State of Vermont
Agency of Human Services

Global Commitment to Health
11-W-00194/1

Section 1115
Demonstration Year: 4
(10/1/2008 – 9/30/2009)

Quarterly Report for the period
July 1, 2009 to September 30, 2009

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

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

One of the Terms and Conditions of the Global Commitment Waiver requires the State "to submit progress reports 60 days following the end of each quarter. ***This is the fourth quarterly report for waiver year four, covering the period from July 1, 2009 to September 30, 2009.***

Enrollment Information and Counts

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

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

Enrollment counts are person counts, not member months.

Demonstation Population	Current Enrollees Last Day of Qtr 9/30/2009	Previously Reported Enrollees Last Day of Qtr 6/30/2009	Variance 9/30/09 to 6/30/09
Demonstration Population 1:	43,369	42,782	1.37%
Demonstration Population 2:	42,781	42,841	-0.14%
Demonstration Population 3:	9,711	9,563	1.55%
Demonstration Population 4:	N/A	N/A	N/A
Demonstration Population 5:	1,127	1,159	-2.76%
Demonstration Population 6:	2,683	2,757	-2.68%
Demonstration Population 7:	30,864	30,230	2.10%
Demonstration Population 8:	7,406	7,821	-5.31%
Demonstration Population 9:	2,552	2,581	-1.12%
Demonstration Population 10:	N/A	N/A	N/A
Demonstration Population 11:	8,951	8,236	8.68%

Green Mountain Care Outreach / Innovative Activities

During the fourth quarter, the Office of Vermont Health Access continued its efforts to reach recent graduates and their parents about Green Mountain Care. During July the Lake Champlain Regional Chamber of Commerce, Vermont's largest business organization, informed its 6,000 members that Green Mountain Care was available to dependents that aged off their parents' plans. The Vermont League of Cities and Towns followed suit by contacting all 234 of its member towns. They used email, newsletter and direct mail to 2,500 subscribers of their association's health plan. In it they asked parents to verify whether or not their dependents were students, and if not, information was provided about Green Mountain Care.

The OVHA has found that partnering with other state agencies is an effective means of outreach. In efforts to reach farmers during these economically challenging times, the Department of Agriculture included an article about Green Mountain Care in a special resource newsletter. During the month of September, we also partnered with the State Lottery which printed a message about Green Mountain Care on all Powerball and Megabucks Plus tickets.

For the second year in a row, Green Mountain Care hosted a booth during a three-day outdoor event which attracted 20,000 people.

Aligning materials, websites and messaging under the Green Mountain Care brand continues to be an on-going effort for the OHVA as well as in other departments within state government. This is essential in order for information to be consistent and easily understood by consumers

During the fourth quarter OVHA also partnered with the Department of Labor to reach a total of 251 laid off workers with information about Green Mountain Care.

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 September there were 10,063 individuals enrolled. (Correction to the third quarter report: Enrollment in the premium assistance programs was 9,377; the 10,697 number given in the report included enrollees in Catamount Health with no premium assistance.)

Vermont submitted a waiver amendment request to CMS in late August to implement two minor changes to eligibility required by H.444, an omnibus health care reform bill passed during the 2009 legislative session. The two changes to the 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. However, because the existing statutory requirement in H.444 to submit the request to CMS can not be rescinded by the Joint Fiscal Committee, the State was obligated to submit the request. The request also noted that this decision to rescind the funds for these purposes would most likely be discussed when the entire General Assembly reconvenes in January, 2010.

Another bill, H.235, passed by the legislature this year charges OVHA with submitting a report 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.

Operational/Policy Developments/Issues

Catamount Health Premium Assistance Programs: The OVHA issues monthly reports on enrollment numbers and demographics, as well as a Catamount Fund financial report. The report that includes the actual enrollment as of the end of September 2009 is included as Attachment 1.

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

The OVHA, in conjunction with the Vermont Department of Health (VDH), has implemented 12 targeted initiatives listed below to provide a comprehensive, balanced approach to improve oral health and oral health access for all Vermonters. Updates as of September 30, 2009 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.

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 is scheduled to continue in SFY 2010.

The Dental Dozen is a multi-pronged effort that reaches out to providers, beneficiaries and future providers for Vermont. The initiatives will require a number of years to achieve measurable improvement and desired results. This concerted effort started in SFY '08 and will continue to receive emphasis and support in the future.

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, engaging them in changing their own behavior, and facilitating their 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 patient 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 who 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 using Adjusted Clinical Group predictive modeling performed by OVHA's Data Unit, and then are stratified into those at highest risk and most likely to benefit from intensive case management services, and those for whom less intensive disease management services are sufficient. 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 began providing face-to-face intensive care coordination case management services in 2006 to the highest risk, 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.

