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
April 1, 2010 to June 30, 2010

August 19, 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. AHS will pay 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 third quarterly report for waiver year five, covering the period from April 1, 2010 through June 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 6/30/2010	Previously Reported Enrollees Last Day of Qtr 3/31/2010	Variance 06/30/10 to 03/31/10
Demonstration Population 1:	44,058	43,933	0.28%
Demonstration Population 2:	43,733	43,734	0.00%
Demonstration Population 3:	10,048	9,910	1.39%
Demonstration Population 4:	N/A	N/A	N/A
Demonstration Population 5:	1,226	1,220	0.49%
Demonstration Population 6:	3,020	2,945	2.55%
Demonstration Population 7:	34,142	33,468	2.01%
Demonstration Population 8:	7,614	7,531	1.10%
Demonstration Population 9:	2,642	2,606	1.38%
Demonstration Population 10:	N/A	N/A	N/A
Demonstration Population 11:	10,423	10,075	3.45%

Green Mountain Care Outreach / Innovative Activities

Green Mountain Care Update: During the third quarter, the Department of Vermont Health Access began the process of positioning itself as a trusted source for information on how federal health care reform dovetail with health insurance options under Green Mountain Care. Commissioner Susan Besio, along with the Deputy Commissioner of Banking, Insurance, Security and Health Care, and Governor Douglas of Vermont, joined the CEO of Blue Cross Blue Shield of Vermont at a briefing about extended coverage for young adults up to age 26. Students from the University of Vermont showed videos they produced to attract recent college graduates to Green Mountain Care. Subsequently, these videos have been posted on the Green Mountain Care and OVHA websites as well as You Tube a popular site for our target market.

The OVHA ran a two-page "info ad" in the publication, Seven Days, which is popular with a younger demographic. The cost of the ad was shared with OVHA's Catamount Health partners, Blue Cross Blue Shield of Vermont and MVP Health Care and directed readers to our website.

A related editorial by Commissioner Susan Besio was picked up by an on-line news source known as Vermont Digger, as well as The Westminster Gazette, a community paper in Southern Vermont. The Lake Champlain Regional Chamber of Commerce ran the editorial in their ENewsletter that was sent to 4,500 businesses.

This quarter our website and screening tool were also overhauled to drive more web traffic from uninsured Vermonters to our site.

During this quarter, the OVHA was involved in five lay offs coordinated by the Vermont Department of Labor, which have informed 87 people about health insurance under Green Mountain Care. This compares to seven lays offs impacting 136 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 continued to grow slowly over the quarter. As of the end of June there were 11,598 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.

As required by Act 25, An Act Relating to Palliative Care, passed by the legislature during the 2009 session, OVHA submitted a report in November 2009 on the programmatic and cost implications of applying for a waiver amendment to provide Medicaid children who have life-limiting illnesses with concurrent palliative and curative care. The legislature added language to the 2011 budget bill to require OVHA to request a waiver to implement a palliative care program for children. Vermont intends to work with CMS to determine if a waiver request is necessary, once model elements are defined.

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 has so far not acted to move forward on implementation.

To ensure the solvency of the Catamount Fund, the Administration proposed a change to the Catamount Health benefit structure that would increase the deductible from $250 to $1200 and increase co-pays for office visits and pharmacy. The legislature approved an increase in the deductible from $250 to $500, and an increase in the co-pays for brand-name and non-preferred drugs. The two Catamount Health carriers are in the process of filing 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, will be effective in October.

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 June 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 is targeted to be $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 OVHA'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 OVHA'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 OVHA'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 OVHA 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 OVHA'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 OVHA 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 OVHA 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 OVHA 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. OVHA 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. OVHA pays an enhanced

rate to PCPs for collaborating with OVHA care coordinators working with their highest risk patients. During the 3rd quarter of FFY 2010, participating providers were reimbursed $150.00 for each beneficiary enrolled in care coordination. As a result of feedback received from the 2009 Provider Satisfaction Survey, billing procedures also were streamlined in the 3rd quarter so providers only have to bill once, at the conclusion of care coordination services. Previously, providers billed each month the beneficiary was participating in care coordination. The amount of the enhanced payment remained the same.

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. During the second full year of operation, from July 1, 2008 through June 30, 2009, 3,189 beneficiaries received face-to-face case management services or telephonic disease management health coaching from a registered nurse.

The OVHA contracted with the University of Vermont (UVM) for VCCI program evaluation, identification of and assistance with 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 3 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 4th quarter FFY 2010.
- OVHA care coordinators expanded meetings and electronic data exchange systems with hospital emergency departments (EDs) for increased collaboration regarding emergency room utilization among VCCI beneficiaries.
- During the 4th quarter of FFY 2009, OVHA care coordinators began providing case management to buprenorphine patients from five pilot provider practices. During the first two quarters of FFY 2010, 45 buprenorphine patients received case management services from OVHA care coordinators.
- During the second quarter of FFY 2010, the average monthly program caseload was 2,016. Monthly caseload includes beneficiaries in active outreach by VCCI staff, as well as those successfully engaged and receiving care coordination or health coaching services.

2,187 unique beneficiaries were served by either OVHA care coordinators or APS disease management health coaches during the first two quarters of FFY 2010 (10/01/2009 through 03/31/2010). This number includes the 45 buprenorphine patients who received case management services from OVHA care coordinators.

Buprenorphine Program

The OVHA, in collaboration with ADAP, maintains a capitated payment program for the treatment of Opiate Dependency (CPTOD). The Capitated Program for the Treatment of Opiate Dependency (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 OVHA notified all of the providers and implemented an automated payment system for the Capitated Program for the Treatment of Opiate Dependency. All claims are now submitted directly to HP Enterprise Services and processed through the MMIS, enabling the OVHA to more accurately budget and track expenditures. The billing requirements are aligned with the treatment complexity levels outlined in the Buprenorphine Provider Agreements. The Buprenorphine Guidelines were revised and the rates were also changed with an effective date of 1 January 2010. All of these changes will streamline the payment procedures and make it more efficient. All of the providers received revised agreements and payment guidelines to ensure a smooth transition. HP Enterprise also provides a service representative for any issues or questions around the payment process.

(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
Total	**$ 159,257.47**
SECOND QUARTER	
Jan-10	$ 32,801.15
Feb-10	$ 31,634.36
Mar-10	$ 30,784.87
Total	**$ 95,220.38**
April-10	$28,865.08
May-10	$29,446.11
June-10	$28,527.56
Total	$86,838.75
GRAND TOTAL	**$341,316.22**

The total for three quarters (October 2009-June 30 2010) is $341,316.22 **(Figure 2)**. As the third quarter in FFY '10, the Capitated Program for the Treatment of Opiate Dependency continues to have 32 providers and approximately 332 beneficiaries enrolled and undergoing opiate addiction treatment. The five piloted practices utilizing OVHA's Chronic Care Initiative care coordinators account for approximately 47% of the total number of buprenorphine beneficiaries enrolled with a capitated treatment provider. The enhanced remuneration coupled with the care coordination in the five (5) pilot areas continues to be successful at improving access to clinically appropriate health care information and services and encouraging and empowering beneficiaries to self-manage their chronic conditions.

Mental Health – Vermont Futures Planning

Community System Development

The six-bed Meadowview community residential recovery program is operating at capacity and has successfully transitioned six residents from Vermont State Hospital. These are individuals who would have otherwise remained 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". The Board and developer will work to create a new 501 C-3 organization 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 is still under review 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.

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 is under review and DMH has been responding to questions as brought forward by BISHCA staff and interested parties. 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 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 current proposed site spans two different zoning districts. Local residents are expressing opposition to the placement of the fenced, outdoor yard in a conservation district and to the site lines of the building from nearby residences. The BGS commissioner is required to make a report on 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 the Managed Care Organization (MCO) 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.

[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.

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 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, Dartmouth Medical School, and Fletcher Allen Health Care.

The full plan is available at the DMH website: Mental Health.Vermont.gov

Financial/Budget Neutrality Development/Issues

AHS received CMS' approval on December 23, 2009 (effective December 31, 2009) to include three new populations in the GC Waiver: Catamount 200-300% FPL, ESIA 200-300% FPL, and VPharm3. On May 20, 2010, AHS received further clarification and confirmation from CMS that it is also acceptable to pay DVHA the existing PMPMs for the VScript Expanded population. Accordingly, beginning with the July 1, 2010 GC Capitation Payment, AHS began paying DVHA at the PMPM rate set for the GlobalRx Non-Dual MEG for this population.

AHS' actuarial consultant, Aon, is currently working to produce certified rate ranges for the FFY11 period. AHS anticipates delivery of the FFY11 IGA, including actuarially sound rates, to CMS on or before September 1, 2010.

On July 16, 2010, Vermont received notice from CMS that our QE1210 E-FMAP rate would be reduced from 69.96% to 68.83% due to the decrease in Vermont's unemployment rate. At this time, Congress has not enacted legislation to extend ARRA beyond 12/31/2010, or to extend its hold harmless provisions beyond 6/30/2010. These issues, if unresolved, will present a considerable financial challenge for Vermont in the coming months. Accordingly, the State may be required to amend its current Medicaid program offerings beyond January 1, 2011, in response to future fiscal challenges; as such, AHS may request to reopen the FFY11 rates if necessary.

