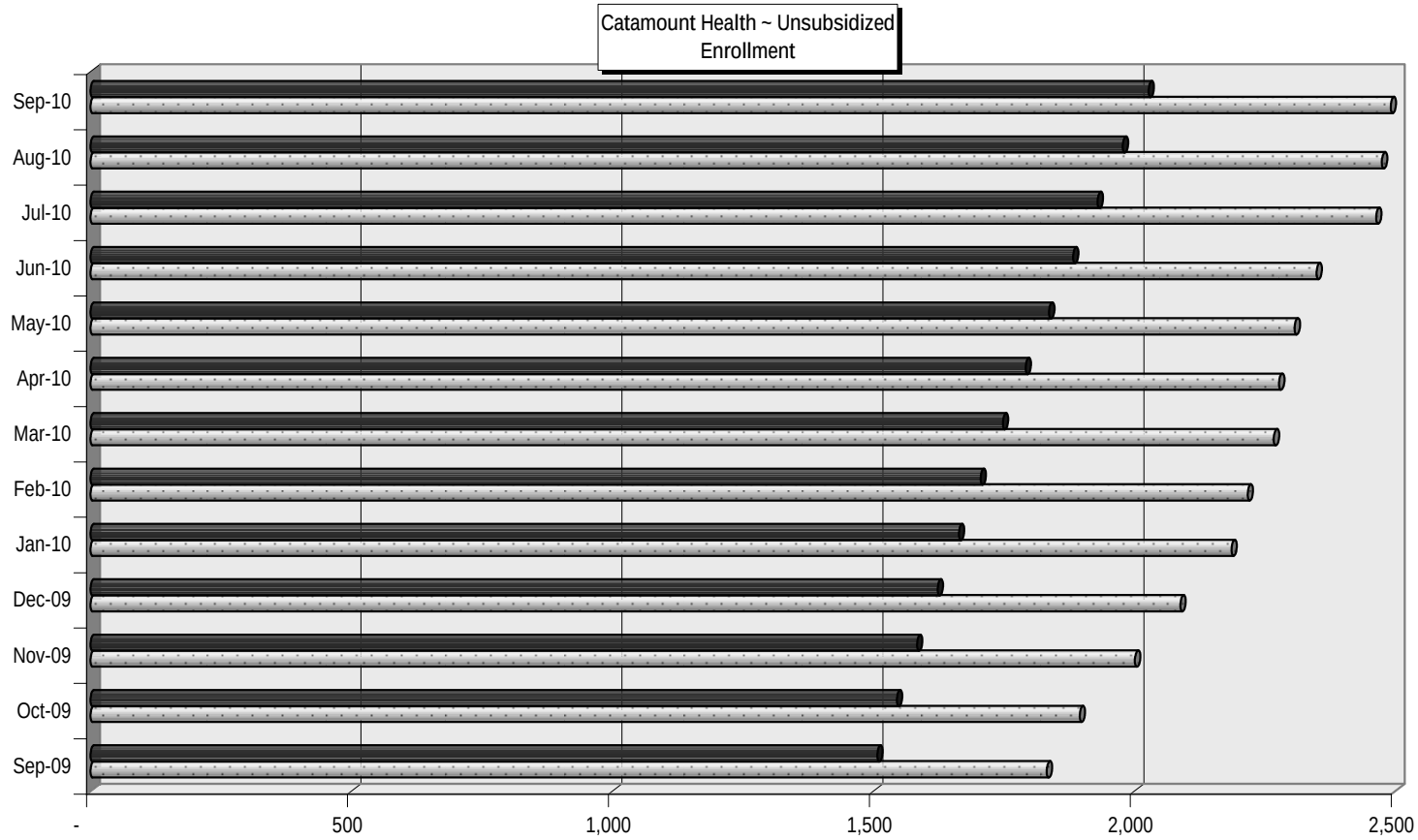
	Sep-09	Oct-09	Nov-09	Dec-09	Jan-10	Feb-10	Mar-10	Apr-10	May-10	Jun-10	Jul-10	Aug-10	Sep-10
Projected	8,914	9,206	9,498	9,822	9,349	9,577	9,803	10,028	10,250	10,472	10,649	10,867	11,083
Actual	8,477	8,802	8,954	9,138	9,339	9,503	9,755	10,163	9,902	9,943	9,823	9,839	10,087



	Sep-09	Oct-09	Nov-09	Dec-09	Jan-10	Feb-10	Mar-10	Apr-10	May-10	Jun-10	Jul-10	Aug-10	Sep-10
Projected	678	700	722	744	765	787	809	831	853	875	897	919	940
Actual	633	706	692	698	708	744	749	745	759	729	702	731	729



	Sep-09	Oct-09	Nov-09	Dec-09	Jan-10	Feb-10	Mar-10	Apr-10	May-10	Jun-10	Jul-10	Aug-10	Sep-10
Projected	1,205	1,210	1,212	1,214	1,122	1,132	1,141	1,150	1,157	1,164	1,395	1,426	1,456
Actual	953	962	959	968	958	954	952	942	923	926	926	921	906



	Sep-09	Oct-09	Nov-09	Dec-09	Jan-10	Feb-10	Mar-10	Apr-10	May-10	Jun-10	Jul-10	Aug-10	Sep-10
Projected	1,507	1,545	1,584	1,623	1,664	1,705	1,748	1,792	1,836	1,882	1,929	1,978	2,027
Actual	1,832	1,895	2,001	2,088	2,186	2,217	2,267	2,277	2,307	2,349	2,463	2,474	2,491