Beginning 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 care coordination. This unique and sophisticated 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 chronic care management computer 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. Participating providers are reimbursed $55 for meeting with care coordination staff when one of their patients is enrolled in care coordination services, $55 for a "discharge" meeting to emphasize the importance of a smooth transition to a less intense level of service, and an enhanced capitated payment rate of $15 per month for each care coordination participant.

July 1, 2009, marked the beginning of the third year of expanded operations. During the first two years, some level of intervention services was provided to over 25,000 beneficiaries. Vermont's state budget rescission for State Fiscal Year 2009 included elimination of $872,720, or approximately 25%, from the funds budgeted for the APS Healthcare contract. As a result, resources were refocused and services changed for some beneficiaries effective October 1, 2008. Specifically, efforts focused 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 services from a registered nurse. The goal for year 3 is to provide the same level of services to an additional 4,000 members.

During the third quarter of FFY 2009, the OVHA contracted with the University of Vermont (UVM) for VCCI program monitoring, evaluation, and identification of quality improvement projects. UVM began a thorough evaluation of VCCI administrative (claims) data, and began a Medical Record Review during the fourth quarter. 1,000 chart audits are being conducted on VCCI beneficiaries with diabetes and/or hypertension. Using administrative and MRR data, UVM will identify clinical quality measures amenable to performance improvement activities likely to have the greatest impact on the VCCI managed population, assist with implementing quality improvement activities, and evaluate the VCCI's success at improving clinical and utilization outcomes.

Highlights of the Vermont Chronic Care Initiative

- Utilization and savings trend data are not yet available for program Year 2, due to the requirement for a 6 month claims run out period. (During Year 1, hospital admissions were reduced by 10.66% and emergency room used decreased by 6%.)
- OVHA Care Coordinators began providing case management to buprenorphine patients from five pilot provider practices. CareConnection® was enhanced to accommodate tracking of identified buprenorphine measures and data are transferred monthly from APS to the buprenorphine evaluation team at UVM.
- During the fourth quarter of FFY 2009, the average monthly program caseload was 2,042. The average monthly caseload for all FFY 2009 was 3,339. Monthly caseload includes beneficiaries in active outreach by CCI staff, as well as those successfully engaged and receiving care coordination or health coaching services.
- 2,963 unique beneficiaries were served by either OVHA care coordinators or APS disease management health coaches since the beginning of FFY 2009 (10/1/08 to 9/30/09). Beginning July 1, 2009, additional services were required before a beneficiary could be considered "served." 247 members were served during the fourth quarter of FFY 2009. During the second full program year of enhanced services (7/1/08 to 6/30/09), the VCCI provided care coordination and/or nurse health coaching services to 3,189 different beneficiaries.

Buprenorphine Program: Many physicians limit the number of opiate dependent patients they treat because of the challenging nature of caring for this population (i.e., missed appointments, diversion, time spent by office staff, complex medical needs). The end result is that most physicians see far fewer patients than they could. The Office of Vermont Health Access (OVHA), in cooperation with the Vermont Department of Health (VDH) Alcohol & Drug Abuse Program (ADAP), the Department of Corrections (DOC), and the commercial insurers, aims to increase access for patients to Buprenorphine services, increase the number of physicians in Vermont licensed to prescribe Buprenorphine and to support practices caring for the opiate dependent population.

In July 2008, the legislature appropriated an additional $500,000 for SFY'09 to continue the Buprenorphine Program. The OVHA, in collaboration with ADAP, will utilize these funds to maintain the capitated payment program which increases reimbursement to physicians in a step-wise manner depending on the number of patients treated by a physician who was enrolled in the program.

The Capitated Payment Methodology is depicted below:

Level	Complexity Assessment	Rated Capitation Payment				Final Capitated Rate (depends on the number of patients per level, per provider)
III.	Induction	$348.97	+	**BONUS**	=	
II.	Stabilization/Transfer	$236.32				
I.	Maintenance Only	$101. 28				

Buprenorphine Program Payment Summary FFY '09	
Oct-08	$ 34,942.14
Nov-08	$ 34,723.02
Dec-08	$ 36,569.72
Jan-09	$ 40,406.92
Feb-09	$ 39,303.34
Mar-09	$ 35,056.95
April-09	$ 36,993.53
May-09	$ 49,150.85
June-09	$ 43,934.51
July-09	$ 65,686.23
Aug-09	$ 58,996.59
Sept-09	$ 55,450.68
Total	$ 531,214.48