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 4/30/2010	Month 2 5/31/2010	Month 3 6/30/2010	Total for Quarter Ending 3 rd Qtr FFY '10	Total for Quarter Ending 2 nd Qtr FFY '10	Total for Quarter Ending 1st Qtr FFY '10	Total for Quarter Ending 4th Qtr FFY '09	Total for Quarter Ending 3nd Qtr FFY '09	Total for Quarter Ending 1st Qtr FFY '09	Total for Quarter Ending 4th Qtr FFY '08	Total for Quarter Ending 3rd Qtr FFY '08	Total for Quarter Ending 2nd Qtr FFY '08	Total for Quarter Ending 1st Qtr FFY '08
Demonstration Population 1:	44,054	44,056	44,058	132,168	131,930	131,513	129,656	128,203	125,825	123,997	122,281	121,926	120,113
Demonstration Population 2:	44,042	44,090	43,733	131,865	130,746	129,075	128,698	128,590	122,210	121,981	123,283	122,118	120,309
Demonstration Population 3:	10,162	10,034	10,048	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
Demonstration Population 5:	1,243	1,232	1,226	3,701	3,614	3,546	3,410	3,568	3,832	3,850	3,767	3,542	3,767
Demonstration Population 6:	2,954	2,998	3,020	8,972	8,495	8,218	8,088	7,480	8,208	7,428	7,357	6,208	6,084
Demonstration Population 7:	34,124	34,928	34,142	103,194	98,576	92,217	89,158	87,116	75,277	74,301	73,966	72,336	65,803
Demonstration Population 8:	7,498	7,595	7,614	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	2,659	2,642	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
Demonstration Population 11:	10,325	10,697	10,423	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 Performance Improvement Project (PIP) work group met to discuss the next steps of the project and to prepare for this year's External Quality Review Organization (EQRO) PIP validation. The steps discussed included the following: analyze data, interpret study results, and report baseline data. A work plan was developed and agreed upon by all members of the group. Baseline data collection will run through the beginning of next quarter. The AHS

also met with Managed Care Entity (MCE) staff responsible for calculating and reporting the set of measures that will be used to monitor MCE performance during this year. It was decided that the OVHA would contract with a HEDIS certified software vendor in order to meet its reporting requirements. During this quarter, the AHS Quality Improvement Manager also participated in a conference call between the EQRO and OVHA related to how the use of a certified software vendor will impact this year's Performance Measure Validation Review. It is anticipated that initial measures and rates will be ready for EQRO review by the end of next quarter. Finally, the State worked with the EQRO to develop a review tool that will be used by the EQRO to assess the MCE's ability to comply with Federal and State Medicaid MCO Access standards (i.e., availability of services, assurances of adequate capacity and services, coordination and continuity of care, and coverage and authorization of services).

Quality Assurance Performance Improvement Committee (QAPI): During this quarter, the Quality Assessment and Performance Improvement (QAPI) Committee continued to discuss the scope of this year's Managed Care Entity (MCE) Compliance Review. The discussion focused on the coverage & authorization of service and coordination and continuity of care requirements contained in the Code of Federal Regulations. The Committee reviewed the specific items associated with this requirement including but not limited to the following: written authorization criteria, mechanism to ensure consistent application of authorization criteria, identification of beneficiaries with special health needs, assessment of needs, and treatment/service planning. Also during this quarter, the group began monitoring/oversight of the MCE QAPI activities using the newly developed reporting/review format. The following MCE QAPI activities were reviewed/discussed: Health Information Systems, Experience of Care Survey, and Performance Improvement Projects. In addition, the group continued to work together to prepare for the two other 2009/2010 mandatory EQRO activities (i.e., performance measure validation and performance improvement project validation). Finally, the group 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.

Quality Strategy: The AHS Quality Improvement Manager and the members of the QAPI committee will review the Quality Strategy on a regular basis and recommend any necessary modifications.

Demonstration Evaluation

At the end of FFY09, the interim evaluation report of the Global Commitment to Health 1115 Waiver prepared by Pacific Health Policy Group (PHPG) accompanied the State's formal waiver extension request to CMS. During this quarter, there was no action taken on Vermont's request. Once the outcome of the waiver extension request is known, the AHS Quality Improvement Manager will meet with the PHPG project manager to modify the current evaluation work plan to correspond with the time period agreed upon in CMS's response to the request.

Reported Purposes for Capitated Revenue Expenditures

Provided that 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: August 19, 2010

ATTACHMENTS

ATTACHMENT 1

Office of Vermont Health Access
SFY 10 Catamount Health Actual Revenue and Expense Tracking
Sunday, July 18, 2010

	SFY '10 BAA				Consensus Estimates for SFY to Date				Actuals thru 6/30/10				
	<=200%	*>200% before 1/1/10*	*>200% after 1/1/10*	*Total*	*<=200%*	*>200% before 1/1/10*	*>200% after 1/1/10*	*Total*	*<=200%*	*>200% before 1/1/10*	*>200% after 1/1/10*	*Total*	*% of SFY to-Date*
TOTAL PROGRAM EXPENDITURES													
Catamount Health	32,353,840	5,479,988	6,483,491	44,317,319	32,353,840	5,479,988	6,483,491	44,317,319	31,258,773	6,436,111	7,515,602	45,210,486	102.02%
Catamount Eligible Employer-Sponsored Insurance	1,365,354	259,097	334,275	1,958,726	1,365,354	259,097	334,275	1,958,726	866,035	239,713	236,506	1,342,255	68.53%
Subtotal New Program Spending	33,719,193	5,739,085	6,817,766	46,276,045	33,719,193	5,739,085	6,817,766	46,276,045	32,124,809	6,675,825	7,752,108	46,552,741	100.60%
Catamount and ESI Administrative Costs	1,254,021	471,714	471,714	2,197,448	1,254,021	471,714	471,714	2,197,448	1,254,021	607,033	314,476	2,175,530	99.00%
TOTAL GROSS PROGRAM SPENDING	34,973,214	6,210,799	7,289,480	48,473,493	34,973,214	6,210,799	7,289,480	48,473,493	33,378,830	7,282,858	8,066,584	48,728,271	100.53%
TOTAL STATE PROGRAM SPENDING	**10,505,954**	**6,210,799**	**3,008,368**	**19,725,120**	**10,505,954**	**6,210,799**	**3,008,368**	**19,725,120**	**10,027,000**	**7,282,858**	**3,314,559**	**20,624,417**	**104.56%**
TOTAL OTHER EXPENDITURES													
Immunizations Program	-	1,327,000	1,250,000	2,577,000	-	1,327,000	1,250,000	2,577,000	-	1,327,000	955,902	2,282,902	88.59%
VT Dept. of Labor Admin Costs Assoc. With Employer Assess.	-	197,036	197,036	394,072	-	197,036	197,036	394,072	-	197,036	210,585	407,621	103.44%
Marketing and Outreach	500,000	-	-	500,000	500,000	-	-	500,000	500,000	-	-	500,000	100.00%
Blueprint	-	923,357	923,357	1,846,713	-	923,357	923,357	1,846,713	-	923,357	830,936	1,754,293	95.00%
TOTAL OTHER SPENDING	500,000	2,447,393	2,370,393	5,317,785	500,000	2,447,393	2,370,393	5,317,785	500,000	2,447,393	1,997,424	4,944,816	92.99%
TOTAL STATE OTHER SPENDING	**150,200**	**2,447,393**	**2,370,393**	**4,967,985**	**150,200**	**2,447,393**	**2,370,393**	**4,967,985**	**150,200**	**2,447,393**	**1,997,424**	**4,595,016**	**92.49%**
TOTAL ALL STATE SPENDING	**10,656,154**	**8,658,191**	**5,378,761**	**24,693,105**	**10,656,154**	**8,658,191**	**5,378,761**	**24,693,105**	**10,177,200**	**9,730,250**	**5,311,983**	**25,219,433**	**102.13%**
TOTAL REVENUES													
Catamount Health Premiums	4,851,343	1,800,889	2,305,426	8,957,657	4,851,343	1,800,889	2,305,426	8,957,657	4,773,771	1,704,249	2,235,615	8,713,635	97.28%
Catamount Eligible Employer-Sponsored Insurance Premiums	378,607	158,259	204,249	741,115	378,607	158,259	204,249	741,115	305,240	115,175	136,986	557,401	75.21%
Subtotal Premiums	5,229,949	1,959,148	2,509,675	9,698,772	5,229,949	1,959,148	2,509,675	9,698,772	5,079,011	1,819,424	2,372,601	9,271,036	95.59%
Federal Share of Premiums	(3,658,873)	-	(1,473,932)	(5,132,805)	(3,658,873)	-	(1,473,932)	(5,132,805)	(3,553,276)	-	(1,397,699)	(4,950,975)	96.46%
TOTAL STATE PREMIUM SHARE	1,571,077	1,959,148	1,035,743	4,565,967	1,571,077	1,959,148	1,035,743	4,565,967	1,525,735	1,819,424	974,902	4,320,061	94.61%
Cigarette Tax Increase ($.60 / $.80)				9,774,300				9,774,300				9,995,005	102.26%
Floor Stock				340,934				340,934				341,858	0.00%
Employer Assessment				7,121,207				7,121,207				7,233,000	101.57%
Interest				-				-				17,785	0.00%
State Fund Transfer due to Enhanced ARRA				(3,352,082)				(3,352,082)				(3,206,525)	95.66%
TOTAL OTHER REVENUE				13,884,359				13,884,359				14,381,124	103.58%
TOTAL STATE REVENUE	**1,571,077**	**1,959,148**	**1,035,743**	**18,450,326**	**1,571,077**	**1,959,148**		**18,450,327**	**1,525,735**	**1,819,424**		**18,701,184**	**101.36%**
State-Only Balance				(6,242,779)				(6,242,779)				(6,518,249)	
Carryforward				7,311,891				7,311,891				7,311,891	
(DEFICIT)/SURPLUS				**1,069,111**				**1,069,112**				**793,641**	
Reserve Account Funding				-				-				-	
REVISED (DEFICIT)/SURPLUS WITH RESERVE FUNDING				**1,069,111**				**1,069,112**				**793,641**	