Attachment 2

Global Commitment Expenditure Tracking

QE	Quarterly Expenditures	PQA: WY1	PQA: WY2	PQA: WY3	PQA: WY4	PQA: WY5	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	Variance to Cap under/(over)	MBES reported Program cost (Current and PQA)	variance
1205	$ 178,493,793							$ 178,493,793					178,493,793	$ -
0306	$ 189,414,365	$ 14,472,838					$ 14,472,838	$ 203,887,203					203,887,203	$ -
0606	$ 209,647,618	$ (14,172,165)					$ (14,172,165)	$ 195,475,453					195,475,453	$ -
0906	$ 194,437,742	$ 133,350					$ 133,350	$ 194,571,092					194,571,092	$ -
WY1 SUM	$ 771,993,518	$ 434,023	$ -				$ 434,023	**$ 782,159,845**	**$ 4,620,302**	**$ 786,780,147**	**$ 1,015,000,000**	**$ 228,219,853**		
1206	$ 203,444,640	$ 8,903					$ 8,903	$ 203,453,543					205,413,310	$ 1,959,767
0307	$ 203,804,330	$ 8,894,097	$ -				$ 8,894,097	$ 212,698,427					212,698,427	$ -
0607	$ 186,458,403	$ 814,587	$ (68,408)				$ 746,179	$ 187,204,582					187,204,582	$ -
0907	$ 225,219,267	$ -	$ -				$ -	$ 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				
Cumulative										**$ 1,596,128,945**	**$ 1,936,000,000**	**$ 339,871,055**		
1207	$ 213,871,059	$ -	$ 1,010,348		$ -	$ -	$ 1,010,348	$ 214,881,406					214,881,405	$ (1)
0308	$ 162,921,830	$ -	$ -	$ -	$ -	$ -	$ -	$ 162,921,830					162,921,830	$ (0)
0608	$ 196,466,768	$ 14,717	$ -	$40,276,433	$ -	$ -	$ 40,291,150	$ 236,757,918					236,757,917	$ (1)
0908	$ 228,593,470	$ -	$ -	$ -	$ -	$ -	$ -	$ 228,593,470					228,593,469	$ (1)
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				
Cumulative										**$ 2,484,316,097**	**$ 2,848,000,000**	**$ 363,683,903**		
1208	$ 228,768,784		$ -	$ -	$ -	$ -	$ -	$ 228,768,784					228,768,784	$ 0
0309	$ 225,691,930		$ (16,984,221)	$38,998,635	$ (4,144,041)	$ -	$ 17,870,373	$ 243,562,303					243,562,302	$ (1)
0609	$ 204,169,638		$ -	$ 686,851	$ 5,522,763	$ -	$ 6,209,614	$ 210,379,252					210,379,251	$ (1)
0909	$ 235,585,153		$ -	$ 30,199	$34,064,109	$ -	$ 34,094,308	$ 269,679,461					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				
Cumulative										**$ 3,425,180,534**	**$ 3,779,000,000**	**$ 353,819,466**		
1209	$ 241,939,196				$ 5,192,468	$ -	$ 5,192,468	$ 247,131,664					247,131,664	$ 0
0310	$ 246,257,198				$ 531,141	$ 4,400,166	$ 4,931,306	$ 251,188,504					251,188,504	$ -
0610	$ 253,045,787				$ 248,301	$ 5,260,537	$ 5,508,838	$ 258,554,625					258,554,625	$ -
0910	$ 252,294,668			$ (115,989)	$ (261,426)	$ 3,348,303	$ 2,970,888	$ 255,265,556					255,265,556	$ -
WY5 SUM	$ 993,536,849	$ -	$ -	$ (115,989)	$ 5,710,484	$13,009,006	$ 18,603,501	$ 1,006,545,855	**$ 5,949,605**	$ 1,012,495,460				
Cumulative										**$ 4,437,675,994**	**$ 4,700,000,000**	**$ 262,324,006**		
	$ 4,280,525,638	$ 10,166,327	$ (16,042,281)	$79,876,130	$41,153,315	$13,009,006		$ 4,408,688,134	$ 28,987,860				4,410,647,896	

PQA = Prior Quarter Adjustments

VERMONT

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

Agency of Human Services

Complaints Received by Health Access Member Services
June 1, 2010 – September 30, 2010

Eligibility forms, notices, or process	27
ESD Call-center complaints (IVR, rudeness, hold times)	28
Use of social security number as identifiers	1
General premium complaints	16
Catamount Health Assistance Program premiums, process, ads, plans	1
Coverage rules	3
Member services	4
Eligibility rules	5
Eligibility local office	9
Prescription drug plan complaint	0
Copays/service limit	0
Pharmacy coverage	0
Provider issues (perceived rudeness, refusal to provide service, prices) (variety of provider types)	4
Provider enrollment issues	0
Chiropractic coverage change	0
Shortage of enrolled dentists	0
Green Mountain Care Website	0
OVHA	3
Total	**101**

VERMONT

Agency of Human Services

Grievance and Appeal Quarterly Report
Medicaid MCO All Departments Combined Data
July 1, 2010 – September 30, 2010

The MCO is composed of various administrative areas within the Agency of Human Services (AHS). These include: the Department of Vermont Health Access (DVHA), the Department for Children and Families (DCF), the Department of Mental Health (DMH), the Department of Disabilities, Aging and Independent Living (DAIL), and the Department of Health (VDH). Also included in the MCO are the Designated Agencies (DA) and Specialized Service Agencies (SSA) that provide service authorizations for DMH and DAIL. Each entity should have at least one assigned grievance and appeal coordinator who enters data into the MCO database. This report is based on data compiled on October 6, 2010, from the centralized database for grievances and appeals that were filed from July 1, 2010 through September 30, 2010.