As of the 1st quarter in FFY '09, the Capitated Program for the Treatment of Opiate Dependency (CPTOD) as implemented by the OVHA has 30 enrolled providers, approximately 386 patients undergoing opiate addiction treatment and has paid $106,234.88 to the 30 providers. In the 2nd quarter in FFY '09 the program has 30 enrolled providers, approximately 397 patients are undergoing treatment and $221,002.09 has been paid out to the 30 providers. In the 3rd Qtr in FFY '09 the program has 33 enrolled providers, approximately 412 patients are undergoing treatment and a total of $351,080.98 has been paid out to the 33 providers. In the 4th quarter in FFY '09 the program has 32 enrolled providers, approximately 496 patients are undergoing treatment and $531,214.48 has been paid out to the 32 providers. The program continues to be successful at increasing patient access to providers who are licensed to prescribe Buprenorphine in Vermont.

In 2009 OVHA started enrolling beneficiaries' who are on buprenorphine into case management services, which will be provided by OVHA's Chronic Care Initiative (CCI). Initially, the OVHA assigned case managers to four practice sites and in September a fifth site was added. APS was involved in the beginning of the start-up and agreed to update their case management software so that the care coordinators can record all of the data that will be used by UVM to evaluate the success of the program. Additionally, APS provides UVM with the monthly data refreshes on the individuals that are eligible for the program. OVHA, ADAP, and UVM meet on a bi-monthly basis to review the work plan and to identify areas for improvement in the program. In addition, meetings have occurred between ADAP, OVHA, and the five practice sites to review the program metrics and to review the expectations of the provider contracts as it relates to evidenced based guidelines. The goal is to provide an optimum environment for Medicaid beneficiaries to receive treatment for opiate addiction while also providing support to the medical offices that care for this challenging population.

Mental Health – Vermont Futures Planning

The community-based programs designed to reduce the need for State Hospital services and provide a cost effective alternative to care at Vermont State Hospital are entering the final phase of development. Meadowview - the six-bed community residential recovery program in the Brattleboro area is under contract and renovations to the facility are expected to be completed by mid-November 2009 and the program expects to begin accepting residents in early December. The program team, in collaboration with the VSH clinical leadership, is identifying potential residents from patients currently at VSH whose treatment needs exceed the capacities of the ongoing care system. Meadowview will be licensed as a Level Three Residential Care Facility, will become the newest program in the Community

Rehabilitation and Treatment (CRT) system, and will offer a clinically appropriate, lower cost alternative to inpatient care.

The team developing the peer crisis alternative program presented a detailed report with implementation recommendations to the Transformation Council (the multi-stakeholder group created in statute to guide the Futures planning) and the recommendation to hire a project developer and create a new 501 C-3 organization for the program has been accepted. A program development contract with Vermont's state-wide mental health consumer organization is in process.

The consultation to design a care management system has been completed. A representative steering committee of inpatient and community providers has met and beginning this fall three working groups are:

- Developing consensus medical clearance protocols for all hospital emergency departments to use when referring individuals for psychiatric inpatient care
- Creating a real-time "bed board" to identify inpatient and crisis bed availability state-wide for use by the emergency and inpatient providers.
- Use of a standardized assessment tool (the LOCUS) to describe clinical acuity and to help guide placement dispositions state –wide.

The planning to develop a 15-bed secure (locked) adult psychiatric treatment and recovery residential program on the grounds of the state office complex in Waterbury described in the FFY 08 annual report and the last quarterly report is proceeding. Clinical leaders from the VSH and the community are meeting to design the treatment program under the leadership of the DMH medical director. An architectural team with expertise in the design of psychiatric treatment facilities meets bi-weekly with consumers, family members, and service providers to design the proposed building. More than twenty planning meetings have been convened between April and October 2009 involving peers, family members, clinical leaders and architects. The design work on staffing, programming, and architecture will culminate in a Certificate of Need Application in the winter of 2010 (pending legislative approval).

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 proposed, it will provide a clinically appropriate lower cost option to hospital-level care and will be included in the Community Rehabilitation and Treatment (CRT) program.

On June 28th the Department of Mental Health issued a Request for Bids and Conceptual Proposals for VSH replacement inpatient services. The "RFP" was sent to each of Vermont's hospitals and to Dartmouth Hitchcock Medical Center. The RFP detailed the requirements for VSH replacement services and solicits bids or planning proposals including estimated costs to operate new or enhanced inpatient services, staffing plans, capital costs for renovation or new construction, revenue projections, and implementation timeframes. Five hospitals provided letters of intent to propose replacement inpatient services: Fletcher Allen Health Care, Rutland Regional Medical Center, Springfield Hospital, Dartmouth Hitchcock Medical Center, and the Brattleboro Retreat.