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

Green Mountain Care Enrollment Report

June 2010

TOTAL ENROLLMENT BY MONTH

	Jul-07	Nov-07	Jul-08	Nov-08	Jul 09	Aug 09	Sep 09	Oct 09	Nov 09	Dec 09	Jan 10	Feb 10	Mar 10	Apr 10	May 10	June 10
Adults:																
VHAP-ESIA	-	35	672	759	966	955	953	962	959	968	958	954	952	942	923	926
ESIA	-	21	336	499	586	589	633	706	692	698	708	744	749	745	759	729
CHAP	-	320	4,608	6,120	7,988	8,235	8,477	8,802	8,954	9,138	9,339	9,503	9,755	10,163	9,902	9,943
Catamount Health	-	120	697	932	1,339	1,404	1,455	1,516	1,556	1,660	1,651	1,709	1,733	1,752	1,790	1,924
Total	-	376	6,313	8,310	10,879	11,183	11,518	11,986	12,161	12,464	12,656	12,910	13,189	13,602	13,374	13,522

	Jul-07	Nov-07	Jul-08	Nov-08	Jul 09	Aug 09	Sep 09	Oct 09	Nov 09	Dec 09	Jan 10	Feb 10	Mar 10	Apr 10	May 10	June 10
Adults:																
VHAP	23,725	24,849	26,441	26,860	31,270	31,605	31,629	32,469	32,429	33,067	33,469	33,965	35,010	36,010	34,801	34,570
Other Medicaid	69,764	69,969	70,947	35,601	37,930	38,117	38,207	37,689	37,689	38,411	37,852	39,053	39,181	39,483	39,266	39,368
Children:																
Dr Dynasaur	19,738	19,733	19,960	20,511	20,705	20,466	20,525	20,434	20,418	20,472	20,503	20,489	20,602	20,707	20,262	19,882
SCHIP	3,097	3,428	3,396	3,527	3,398	3,412	3,430	3,412	3,446	3,451	3,405	3,432	3,514	3,564	3,513	3,478
Other Medicaid*	Included	Included	Included	34,015	37,671	37,605	37,579	37,212	37,291	38,116	38,261	38,678	38,531	38,862	39,325	39,157
Total	116,324	117,979	120,744	120,514	130,974	131,205	131,370	131,216	131,273	133,517	133,490	135,617	136,838	138,626	137,167	136,455
TOTAL ALL	116,324	118,355	127,057	128,824	141,853	142,388	142,888	143,202	143,434	145,981	146,146	148,527	150,027	152,228	150,541	149,977

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

June 2010 Demographics

Income	VHAP-ESIA*	ESIA*	CHAP*	TOTAL
0-50%	26	2	514	
50-75%	35	-	112	
75-100%	121	4	137	
100-150%	450	13	414	
150-185%	279	236	3700	
185-200%	9	216	2324	
200-225%	1	153	1340	
225-250%	3	63	859	
250-275%	-	39	398	
275-300%	2	3	145	
Total	926	729	9,943	11,598

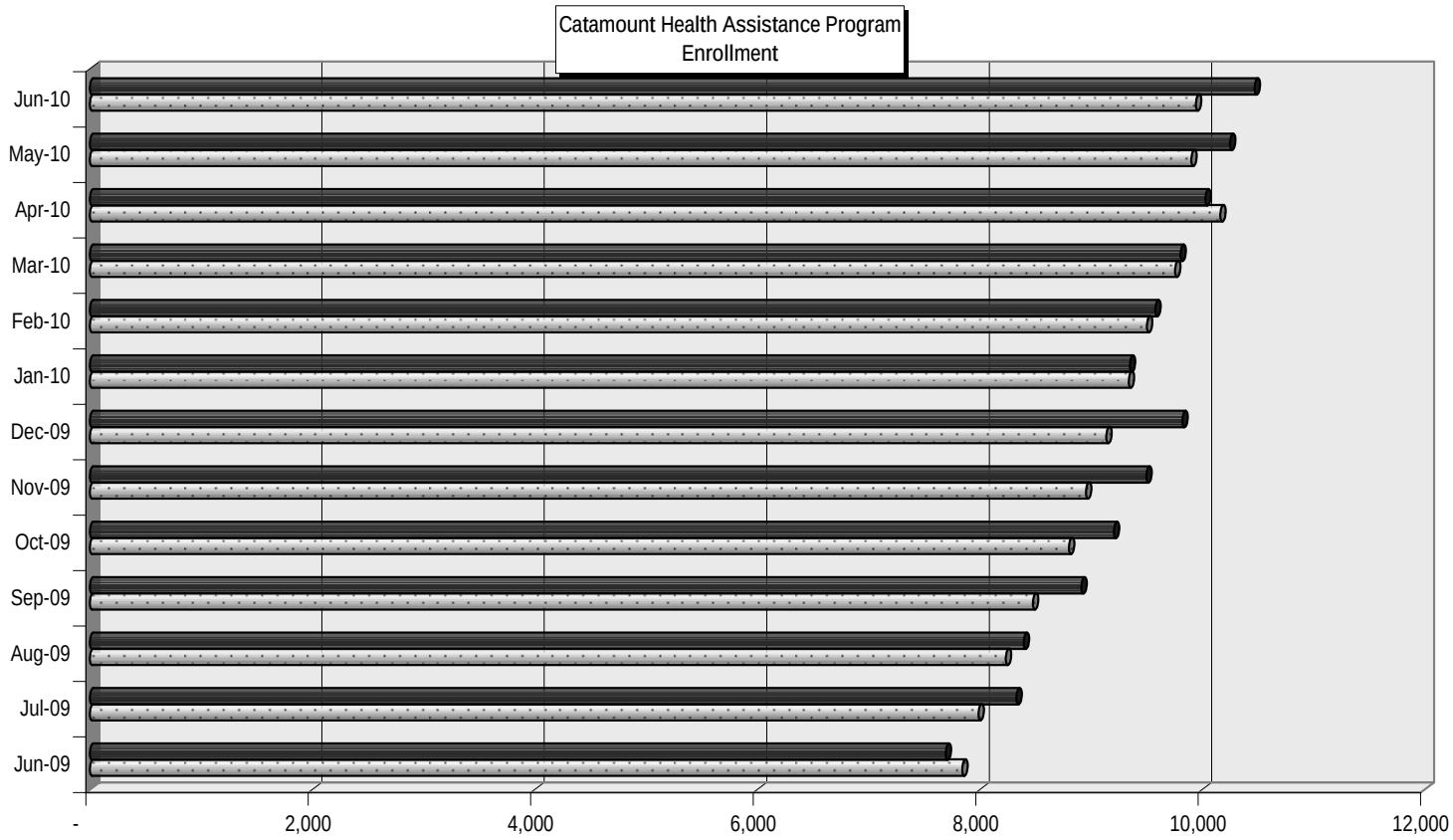
Age	VHAP-ESIA	ESIA	CHAP	TOTAL
18-24	60	80	2238	
25-35	260	182	1704	
36-45	341	205	1608	
46-55	214	189	2108	
56-64	50	73	2283	
65+	1	-	2	
Total	926	729	9,943	11,598

Green Mountain Care Enrollment Report (continued)