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

During this quarter, there were 21 grievances filed with the MCO; 14 were addressed during the quarter, none were withdrawn and seven 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 29 days. Acknowledgement letters of the receipt of a grievance must be sent within five days; the average was three days, although two letters were sent late. Of the grievances filed, 76% were filed by beneficiaries, 24% were filed by a representative of the beneficiary. Of the 21 grievances filed, DMH had 71%, DAIL had 19%, and DVHA had 10%. There were no grievances filed for the DCF, or VDH during this quarter.

There were five cases that were pending from all previous quarters which were resolved this quarter.

There were two Grievance Reviews filed this quarter through DMH. Acknowledgement letters of the receipt of a grievance review must be sent within five days; both were sent on the same day. There are eight 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 39 appeals filed with the MCO; 11 requested an expedited decision but none met the criteria. Of these 39 appeals, 22 were resolved (56% of filed appeals), four were withdrawn (10%), and nine were still pending (33%). In 10 cases (46% of those resolved), the original decision was upheld by the person hearing the appeal, four cases (18% of those resolved) were reversed, four were modified (18%), and four were approved by the applicable department/DA/SSA before the appeal meeting (18% of those resolved).

Of the 22 appeals that were resolved this quarter, 86% were resolved within the statutory time frame of 45 days; 59% were resolved within 30 days. The average number of days it took to resolve these cases was 27 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 one day, although three letters were sent late.

Of the 39 appeals filed, 24 were filed by beneficiaries (62%), 14 were filed by a representative of the beneficiary (36%), one was filed by a provider (2%), and none were filed by someone else at the request of the beneficiary. Of the 39 appeals filed, DVHA had 62%, DAIL had 31%, and DMH had 7%.

As each appeal was received the grievance and appeal coordinator assigned it to an action category that related to the content of the appeal as defined in rule 7110 (see above). There were 32 appeals for a denial or limitation of authorization of a requested service or eligibility for service (82%), six were for a reduction/suspension/termination of a previously authorized covered service or service plan (15%).

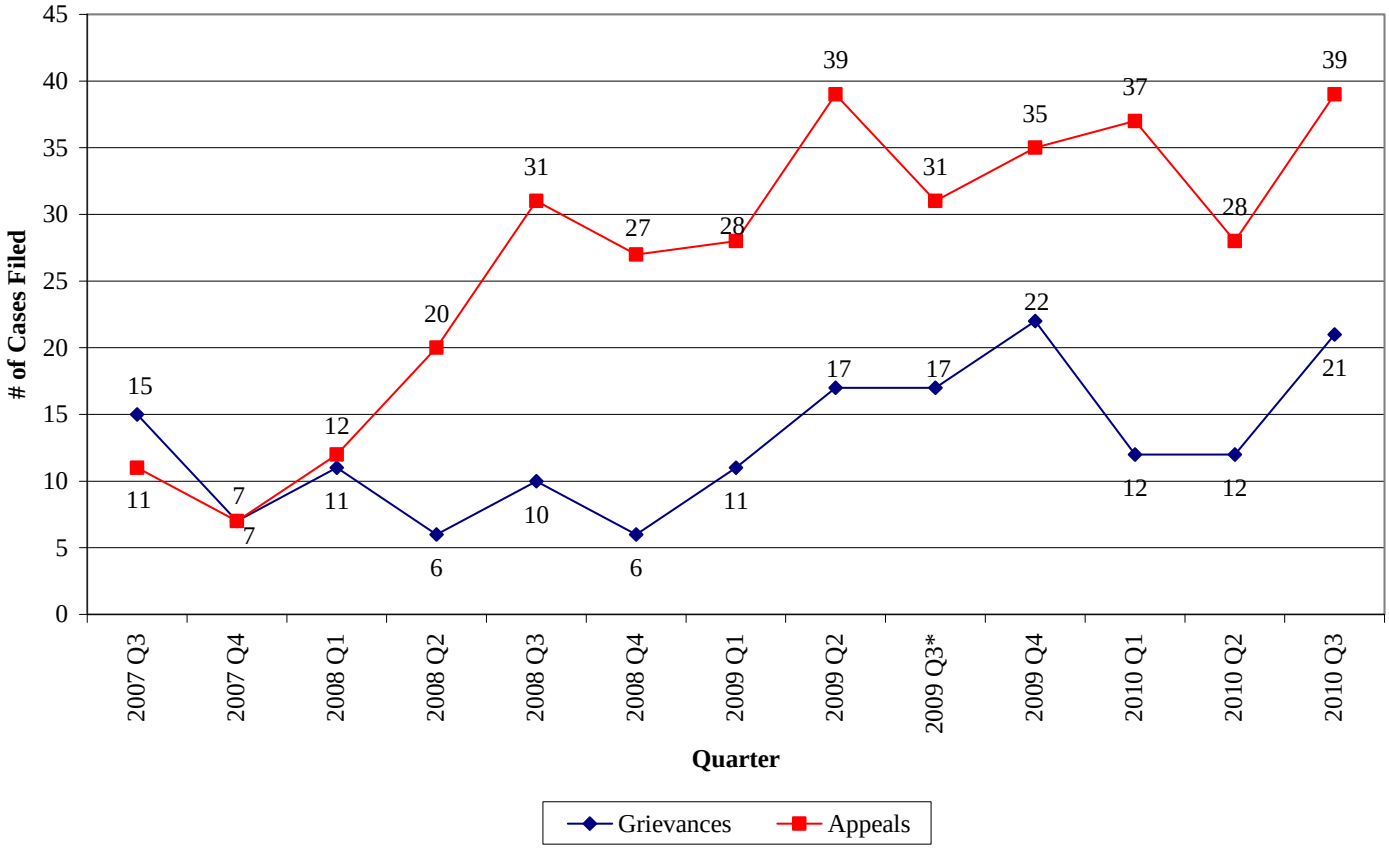
There were two DAIL, one VDH, and one DCF cases filed between April 1, 2010, and June 30, 2010 that were still pending at the beginning of this quarter. In addition, there were three DAIL cases that were still pending from before April 1, 2010. There were nine pending cases that were resolved this quarter; 56% of these cases were upheld (three for DVHA and 2 for DAIL), three were reversed (33%), none were modified, one was withdrawn (10%), and none were approved before the appeal hearing. 56% of these cases were resolved within 30 days, 78% in 45 days, and 100% within 59 days. On September 30, 2010 there were seven cases still pending; five for DAIL (two for DAIL's DS program through Northeast Kingdom Human Services for 681 days, and one for DAIL's Attendant Services for 391 days), one for DCF and one for VDH.

Beneficiaries can file an appeal and a fair hearing at the same time, and they can file a fair hearing if their appeal is not decided in their favor. There were no fair hearings filed this quarter. Two DAIL cases were withdrawn this quarter. There are a total of four fair hearings still pending as of the end of this quarter, two for DAIL and two for DVHA. Last quarter there was a total of 21 fair hearings still pending as of the end of the quarter (five for DAIL and 16 for DVHA). Many of the DVHA cases had not been properly closed in the database until this quarter (with closure dates from previous quarters) which would explain the discrepancy between the relatively small number of pending fair hearings this quarter as opposed to large number pending last quarter.

Other Information:

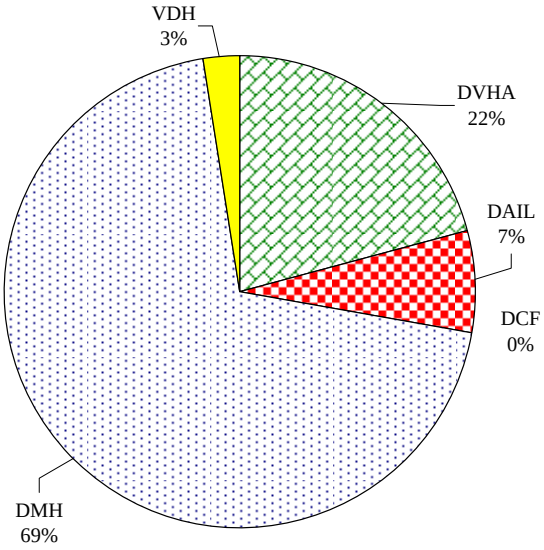
DCF has not yet implemented the MCO Grievance and Appeal process; however, DCF has relied to date on previous internal grievance and appeal processes to handle matters when they arise, and is working towards implementation. There are two persons in the DCF Commissioner's Office who have been trained in the MCO Grievance & Appeal process, although front-line DCF staff have not been identified or trained. The MCO Grievance and Appeal Coordinator has agreed to provide all the necessary training to DCF staff.

Medicaid MCO Grievances & Appeals

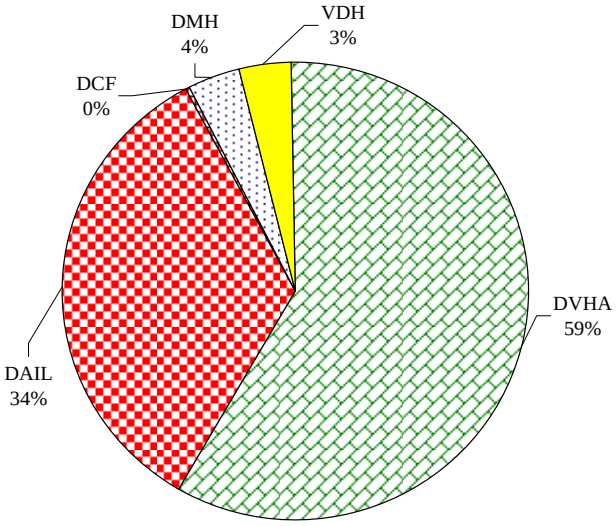


MCO Grievance & Appeals by Department from July 1, 2007 through September 30, 2010