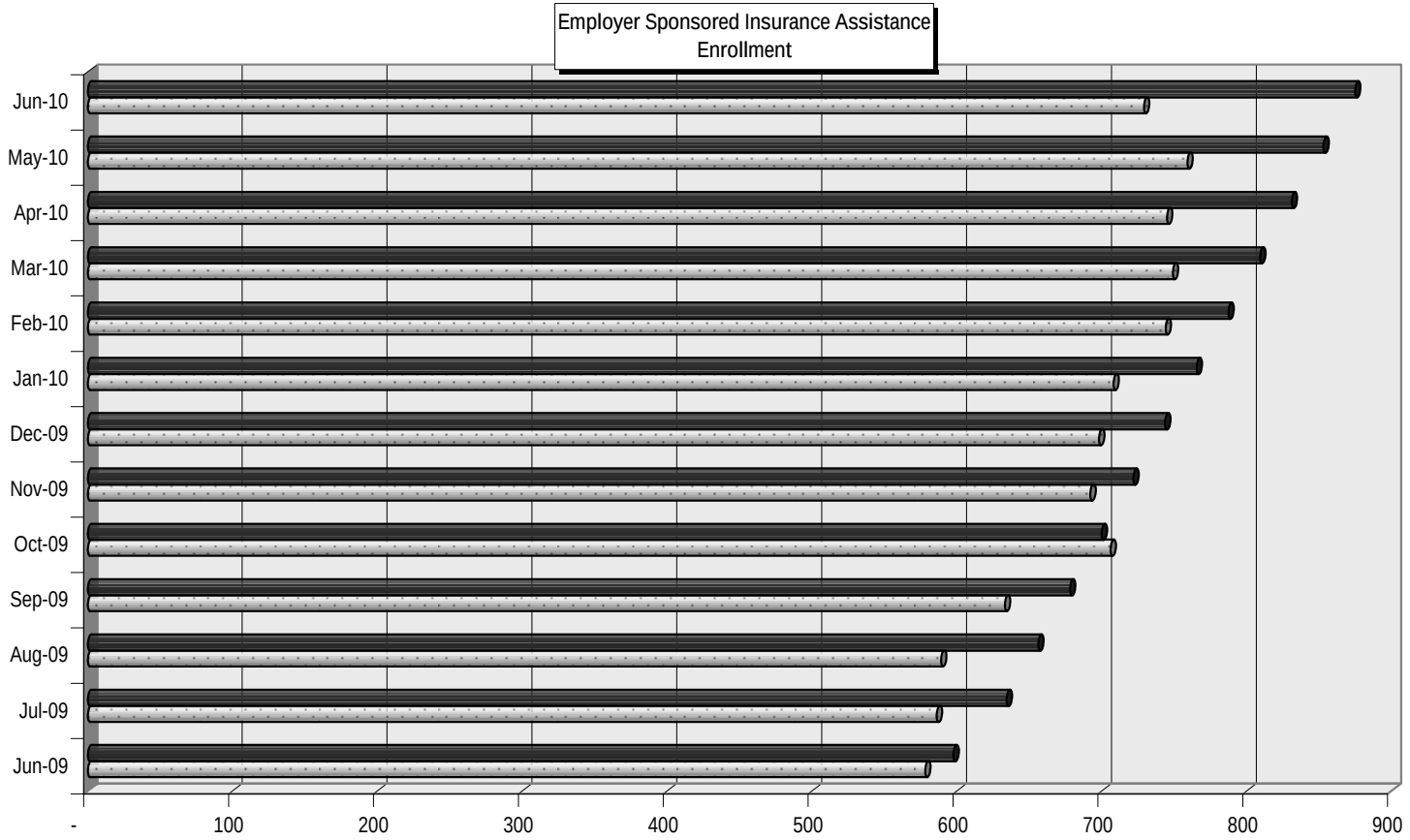
June 2010 Demographics

Gender	VHAP-ESIA	ESIA	CHAP	TOTAL
Male	318	264	4,340	
Female	608	465	5,603	
Total	926	729	9,943	11,598

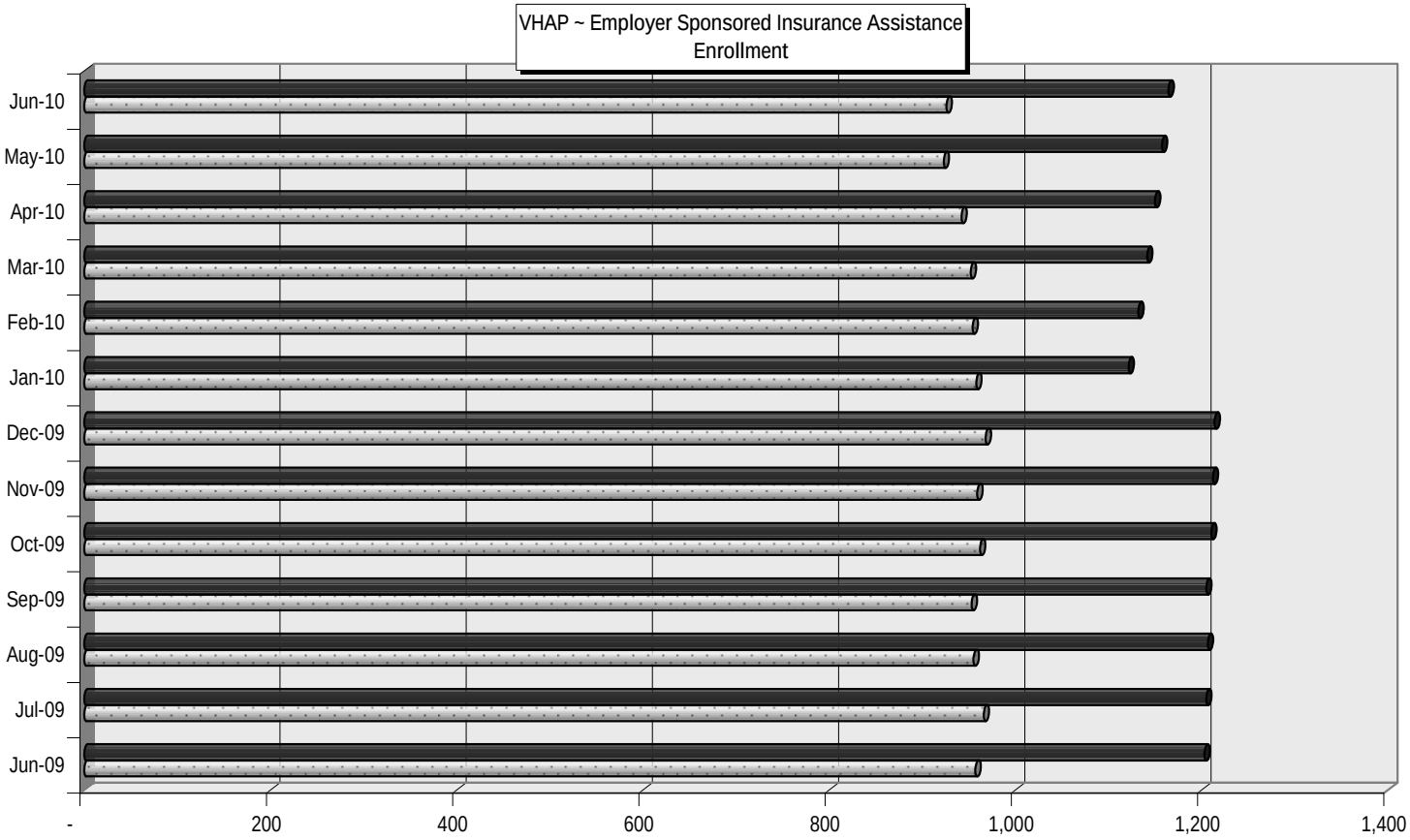
County	VHAP-ESIA	ESIA	CHAP	TOTAL
Addison	56	38	636	
Bennington	78	60	615	
Caledonia	37	33	655	
Chittenden	193	159	1940	
Essex	7	8	124	
Franklin	96	49	643	
Grand Isle	10	8	96	
Lamoille	54	46	528	
Orange	34	28	493	
Orleans	64	44	533	
Other	1	-	5	
Rutland	99	98	1003	
Washington	67	55	938	
Windham	52	49	791	
Windsor	78	54	943	
Total	926	729	9,943	11,598



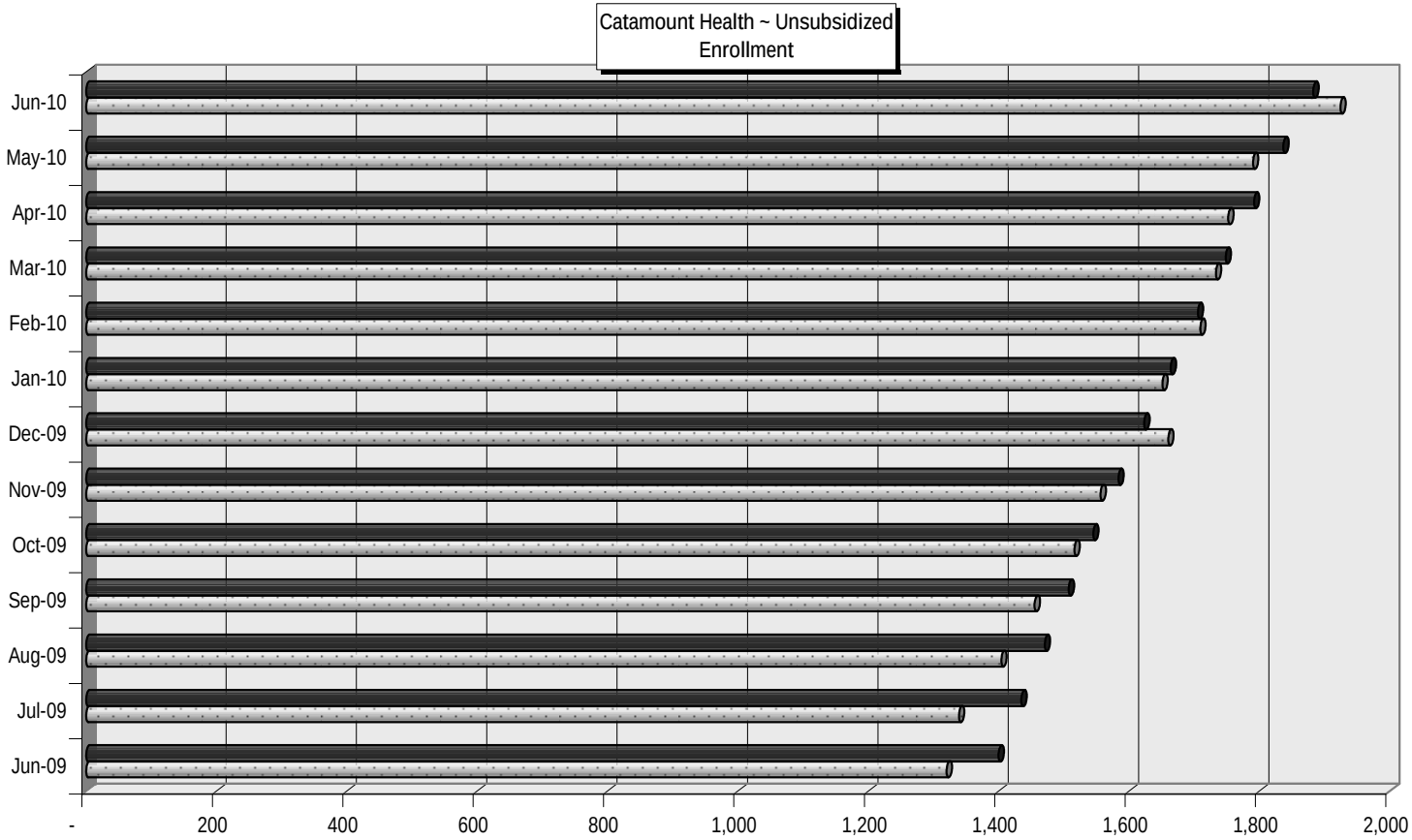
	Jun-09	Jul-09	Aug-09	Sep-09	Oct-09	Nov-09	Dec-09	Jan-10	Feb-10	Mar-10	Apr-10	May-10	Jun-10
Projected	7,694	8,329	8,394	8,914	9,206	9,498	9,822	9,349	9,577	9,803	10,028	10,250	10,472
Actual	7,842	7,988	8,235	8,477	8,802	8,954	9,138	9,339	9,503	9,755	10,163	9,902	9,943