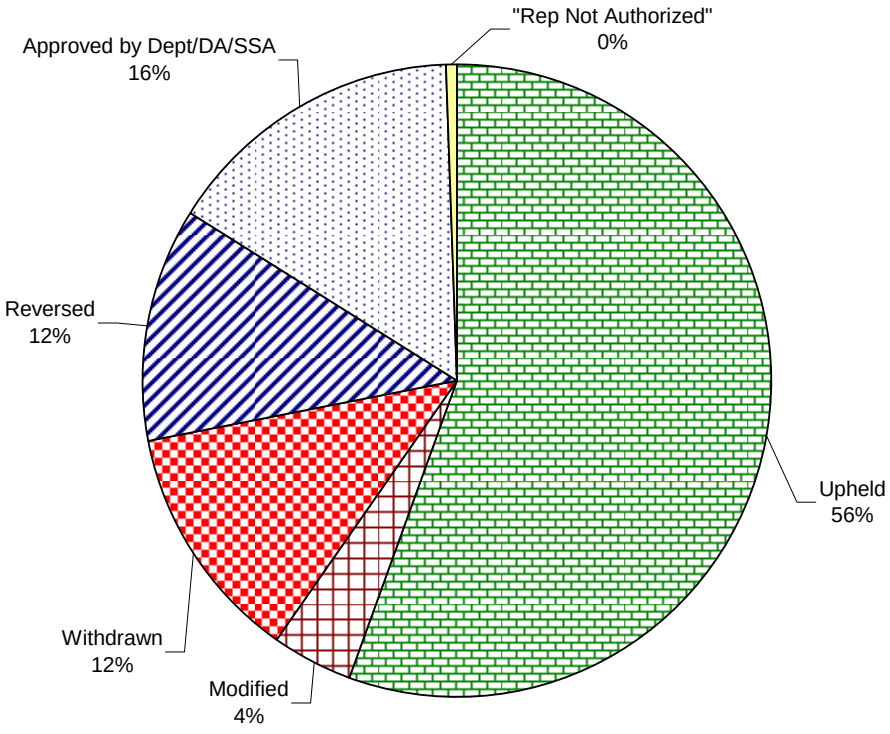
Grievances



Appeals



MCO Appeal Resolutions from July 1, 2007 through September 30, 2010



Grievance and Appeal Quarterly Report
Medicaid MCO All Departments Combined Data
for the period: July 1, 2010 – September 30, 2010

Grievances

Total number of grievances filed: 21

Number pending: 7 *DAIL-2; DMH-5*

Number withdrawn: 0

Number addressed: 14 *DAIL-2; DMH-10; DVHA-2*
- Within 90 days: 100%
- Exceeding 90 days: %

Number of grievances filed too late: 0

Average number of days from "pertinent issue" to filing grievance: 11

Average number of days from filing to entering into database: 8

Average number of days from filing to being addressed: 29

Average number of days to send acknowledgement letter: 3

Number of late acknowledgement letters: 2 *DAIL-1; DMH-1*

Number of grievance reviews requested: 2 *DMH*

Average number of days to send grievance review acknowledgement letter: 0 = Sameday

Number of grievance reviews addressed: 0

Source of grievance request:

Beneficiary:	16	76%
Beneficiary Representative:	5	24%
Other:	0	0%

Number related to:

DVHA:	2	10%
DAIL:	4	19%
DCF:	0	0%
DMH:	15	71%
VDH:	0	0%

Top services grieved:
1. Mental Health Services (9)
2. Substance Abuse Services (2)
3. Long-Term Care (2)

Number by category: [Check ALL that apply]

Staff/Contractor:	5
Program Concern:	2
Management:	1
Policy or Rule Issue:	1
Quality of Service:	4
Service Accessibility:	0
Timeliness of Service Response:	0
Service Not Offered/Available:	0
Other:	6
Enrollee Rights:	0
Adverse Effect/Exercising Rights:	0

* * * * * *

Number pending from all previous quarters: 0

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

Number that were pending in previous quarters and addressed this quarter: 5
- Within 90 days: 20% *DMH*
- Exceeding 90 days: 80% *DMH*

Number of grievances still pending at the end of this quarter: 7

Number of grievance reviews pending from all previous quarters: 8 *DAIL-1; DMH-7*

Number of pending grievance reviews addressed this quarter: 0

Appeals

Number of appeals filed: 39

Number pending: 13 *DVHA-6; DAIL-5; DMH-2*

Number withdrawn: 4 *DAIL-3; DVHA-1*

Number resolved: 22
- Number upheld: 10 46% *DVHA-6; DAIL-4*
- Number reversed: 4 18% *DVHA-3; DMH-1*
- Number modified: 4 18% *DVHA-2; DAIL-1*
- Number approved by Dept/DA/SSA: 4 18% *DVHA-4*

Number of cases extended: 1
- by beneficiary: 1
- by MCO: 0

Resolved time frames
- Within 30 days: 59% *DVHA-12; DMH-1*
- Within 45 days: 86% *DVHA-16; DAIL-2; DMH-1*
- Within 59 days: 100%
  - 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: 27

Average number of days from filing to resolution when extended: 57

Average number of days to send acknowledgement letter: 1

Number of late acknowledgement letters: 3 *DVHA-1; DMH-1; DAIL-1*

Average number of days from filing to withdrawing: 12

Average number of days to send withdrawal letter: 0 = Sameday

Number of late withdrawal letters: 0

Source of appeal request:

Beneficiary:	24	62%
Beneficiary Representative:	14	36%
Provider:	1	2%
Other:	0	0%

Number related to:

DVHA:	24	62%
DAIL:	12	31%
DCF:	0	0%
DMH:	3	7%
VDH:	0	0%

Top services appealed:
1. Prescriptions (13)
2. Personal Care Services (11)
3. Transportation (6)
4. Surgical Services (2)

Number of beneficiaries that requested that their services be continued: 4 10%

Of those that requested their services be continued:

Number that met criteria:	4	100%
Number that did not meet criteria:	0	0%

Number by category:

1. Denial or limitation of authorization of a requested service or eligibility for service:	32
2. Reduction/suspension/termination of a previously authorized covered service or service plan:	6
3. Denial, in whole or in part, of payment for a covered service:	0
4. Failure to provide clinically indicated covered service when the MCO provider is a DA/SSA:	0
5. Denial of a beneficiary request to obtain covered services outside the network:	0
6. Failure to act in a timely manner when required by state rule:	0

Expedited Appeals

Number of expedited appeals filed: 11

Number of expedited appeals that:
Met criteria: 0
Did not meet criteria: 11

For those MEETING criteria

Number pending:0

Number of expedited appeals filed too late: 0

Number resolved: 0
Number upheld: 0 0%
Number reversed: 0 0%
Number modified: 0 0%
Number approved by Dept/DA/SSA: 0 0%

Average number of days from Notice of Action to filing expedited appeal: 0

Average number of days from filing to entering data into database: 0

Number of late resolutions: 0 0%

Source of appeal:
Beneficiary: 0 0%
Beneficiary Representative: 0 0%
Provider: 0 0%
Other: 0 0%