	Jun-09	Jul-09	Aug-09	Sep-09	Oct-09	Nov-09	Dec-09	Jan-10	Feb-10	Mar-10	Apr-10	May-10	Jun-10
Projected	597	634	656	678	700	722	744	765	787	809	831	853	875
Actual	578	586	589	633	706	692	698	708	744	749	745	759	729



	Jun-09	Jul-09	Aug-09	Sep-09	Oct-09	Nov-09	Dec-09	Jan-10	Feb-10	Mar-10	Apr-10	May-10	Jun-10
Projected	1,203	1,205	1,207	1,205	1,210	1,212	1,214	1,122	1,132	1,141	1,150	1,157	1,164
Actual	957	966	955	953	962	959	968	958	954	952	942	923	926



	Jun-09	Jul-09	Aug-09	Sep-09	Oct-09	Nov-09	Dec-09	Jan-10	Feb-10	Mar-10	Apr-10	May-10	Jun-10
Projected	1,400	1,435	1,471	1,507	1,545	1,584	1,623	1,664	1,705	1,748	1,792	1,836	1,882
Actual	1,320	1,339	1,404	1,455	1,516	1,556	1,660	1,651	1,709	1,733	1,752	1,790	1,924

Global Commitment Expenditure Tracking

Attachment 2

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)
1205	$ 178,493,793							$ 178,493,793				
0306	$ 189,414,365	$ 14,472,838					$ 14,472,838	$ 203,887,203				
0606	$ 209,647,618	$ (14,172,165)					$ (14,172,165)	$ 195,475,453				
0906	$ 194,437,742	$ 133,350					$ 133,350	$ 194,571,092				
WY1 SUM	$ 771,993,518	$ 434,023	$ -				$ 434,023	**$ 782,159,845**	**$ 4,620,302**	**$ 786,780,147**	**$ 1,015,000,000**	**$ 228,219,853**
1206	$ 203,444,640	$ 8,903					$ 8,903	$ 203,453,543				
0307	$ 203,804,330	$ 8,894,097	$ -				$ 8,894,097	$ 212,698,427				
0607	$ 186,458,403	$ 814,587	$ (68,408)				$ 746,179	$ 187,204,582				
0907	$ 225,219,267	$ -	$ -				$ -	$ 225,219,267				
WY2 SUM	$ 818,926,640	$ 9,717,587	$ (68,408)				$ 9,649,179	**$ 802,884,359**	**$ 6,464,439**	$ 809,348,797		
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				
0308	$ 162,921,830	$ -	$ -	$ -	$ -	$ -	$ -	$ 162,921,830				
0608	$ 196,466,768	$ 14,717	$ -	$40,276,433	$ -	$ -	$ 40,291,150	$ 236,757,918				
0908	$ 228,593,470	$ -	$ -	$ -	$ -	$ -	$ -	$ 228,593,470				
WY3 SUM	$ 801,853,126	$ 14,717	$ 1,010,348	$40,276,433			$ 41,301,498	**$ 881,845,245**	**$ 6,457,896**	$ 888,303,141		
Cumulative										**$ 2,484,432,085**	**$ 2,848,000,000**	**$ 363,567,915**
1208	$ 228,768,784		$ -	$ -	$ -	$ -	$ -	$ 228,768,784				
0309	$ 225,691,930		$ (16,984,221)	$38,998,635	$ (4,144,041)	$ -	$ 17,870,373	$ 243,562,303				
0609	$ 204,169,638		$ -	$ 686,851	$ 5,522,763	$ -	$ 6,209,614	$ 210,379,252				
0909	$ 235,585,153		$ -	$ 30,199	$34,064,109	$ -	$ 34,094,308	$ 269,679,461				
WY4 SUM	$ 894,215,505	$ -	$ (16,984,221)	$39,715,685	$35,442,831	$ -	$ 58,174,295	**$ 935,630,245**	**$ 5,478,052**	$ 941,108,297		
Cumulative										**$ 3,425,540,383**	**$ 3,779,000,000**	**$ 353,459,617**
1209	$ 241,939,196				$ 5,192,468	$ -	$ 5,192,468	$ 247,131,664				
0310	$ 246,257,198				$ 531,141	$ 4,400,166	$ 4,931,306	$ 251,188,504				
0610	$ 253,045,787				$ 248,301	$ 5,260,537	$ 5,508,838	$ 258,554,625				
0910							$ -	$ -				
WY5 SUM	$ 741,242,181	$ -	$ -	$ -	$ 5,971,909	$ 9,660,703	$ 15,632,613	$ 750,902,884	**$ 4,414,968**	$ 755,317,852		
Cumulative										**$ 4,180,858,235**	**$ 4,700,000,000**	**$ 519,141,765**
	$ 4,028,230,970	$ 10,166,327	$ (16,042,281)	$79,992,118	$41,414,741	$ 9,660,703		$ 4,153,422,578	$ 27,435,657			

ATTACHMENT 3

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
April 1, 2010 – June 30, 2010

Eligibility forms, notices, or process	23
ESD Call-center complaints (IVR, rudeness, hold times)	32
Use of social security number as identifiers	1
General premium complaints	11
Catamount Health Assistance Program premiums, process, ads, plans	0
Coverage rules	3
Member services	3
Eligibility rules	7
Local district office	10
Prescription drug plan complaint	0
Copays/service limit	1
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	1
Total	**96**

ATTACHMENT 4

VERMONT

Agency of Human Services

Grievance and Appeal Quarterly Report
Medicaid MCO All Departments Combined Data
April 1, 2010 – June 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 July 6, 2010, from the centralized database for grievances and appeals that were filed from April 1, 2010 through June 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 ten grievances filed with the MCO. Seven were addressed during the quarter, none were withdrawn and three 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 24 days. Acknowledgement letters of the receipt of a grievance must be sent within five days, and as the MCO, we averaged five days, although two letters were sent late. Of the grievances filed, 60% were filed by beneficiaries, 3% were filed by a representative of the beneficiary and 10% were filed by someone else at the request of the beneficiary. Of the ten grievances filed, DMH had 80% and DAIL had 20%. There were no grievances filed for the DVHA, DCF, or VDH during this quarter.

Of the two cases that were pending from all previous quarters, both were resolved this quarter, with 100% addressed within the required timeframes.

There was one Grievance Review filed this quarter through the DAIL. Acknowledgement letters of the receipt of a grievance review must be sent within five days, and it was sent on the same day. There are six Grievance Reviews through DMH that were filed in previous quarters have not been addressed yet.

Appeals: Medicaid rule 7110.1 defines actions that a MCO entity 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 twenty-eight appeals filed with the MCO, of which five requested an expedited decision, and one met the criteria. Of these 28 appeals, sixteen were resolved (57% of filed appeals), two were withdrawn (7%), and ten appeals were still pending (35%). In eight cases (50% of those resolved), the original decision was upheld by the person hearing the appeal, four cases (25% of those resolved) were reversed, none were modified, and four were approved by the department/DA/SSA before the appeal meeting (25% of those resolved).

Of the sixteen appeals that were resolved this quarter 100% were resolved within the statutory time frame of 45 days. In addition, 75% of the resolved appeals were resolved within 30 days. The average number of days it took to resolve these cases was 22 days. Acknowledgement letters of the receipt of an appeal must be sent within five days, and as the MCO, we averaged only two days, although one of those letters were sent late.

Of the 28 appeals filed, fifteen were filed by beneficiaries (54%), thirteen were filed by a representative of the beneficiary (46%), none were filed by a provider, and none were filed by someone else at the request of the beneficiary. Of the 28 appeals filed, DVHA had 75%, DAIL had 10%, DCF had 4%, DMH had 7%, and VDH had 4%.

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 21 appeals for a denial or limitation of authorization of a requested service or eligibility for service (75%), 6 were for a reduction/suspension/termination of a previously authorized covered service or service plan (21%), and one was for a denial, in whole or in part, of payment for a covered service (4%).

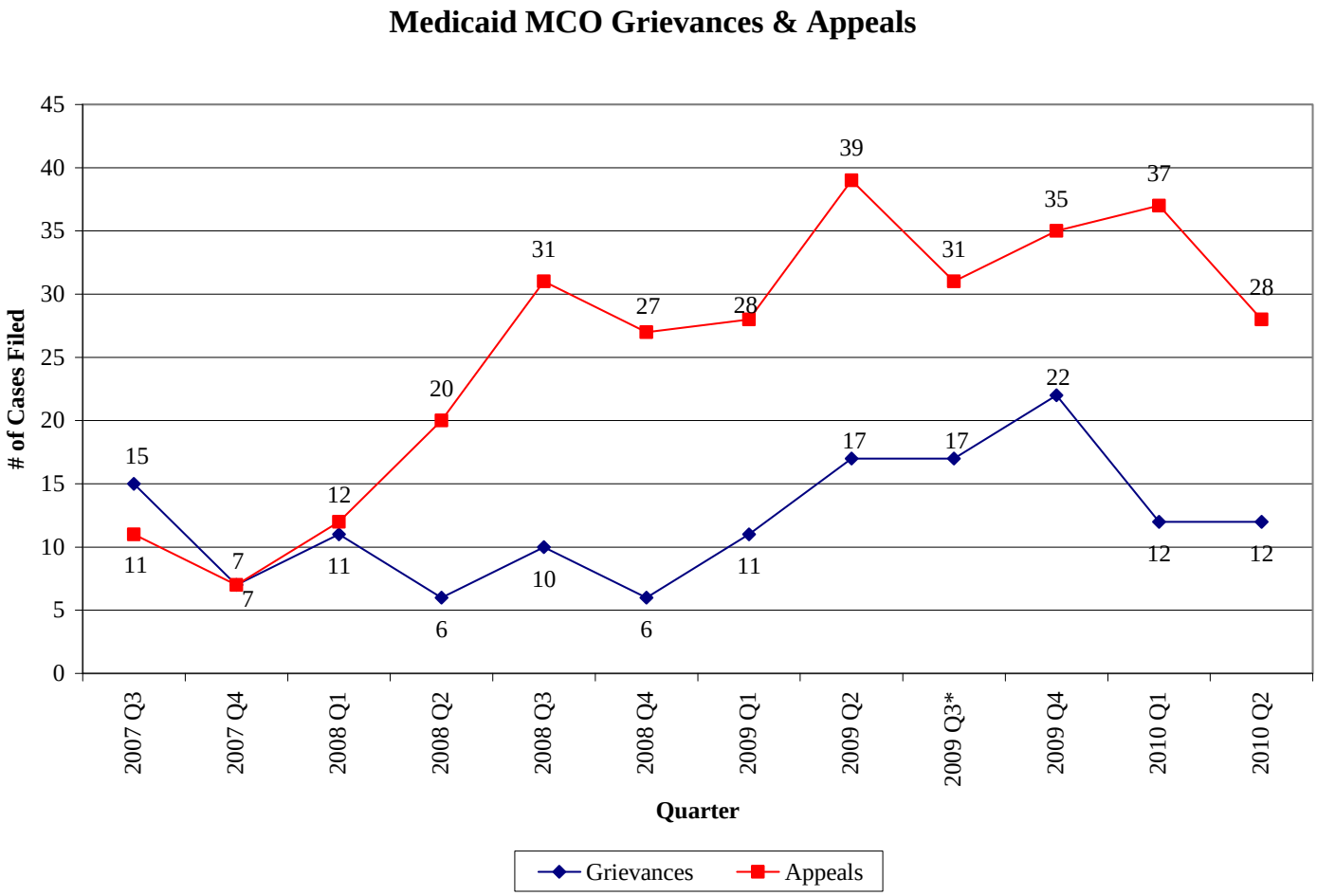
There were seven DAIL, one DMH, and four DVHA cases filed between January 1, 2010, and March 31, 2010 that were still pending at the beginning of this quarter. In addition, there were three DAIL cases that were still pending from before January 1, 2010. Of those fifteen pending cases, twelve were resolved this quarter. 50% of these cases were upheld (four for DAIL, one for DMH, and one for DVHA), two were reversed (17%); three were modified (25%), one was withdrawn (8%), and none were approved before the appeal hearing. 42% of the cases were resolved within thirty days, 83% in forty-five days, and 83% within fifty-nine. On June 30, 2010 there were three cases still pending; three for DAIL; (two for DAIL's DS program through NKHS for 526 days, and one for DAIL's Attendant Services).

Individuals 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 six fair hearings filed this quarter; three for DAIL and three for DVHA. Three were filed concurrently with the appeal, while the other three were filed subsequent to the appeal decision. Five cases are still pending. There were nineteen fair hearings that were pending from previous quarters. Two DVHA cases were upheld and one DAIL case was dismissed. There are a total of twenty-one fair hearings still pending as of the end of this quarter, five for DAIL and sixteen for DVHA.

Other Information:

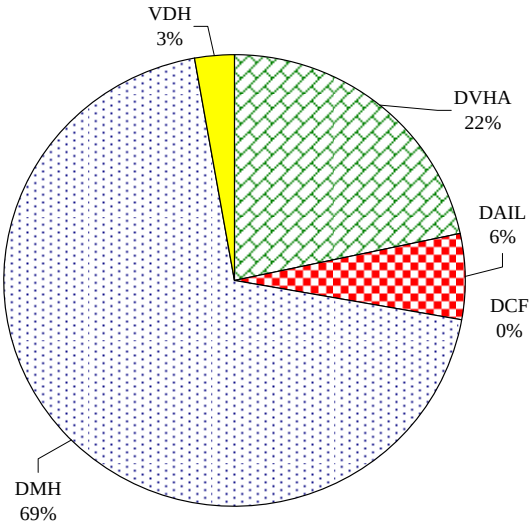
There is one SSA that has refused to be trained in the G&A process (Sterling Area Services) and that DAIL was going to contact them to ensure that an individual was identified and trained. That has still not happened after two years.

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 the Department of Children & Families' staff.

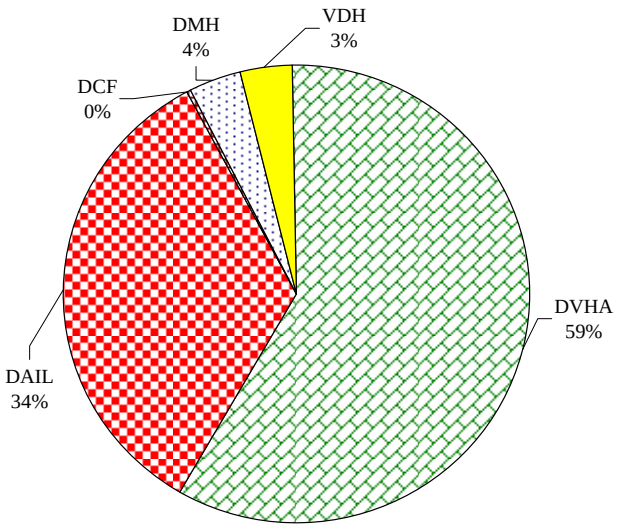


MCO Grievance & Appeals by Department from July 1, 2007 through June 30, 2010

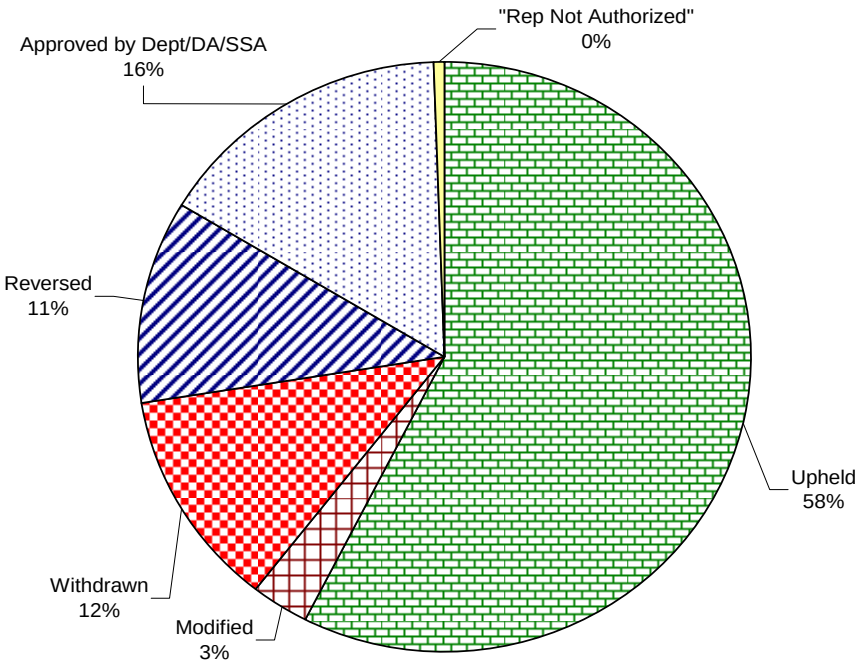
Grievances



Appeals



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



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

Grievances

Total number of grievances filed: 10

Number pending: 3 *DMH*

Number withdrawn: 0

Number addressed: 7 *DAIL-2; DMH-5*
- Within 90 days: 100%
- Exceeding 90 days: 0%