Top service appealed: ( )

Number related to:
DVHA: 0 0%
DAIL: 0 0%
DCF: 0 0%
DMH: 0 0%
VDH: 0 0%

Average number of days from filing to resolution: 0

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

NOT meeting criteria:

Average number of business days to orally notify beneficiary of not meeting criteria: 2

Average number of business days to notify beneficiary in writing of not meeting criteria: 2

Number late letters: 0

* * * * * *

Number pending from last quarter: 4 *DAIL-2; VDH-1; DCF-1*

Number pending from previous quarters: 3 *DAIL-3*

Total pending from ALL quarters: 20 *DVHA-6; DAIL-10; DMH-2; DCF-1; VDH-1*

Number of total pending that were resolved this quarter: 9

Number upheld:	5	56%	*DVHA-3; DAIL-2*
Number reversed:	3	33%	*DVHA-2; DMH-1*
Number modified:	0	0%	
Number approved by Dept/DA/SSA:	0	0%	
Number withdrawn:	1	10%	*DVHA*

Resolution time frames for resolving above cases:

Within 30 days:	56%	*DVHA-4; DMH-1*
Within 45 days:	78%	*DVHA-4; DAIL-2; DMH-1*
Within 59 days:	100%	
Extended (2) vs. Late (0)		
Over 59 days:	0%	

Number of appeals still pending from all previous quarters: 7 *DAIL-5; DCF-1; VDH-1*

Fair Hearings

Total number of Fair Hearings filed: 0

Number of Fair Hearings filed with a concurrent appeal: 0

Number of Fair Hearings filed after appeal resolution: 0

Number pending: 0

Number resolved: 0

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

Average number of days for resolution: 0

* * * * *

Number of pending Fair Hearings from previous quarters: 4 *DAIL-2; DVHA-2*

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

Number upheld:	0	
Number reversed:	0	
Number modified:	0	
Number dismissed:	0	
Number withdrawn:	2	*DAIL*

Average number of days for resolution for pending Fair Hearings from previous quarters: 280

Number of pending Fair Hearings from previous quarters still pending at the end of this quarter: 4 *DAIL-2; DVHA-2*

Office of Health Care Ombudsman

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802-863-2473, 888-884-1955 (TTY)
FAX 802-863-7152

QUARTERLY REPORT
July 1, 2010 – September 30, 2010
to the
DEPARTMENT OF VERMONT HEALTH ACCESS
Submitted by
Trinka Kerr, Vermont Health Care Ombudsman

I. Overview

This is the Office of Health Care Ombudsman's (HCO) report to the Department of Vermont Health Access (DVHA) for the quarter July 1, 2010 through September 30, 2010. We received 318 calls (39% of all calls) from DVHA program beneficiaries this quarter, compared to 242 (36%) last quarter.

Overall call volume this quarter was extremely high. The total number of all cases/all coverages that we opened this quarter was 815, compared to 677 last quarter. This compares to 616 calls in the third quarter of 2009, 503 in 2008, and 627 in 2007. This was the highest call volume for any quarter in the history of the HCO.

The HCO received more calls than usual in each of the months in this quarter. July was the busiest July ever (271 calls), August was the second busiest August (234 calls), and September was the busiest September ever (310 calls) by far. In fact, this September was the second busiest month ever. The only month in which the HCO had more calls was January 2006 (313 calls), which was when Medicare Part D went into effect. [See the table at the end of this narrative for further detail.]

There are several identifiable reasons for this increase in calls. One was that DVHA mailed new ID cards to all its beneficiaries. This generated 30 calls from people who were confused by the cards. Another cause for the increase was a jump in eligibility calls of almost 40%, from 193 to 270. This was most likely due in part to the eligibility processing problems the Department for Children and Families (DCF) had this summer as it continues to implement its Modernization program. In addition, we had a 45% increase in the number of calls from uninsured Vermonters. This increase may also be due to DCF's eligibility determination problems, or it could be due to the increase in Vermonters seeking to get onto state programs due to the continued economic downturn.

The issues that generated the most calls from individuals of any insurance status, counting both primary and secondary issues, were: Medicaid eligibility (140), VHAP eligibility (134), and

complaints about providers (103). Last quarter there were 118 complaints about providers from all calls/all coverages. Provider complaints is an increasing issue category.

A. Eligibility

The percentage of calls related to eligibility for state programs has remained consistently high since Catamount Health went into effect. In 2009 eligibility calls hovered around 25% of all calls. This year they have hovered around 30%. This quarter we had 270 calls related to eligibility or 33.13% of all calls. Last quarter we received 193, or 28.51% of all calls. Calls related to eligibility can be inquiries about the programs generally, or about specific problems with the application process, a denial or a termination. They also can be from people who are already insured seeking information about the programs because they cannot afford the insurance they are on.

The total number of calls from the uninsured increased by 45%, from 55 to 99. These calls are usually about eligibility for state programs. This quarter 69.70% (69) of those calls were regarding eligibility, with access to care a distant second at 17.17% (17).

We continue to see significant numbers of problems related to state program eligibility determinations. A look at primary and secondary issues, reveals some serious problems in this area. Note that this means some of the numbers below overlap; that is, some of the 29 DCF mistake cases could also involve lost paperwork, for example. Of the 270 calls about eligibility this quarter:

- 18 involved application processing delays (compared to 10 last quarter);
- 32 involved the Buy In (Medicare Savings) Programs (compared to14);
- 29 involved DCF mistakes (compared to 26);
- 20 involved lost paperwork, meaning that callers said they submitted paperwork to DCF and were subsequently told there was no record of it (compared to 13);
- 31 involved the Medicaid Spend Down program (compared to 18);
- 4 involved an error by Member Services (compared to 5); and
- 7 involved specific DCF Modernization complaints, listed in the issue section "Other," as these are not necessarily related to eligibility problems (compared to 8).