Number of grievances filed too late: 0

Average number of days from "pertinent issue" to filing grievance: 3

Average number of days from filing to entering into database: 6

Average number of days from filing to being addressed: 24

Average number of days to send acknowledgement letter: 5

Number of late acknowledgement letters: 2 *DMH*

Number of grievance reviews requested: 1 *DAIL*

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

Number of late grievance review acknowledgement letters: 0

Number of grievance reviews addressed: 0

Source of grievance request:

Beneficiary:	6	60%
Beneficiary Representative:	3	30%
Other:	1	10%

Number related to:

DVHA:	0	0%
DAIL:	2	20%
DCF:	0	0%
DMH:	8	80%
VDH:	0	0%

Top services grieved:
1. Mental Health Services (5)
2. Case Management (3)
3. Community Social Supports (1)

Number by category: [Check ALL that apply]

Staff/Contractor:	4
Program Concern:	4
Management:	3
Policy or Rule Issue:	3
Quality of Service:	1
Service Accessibility:	2
Timeliness of Service Response:	2
Service Not Offered/Available:	2
Other:	0
Enrollee Rights:	1
Adverse Effect/Exercising Rights:	0

* * * * * *

Number pending from all previous quarters: 2 *DMH*

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

Number that were pending in previous quarters and addressed this quarter: 2
- Within 90 days: 100% *DMH*
- Exceeding 90 days: 0%

Number of grievances still pending at the end of this quarter: 0

Number of grievance reviews pending from all previous quarters: 6 *DMH*

Number of pending grievance reviews addressed this quarter: 0

Data as of: 07/06/10

Appeals

Number of appeals filed: 28

Number pending: 10 *DAIL-1; DCF-1; DMH-1; DVHA-6; VDH-1*

Number withdrawn: 2 *DVHA*

Number resolved: 16
- Number upheld: 8 50% *DAIL-2; DMH-1; DVHA-5*
- Number reversed: 4 25% *DVHA*
- Number modified: 0 0%
- Number approved by Dept/DA/SSA: 4 25% *DVHA*

Number of cases extended: 2
- by beneficiary: 1
- by MCO: 1

Resolved time frames
- Within 30 days: 75% *DAIL-2; DMH-1; DVHA-9*
- Within 45 days: 100% *DAIL-2; DMH-1; DVHA-11*
- Within 59 days: 100%
  - Extended (0) vs. Late (0)
- Over 59 days: 0%

Number of appeals filed too late: 1

Average number of days from NOA to filing appeal: 22

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

Average number of days from filing to resolution: 22

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

Average number of days to send acknowledgement letter: 2

Number of late acknowledgement letters: 1 *VDH*

Average number of days from filing to withdrawing: 10

Average number of days to send withdrawal letter: 0 = same day

Number of late withdrawal letters: 0

Source of appeal request:

Beneficiary:	15	54%
Beneficiary Representative:	13	46%
Provider:	0	0%
Other:	0	0%

Number related to:

DVHA:	21	75%
DAIL:	3	10%
DCF:	1	4%
DMH:	2	7%
VDH:	1	4%

Top services appealed:
1. Transportation (8)
2. Orthodontic (5)
3. Prescriptions (5)
4. Personal Care (3)

Number of beneficiaries that requested that their services be continued: 4 14%

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:	21
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:	1
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: 5

Number of expedited appeals that:
Met criteria: 1
Did not meet criteria: 4

For those MEETING criteria

Number pending:0

Number of expedited appeals filed too late: 0

Number resolved: 1
Number upheld: 0 0%
Number reversed: 1 100%
Number modified: 0 0%
Number approved by Dept/DA/SSA: 0 0%

Average number of days from Notice of Action to filing expedited appeal: 3

Average number of days from filing to entering data into database: 6

Average number of days from filing to resolution: 4

Number of late resolutions: 1 100%

Source of appeal:

Beneficiary:	1	100%
Beneficiary Representative:	0	0%
Provider:	0	0%
Other:	0	0%

Service appealed: Prescriptions (1)

Number related to:

DVHA:	1	100%
DAIL:	0	0%
DCF:	0	0%
DMH:	0	0%
VDH:	0	0%

Number by category:

1. Denial or limitation of authorization of a requested service or eligibility for service:	1
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: 3

Average number of business days to notify beneficiary in writing of not meeting criteria: 3

Number late letters: 0

* * * * * *

Number pending from last quarter: 12 *DAIL-7; DMH-1; DVHA-4*

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

Total pending from ALL quarters: 15 *DAIL-10; DMH-1; DVHA-4*

Number of total pending that were resolved this quarter: 12

Number upheld:	6	50%	*DAIL-4; DMH-1; DVHA-1*
Number reversed:	2	17%	*DVHA-2*
Number modified:	3	25%	*DAIL-3*
Number approved by Dept/DA/SSA:	0	0%	
Number withdrawn:	1	8%	*DVHA-1*

Resolution time frames for resolving above cases:

Within 30 days:	42%	*DAIL-2; DMH-1; DVHA-2;*
Within 45 days:	83%	*DAIL-5; DMH-1; DVHA-4*
Within 59 days:	83%	
Extended (0) vs. Late (0)		
Over 59 days:	17%	*DAIL-2 [63 & 95 Days]*

Number of appeals still pending from all previous quarters: 3 *DAIL-3; DS-NKMH-2 (526 Days Pend); Attend Srvs-1 (299 Days Pend)*

Fair Hearings

Total number of Fair Hearings filed: 6 *DAIL-3; DVHA-3*

Number of Fair Hearings filed with a concurrent appeal: 3 *DVHA*

Number of Fair Hearings filed after appeal resolution: 3 *DAIL*

Number pending: 5 *DAIL-3; DVHA-2*

Number resolved: 1

Number upheld:	0	
Number reversed:	0	
Number modified:	0	
Number dismissed:	0	
Number withdrawn:	1	*DVHA*

Average number of days for resolution: 21

* * * * *

Number of pending Fair Hearings from previous quarters: 19 DAIL-3; DVHA-16

Number of pending Fair Hearings from previous quarters resolved this quarter: 3

Number upheld:	2	*DVHA*
Number reversed:	0	
Number modified:	0	
Number dismissed:	1	*DAIL*
Number withdrawn:	0	

Average number of days for resolution for pending Fair Hearings from previous quarters: 154

Number of pending Fair Hearings from previous quarters still pending at the end of this quarter: 21 *DAIL-5; DVHA-16*

ATTACHMENT 5

Office of Health Care Ombudsman

264 N. Winooski Ave.
P.O. Box 1367
Burlington, VT 05402
802-863-2316, 800-917-7787 (Voice)
802-863-2473, 888-884-1955 (TTY)
FAX 802-863-7152

QUARTERLY REPORT
April 1, 2010 – June 30, 2010
to the
DEPARTMENT OF VERMONT HEALTH ACCESS

I. Overview

This is the Office of Health Care Ombudsman's (HCO) report to the Department of Vermont Health Access (DVHA) for the quarter April 1, 2010 through June 30, 2010. We received 237 calls (35%) from DVHA program beneficiaries this quarter, compared to 253 (36%) last quarter.

The total number of all cases/all coverages that we opened this quarter was 678, compared to 696 last quarter. This compares to 702 calls in the second quarter of 2009, 687 in 2008, and 645 in 2007. The call volume for each of the months in this quarter was about average as compared to previous years. [See the tables at the end of this narrative for further detail.]

A. Eligibility

The percentage of calls related to eligibility for state programs has remained high. This quarter we had 193 calls related to eligibility or 28.47% of all calls. Last quarter we received 235, or 33.76% of all calls. In 2008 we received 143 calls related to eligibility in the second quarter, or 20.82%. 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 callers who were uninsured dropped to 55, down from 73 last quarter. Calls from the uninsured are usually about eligibility for state programs. This quarter 78.18% of those calls were regarding eligibility, with access to care a distant second at 12.73%. The number of calls from uninsured callers has remained relatively consistent over the past three years. In 2009, 64 callers per quarter on average were uninsured. In 2008 the average was 52. In 2007 it was 64.

We continue to see significant numbers of problems related to eligibility determinations. A look at all issues, not just the primary issues of callers, reveals some serious problems in this area. Note that this means some of the numbers below overlap, that is, some of the 26 Department for Children and Families (DCF) mistake cases could also involve lost paperwork. Of the 193 calls about eligibility this quarter:

- 10 involved application processing delays (compared to 17 last quarter);

- 14 involved the Buy In (Medicare Savings) Programs (compared to25);
- 26 involved DCF mistakes (compared to 32);
- 13 involved lost paperwork, meaning that callers said they gave DCF paperwork and were subsequently told there was no record of it (compared to 17);
- 18 involved the Medicaid Spend Down program (compared to 22);
- 5 involved an error by Member Services (compared to 7); and
- 8 involved DCF Modernization complaints, listed in the issue section "Other" as these are not strictly related to eligibility problems (compared to 3).

In addition to these eligibility issues, the HCO discovered that DCF has not been applying an earned income disregard when determining eligibility for its programs as required by the federal American Recovery and Reinvestment Act of 2009 (ARRA). This income disregard went into effect on January 1, 2010 and sunsets December 31, 2010. The failure to implement it came to light when the HCO was helping a client whose seriously ill son was terminated from Dr. Dynasaur because the Health Access Eligibility Unit (HAEU) had determined the family to be over income by $65. The mother was distraught. We learned that the family had not been given the earned income exclusions required by the ARRA. When the ARRA exclusion was properly applied, the family was $1 under the Dr. D income limit and thus eligible for the program.

DCF acknowledges that the failure to apply the ARRA disregard is a systemic problem potentially affecting many people. It means some individuals may have been incorrectly terminated from benefits, denied benefits or put on the wrong program. DCF has assured the HCO that these problems will be corrected as quickly as possible. The HCO intends to work with DCF to make sure this happens. At this writing DCF has not identified the number of individuals affected, how it will make them "whole" and how quickly this will be accomplished.

B. Access to Care

This quarter we had a total of 184 calls related to Access issues or 27.14% of all calls. Of these, 89 (48%) were from DVHA beneficiaries. In the previous quarter we had 170 total Access calls, with 84 (49%) coming from DVHA beneficiaries. Since only about 35% 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 issues consistently runs about 35%; this quarter it was slightly higher at 37.55%. For beneficiaries of commercial carriers it usually runs about 20-25%. This quarter only 30 individuals on commercial plans called us about access issues. Access is clearly a bigger issue for DVHA beneficiaries.

C. Hybrid programs

We track hybrid program problems, which involve both government and commercial insurance, because these tend to be more complicated and take more time to sort out. We received 109 of our total calls (16%) related to the hybrid programs as the primary issue, compared to 125 calls (18%) last quarter. We received 31 calls about federal Medicare Modernization Act (Medicare Part C, Medicare Part D and VPharm) issues, compared to 49 calls last quarter. For the state

hybrid programs (Catamount Health and the Premium Assistance programs), we received 76 calls this quarter, compared to 76. [See table at the end of this narrative for detail.]

D. Pain Management

The number of calls related to pain management remained about the same this quarter. We received 16 calls with pain management as the primary issue, down from 17 last quarter. However, 25 calls involved a pain management issue, compared to27 last quarter. Of these 25, 12 involved DVHA beneficiaries, which is 48% (compared to 56% last quarter). We had six callers on commercial insurance with a pain management issue. Thus, this continues to be primarily a state program problem.

E. Mental Health and Substance Abuse Treatment

This quarter 13 calls were coded as having a primary issue of mental health treatment access and four as mental health billing. However, nine additional calls involved mental health treatment access as an issue, and three more involved mental health billing, when secondary issues are considered. The primary issue figures do not include substance abuse.

We received no calls related to access to substance abuse treatment as a primary issue this quarter, compared to six last quarter.

F. Access to Dental Care

We received seven calls from DVHA beneficiaries regarding access to dental care. One was from an individual in pain who could not find a dentist who would see him. DVHA gave him direct assistance to find a dentist at the HCO's request. Another person called saying his dentist would not accept Medicaid, but later he did not return our calls, so the case was closed. Two people called saying they couldn't get dental care and upon investigation we determined they had maxed out their $495 in dental care under Medicaid for the year. Two people called saying they needed help getting dental care and we figured out that they had been switched from Medicaid to VHAP (correctly) and so were no longer eligible for a dental benefit. And one beneficiary called because she needed dentures, which is not a covered service.

Note that we also received ten additional calls from individuals who were not DVHA beneficiaries who were also having access to dental care problems.

II. Break down of callers by type of insurance:

- **DVHA programs** (Medicaid, VHAP, VHAP Pharmacy, a Premium Assistance program, VScript, VPharm, or both Medicaid and Medicare) insured **35%** (237 callers), compared to 36% (253) last quarter;
- **Medicare** (Medicare only, Medicare and Medicaid, Medicare and a Medicare Savings Program aka a Buy-In program, or Medicare and VPharm) insured **20%** (139), compared to 18% (126) last quarter;
    - 11% (78) had Medicare only, compared to 11% (76) last quarter;

    - 9% (61) had both Medicare coverage and coverage through a state program such as Medicaid, a Medicare Savings Program aka a Buy-In program, or VPharm, as compared to 7% (50) last quarter;
- **Commercial carriers** (employer sponsored insurance, individual or small group plans, but not including Catamount Health plans) insured **21%** (142), compared to 19% (123) last quarter;
- **8%** (55) identified themselves as **uninsured**, compared to 10% (71) last quarter;
- **4%** (25) had a **Catamount Health** plan, compared to 5% (34) last quarter; and
- The remainder of callers' insurance status was either unknown or not relevant.

III. Disposition of DVHA cases

We closed 250 DVHA cases this quarter, compared to 236 last quarter:

- About 1% (3 calls) from DVHA beneficiaries were resolved in the initial call, compared to 3% (7 calls) last quarter;
- 58% (145 calls) were resolved by advice or referral, after an analysis of the problem. Last quarter 55% (130 calls) were resolved in this manner;
- 19% (47 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 27% (63 calls) were resolved in this manner;
- About 7% (17 calls) were considered complex intervention, which involves complex analysis and more than two hours of an advocate's time, compared to 7% (16 calls) last quarter.

IV. Issues raised by DVHA beneficiaries

We opened 237 cases from DVHA beneficiaries, compared to 253 last quarter. Of these:

- 37.55% (89 calls) involved Access to Care, compared to 33.47% (84 calls) last quarter;
- 16.46% (39 calls) involved Billing/Coverage, compared to 13.44% (34 calls) last quarter;
- 2.53% (6 calls) were coded as Consumer Education, compared to 3.16% (8 calls) last quarter;
- 29.11% (69 calls) involved Eligibility, compared to 34.78% (88 calls) last quarter; and
- 13.92% (33 calls) involved Other issues, compared to 15.42% (39 calls) last quarter, which includes Medicare Part D calls.

A. Access to Care

We received 89 DVHA Access to Care calls, compared to 84 last quarter. The top call volume primary issues within this category were:

- 21 involved access to Prescription Drugs (with none about VPharm Therapeutic Substitution), compared to 19 last quarter;
- 10 involved Specialty Care, compared to 9 last quarter;
- 10 involved Transportation, compared to 3;

- 9 involved Pain Management, compared to 10; and
- 9 involved Dental, Dentists or Orthodontics, compared to 9.

The top access issues when secondary issues are considered as well were:

- 31 Prescription Drug;
- 24 Specialty Care;
- 13 Transportation;
- 12 Pain Management;
- 11 Dental, Dentists and Orthodontia;
- 11 Affordability;
- 10 Delay in Obtaining Care;
- 10 Mental Health;
- 9 Clinical Denial of Care;
- 8 Urgent Care; and
- 6 Primary Care Doctor.

B. Billing/Coverage

We received 39 DVHA primary issue calls in this category, compared to 34 last quarter:

- 12 involved Medicaid/VHAP Managed Care, compared to 12 last quarter; and
- 9 involved Hospital Billing, compared to 9 last quarter.

C. Eligibility

We received 69 DVHA primary issue calls in this category from current DVHA beneficiaries, compared to 86 last quarter:

- 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

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	
August	189	236	214	216	250	152	173	
September	222	191	172	181	167	147	218	
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	1375

Catamount Health & Premium Assistance

	2007	2008	2009	2010
January		39	24	23
February		21	19	20
March		29	21	33
April		22	11	20
May		17	19	19
June		29	21	37
July		20	20	
August		14	17	
September		17	20	
October	27	25	20	
November	30	12	11	
December	23	23	11	
Total	80	268	214	152

Medicare Modernization Act--Part D, Part C (added 6/08) & VPharm

	2006	2007	2008	2009	2010
January	118	64	32	21	21
February	28	20	35	16	13
March	29	27	18	23	15
April	43	28	19	9	11
May	83	25	15	18	6
June	80	26	18	22	14
July	43	19	15	16	
August	39	28	7	4	
September	25	17	9	30	
October	32	14	13	7	
November	37	25	15	9	
December	35	21	16	5	
Total	592	314	212	180	80

All Eligibility, by County

County	All Eligibility	Lost Paperwork	DCF Mistakes
Unknown	38	1	4
Addison	6	1	0
Bennington	11	0	1
Berkshire	1	0	0
Caledonia	8	1	4
Chittenden	50	5	8
Franklin	7	1	0
Lamoille	8	0	2
Middlesex	1	0	0
Orange	3	2	0
Orleans	7	0	0
Rutland	15	2	1
Suffolk	1	0	0
Washington	14	0	4
Windham	16	0	0
Windsor	7	0	2
Total	193	13	26

ATTACHMENT 6

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