B. Access to Care

This quarter we had a total of 214 calls related to Access issues or 26.26% of all calls. Of these, 105 (49%) were from DVHA beneficiaries. In the previous quarter we had 184 total Access calls, with 89 (48%) coming from DVHA beneficiaries. Since only about 39% of our total calls were from DVHA callers, this is a comparatively high percentage of calls regarding Access issues, and remains a cause of some concern. The percentage of calls from DVHA beneficiaries about access consistently runs about 35%; this quarter it was slightly lower at 33.02%. For beneficiaries of commercial carriers it usually runs about 20-25%. This quarter only 28 individuals on commercial plans called us about access issues. Access is clearly a bigger issue for DVHA beneficiaries.

A notable new access issue is affordability. We recently started tracking this because we were getting more and more calls from individuals saying that they couldn't afford health care services. Often these complaints were from people who had insurance. We had 15 callers for whom affordability was the primary issue, but we had an additional 64 callers for whom it was a significant secondary issue. Of these 64 calls, 29 were from Medicare beneficiaries, 24 were from DVHA beneficiaries, 23 were from commercially insured individuals, and 15 were from uninsured Vermonters. (The total doesn't add up to 64 because Medicare beneficiaries can also have commercial plans or some coverage through DVHA.) A number of Medicare beneficiaries told us they were going without care because they couldn't afford the cost-sharing. This may be connected to the dramatic jump (14 to 32) in eligibility calls regarding the Medicare Buy In programs, which help subsidize Medicare.

We also received calls from two elderly individuals who were unable to get <u>any</u> insurance. Because they were over age 65 they were eligible for Medicare. However, because they did not have the requisite work quarters they could only get Medicare if they paid for it, which would cost over $900 per month, an amount neither could afford. Because they were technically eligible for Medicare, they were prohibited from enrolling in VHAP or Catamount Health. They also could not afford any commercial plans, and thus remain uninsured. **This is a situation that should be remedied by the legislature.**

1. **Access to Pain Management**

The number of calls related to pain management remained the same this quarter. We received 16 calls with pain management as the primary issue in both quarters. However, 22 calls involved a pain management issue as a primary or secondary issue, compared to 25 last quarter. Of these 22, 12 involved DVHA beneficiaries, which is 56% (compared to 48% last quarter) of the pain related calls. We had only one caller on commercial insurance with a pain management issue, compared to six last quarter. Thus, this continues to be primarily a state program problem. These continue to be some of our most difficult calls, as we are generally not able to do much to help callers.

2. **Access to Mental Health and Substance Abuse Treatment**

We had an overall increase in access to mental health treatment related calls this quarter: 19 versus 13 last quarter. However, only seven of these involved DVHA beneficiaries. In addition, there were two calls related to mental health billing, compared to four last quarter. None of these was from a DVHA beneficiary. We also received four calls which were coded with a primary issue of access to substance abuse treatment. Only two of these were from DVHA beneficiaries. Last quarter we had no substance abuse treatment cases categorized as a primary issue.

3. **Access to Dental Care**

The HCO received 25 total calls from individuals having problems accessing dental care, coded as a primary or a secondary issue. Of these, 13 were from DVHA beneficiaries. If we look just at dental care as a primary issue, we received six calls from DVHA program beneficiaries. Three of these were from Medicaid beneficiaries who needed extensive dental work above the $495

annual dental cap. One was from a VHAP beneficiary, which has no dental coverage. One was a plea for help getting dentures, which is not a Medicaid covered service. One was from an individual who did not like his dentist, but was afraid to leave because he could not find another. We had an additional two calls from DVHA beneficiaries who were looking for a dentist. Individuals who called about finding a dentist were referred to Member Services.

4. Access to Prescription Drugs

At the last quarterly meeting DVHA requested more detail regarding access to prescription drug cases. This quarter we had 21 calls where medications were the primary issue. It was a little difficult to categorize some of these calls, but here's a summary:

- 6 involved Medicare Part D plan problems;
- 3 involved beneficiaries whose doctors refused to treat them any longer and also refused to continue prescribing medications;
- 3 involved the loss of VHAP;
- 2 involved Medicaid prior authorization denials;
- 1 involved denials for off label use by both the primary commercial insurer, and the secondary insurer, Medicaid;
- 1 was because the beneficiary could not afford the required copayments;
- 1 was because a doctor refused to write a prescription because the beneficiary had missed an appointment;
- 1 was because there was no Medicaid rebate available for the medication;
- 1 was because no Medicaid prior authorization had been requested;
- 1 was because the doctor refused to submit a Medicaid prior authorization request; and
- 1 was from a Medicaid beneficiary who said she simply that she was unable to get her medication, but subsequently did not follow up with the HCO.

5. Access to Transportation

At the last quarterly meeting DVHA requested more detail regarding the access to transportation cases. We had nine cases in which access to transportation was the primary issue:

- 4 were related to the individual's access to a vehicle but inability to drive, usually due to a disability;
- 2 were from VHAP beneficiaries (transportation is not a covered service for VHAP);
- 1 was from a beneficiary with multiple disabilities who wanted to have access to taxi service rather than the bus because of her difficulties riding the bus;
- 1 involved multiple issues related to ride providers showing up late resulting in the beneficiary missing medical appointments as well as the beneficiary not showing up for scheduled rides due to medical problems; and
- 1 was a denial because there were providers that were closer to the beneficiary.

II. Call volume by type of insurance:

Some of the numbers related to Catamount Health coverage have shifted slightly this quarter compared to last quarter. This is because we reclassified beneficiaries with Catamount Health plans as being commercially insured. Prior to this, it turns out, they were not included in either the commercially insured numbers or the DVHA beneficiary numbers, although they did appear in the All Coverages numbers. Also, I put premium assistance beneficiaries into the DVHA category. It is very difficult to figure out how to categorize hybrid plans for reporting purposes when the reports must show beneficiaries as having primary coverage that is either commercial insurance or DVHA insurance. Our data system cannot report them as both, and in fact, to count them that way would double count some calls. **We should discuss how to categorize calls from individuals on hybrid insurance programs in the future**, as with our new database, it is relatively easy to change the categories.

- **DVHA programs** (Medicaid, VHAP, VHAP Pharmacy, a Premium Assistance program, VScript, VPharm, or both Medicaid and Medicare) insured **39%** (318 calls), compared to 36% (242) last quarter;
- **Medicare** (Medicare only, Medicare and a Medicare Supplemental Plan aka Medigap, Medicare and Medicaid, Medicare and a Medicare Savings Program aka a Buy-In program, or Medicare and VPharm) insured **24%** (192), compared to 20% (139) last quarter;
    - 12% (99) had Medicare only;
    - 11% (89) had both Medicare coverage and coverage through a state program such as Medicaid, a Medicare Savings Program aka a Buy-In program, or VPharm;
- **Commercial carriers** (employer sponsored insurance, individual or small group plans, including Catamount Health plans) insured **17%** (137), compared to 25% (167) last quarter;
- **12%** (99) identified themselves as **uninsured**, compared to 8% (55) last quarter;
- **4%** (32) had a **Catamount Health** plan, compared to 4% (25) last quarter; and
- The remainder of callers' insurance status was either unknown or not relevant.

III. Disposition of DVHA cases

We closed 303 DVHA cases this quarter, compared to 250 last quarter:

- About 4% (12 calls) from DVHA beneficiaries were resolved in the initial call, compared to 1% (3 calls) last quarter;
- 59% (178 calls) were resolved by advice or referral, after an analysis of the problem. Last quarter 58% (145 calls) were resolved in this manner;
- 25% (77 calls) were resolved by direct intervention on the caller's behalf, including advocacy with DVHA and providers, writing letters, gathering medical information, and representation at fair hearings. Last quarter 19% (47 calls) were resolved in this manner;
- About 3% (10 calls) were considered complex intervention, which involves complex analysis and more than two hours of an advocate's time, compared to 7% (17 calls) last quarter.

IV. Issues raised by DVHA beneficiaries

We opened 318 cases from DVHA beneficiaries, compared to 237 last quarter. Of these:

- 33.02% (105 calls) involved Access to Care, compared to 36.36% (88 calls) last quarter;
- 15.09% (48 calls) involved Billing/Coverage, compared to 16.53% (40 calls) last quarter;
- 2.52% (8 calls) were coded as Consumer Education, compared to 2.89% (7 calls) last quarter;
- 32.29% (103 calls) involved Eligibility, compared to 30.17% (73 calls) last quarter; and
- 32.39% (52 calls) involved Other issues, compared to 13.64% (33 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 105 DVHA Access to Care calls, compared to 88 last quarter. The top call volume primary issues within this category were:

- 17 calls involved access to Prescription Drugs, compared to 21 last quarter;
- 11 involved Pain Management, compared to 9;
- 10 involved Durable Medical Equipment (DME), Supplies, or Wheelchairs;
- 9 involved Transportation, compared to 10;
- 9 involved Mental Health or Substance Abuse treatment; and
- 8 involved Dental, Dentists or Orthodontics, compared to 8;

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

- 30 Prescription Drug;
- 24 Affordability;
- 20 Transition/Continuity of Care;
- 15 Specialty Care;
- 14 Primary Care Doctor;
- 13 Dental, Dentists or Orthodontia;
- 12 Mental Health;
- 12 Pain Management; and
- 12 Transportation.

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 48 DVHA primary issue calls in this category, compared to 39 last quarter:

- 21 involved Medicaid/VHAP Managed Care, compared to 12 last quarter;

- 4 involved Claim Denials; and
- 4 involved Hospital Billing, compared to 9 last quarter.

C. Eligibility

Eligibility cases are those in which the individual is seeking to get or retain government subsidized health insurance. This quarter we received 270 calls from individuals with a primary issue of eligibility, but we received a whopping 677 calls from individuals for whom eligibility was either a primary or secondary issue.

We received 103 eligibility calls from current DVHA beneficiaries, compared to 69 last quarter, which were coded as a primary issue:

- 28 involved Medicaid eligibility, compared to 30 last quarter;
- 15 involved VHAP, compared to 27;
- 7 involved the Buy In Programs, aka Medicare Savings Programs, compared to 12; and
- 8 involved Catamount Health and Premium Assistance, compared to 6. 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.

V. Tables on All Calls by month and year

All Cases

	2003	2004	2005	2006	2007	2008	2009	2010
January	241	252	178	313	280	309	240	218
February	187	188	160	209	172	232	255	228
March	177	257	188	192	219	229	256	250
April	161	203	173	192	190	235	213	222
May	234	210	200	235	195	207	213	206
June	252	176	191	236	254	245	276	251
July	221	208	190	183	211	205	225	271
August	189	236	214	216	250	152	173	234
September	222	191	172	181	167	147	218	310
October	241	172	191	225	229	237	216	
November	227	146	168	216	195	192	170	
December	226	170	175	185	198	214	161	
Total	2578	2409	2200	2583	2560	2604	2616	2190

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 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