The proposal responses outlined several opportunities and the Department of Mental Health is conducting follow up work on each of them. Four of the proposals were "conceptual" indicating that they are in the very early stages of planning. These are:

- Springfield Hospital proposes to re-focuses the current 10-bed psychiatric inpatient program to serve much higher level acuity patients and to develop a 10-bed medically monitored crisis stabilization program.
- The Brattleboro Retreat proposes developing a new 16-bed acute care inpatient program with a licensing partner (perhaps the Brattleboro Memorial Hospital).
- Dartmouth Hitchcock Medical Center and the Veteran's Administration Hospital in White River Jct. propose creating a new psychiatric inpatient program on the VA campus.
- Fletcher Allen Health care offers that it could begin planning for a twenty-bed expansion program in 2014 or 2015.

The Rutland Regional Medical Center offered a bid to build a new 28-bed program to replace the current service (whose facilities are extremely limited) and develop an expansion program to help replace Vermont State Hospital services. Center and the White River Junciton Veteran's Administration Hospital responses will be used to develop a "Master Plan" to replace VSH as required by the Legislature.

Consistent with the requirements in the Vermont 2010 Capital Bill, DMH and RRMC are exploring options to capitalize the construction of a new building for the expansion program on the RRMC campus. On October 1st the Joint Fiscal Office and the Treasurer's office provided the Joint Fiscal and Mental Health Oversight Committees with an independent assessment of the feasibility of the proposed capitalization approach. The report found the approach "reasonably feasible" but difficult to implement in the current market. On October 28th the two Legislative Oversight Committees voted not to object to continue planning for this project. Further exploration of the capital markets and potential refinement of the proposed structure will therefore continue.

As envisioned, the 28-bed program would provide voluntary, involuntary, and special designation acute intensive involuntary inpatient care in three programmatic and physical clusters. The program would operate as a single, integrated service with patients being admitted to and transferring between programmatic levels based on clinical needs. The bid proposal offered by RRMC included staffing and operations costs which provide a preliminary basis for rate-setting for the program.

Financial/Budget Neutrality Development/Issues

On August 31, 2009, AHS submitted the IGA for FFY10 to CMS. Effective October 1, 2009, AHS began paying OVHA the PMPM capitation payment per the rates in the IGA for FFY10, in addition to the monthly FFY09 trueup payments. The September 1, 2009 capitation payment reflects the last payment made for FFY08; no further trueups for FFY08 will occur past that point.

AHS received guidance of EFMAP recalculation for QE0609 from the Department of Health and Human Services on July 31, 2009. The EFMAP was raised from 9.38% to 10.51% for that quarter; accordingly, AHS drew in an additional $2.3M in ARRA funding for QE0609 on August 4, 2009.

AHS and OVHA are currently working with EDS to ensure that our reporting capabilities will be able to support the new CMS-MBES system requirements for the QE1209 CMS-64 submission.

Member Month Reporting

Demonstration project eligibility groups are not synonymous with Medicaid Eligibility Group reporting

in this table. For example, an individuals in the Demonstration population 4 HCBS (home and community based services) and Demonstration Project 10 may in fact be in Medicaid Eligibility Group 1 or 2. Thus the numbers below may represent duplicated population counts.

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

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

Demonstation Population	Month 1	Month 2	Month 3	Total for Quarter Ending 4th Qtr	Total for Quarter Ending 3nd Qtr	Total for Quarter Ending 1st Qtr	Total for Quarter Ending 4th Qtr	Total for Quarter Ending 3rd Qtr	Total for Quarter Ending 2nd Qtr	Total for Quarter Ending 1st Qtr
	7/15/2009	8/15/2009	9/15/2009	FFY '09	FFY '09	FFY '09	FFY '08	FFY '08	FFY '08	FFY '08
Demonstration Population 1:	43,061	43,320	43,275	129,656	128,203	125,825	123,997	122,281	121,926	120,113
Demonstration Population 2:	42,994	42,847	42,857	128,698	128,590	122,210	121,981	123,283	122,118	120,309
Demonstration Population 3:	9,816	9,825	9,787	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
Demonstration Population 5:	1,129	1,145	1,136	3,410	3,568	3,832	3,850	3,767	3,542	3,767
Demonstration Population 6:	2,784	2,702	2,602	8,088	7,480	8,208	7,428	7,357	6,208	6,084
Demonstration Population 7:	29,437	29,807	29,914	89,158	87,116	75,277	74,301	73,966	72,336	65,803
Demonstration Population 8:	7,195	7,323	7,387	21,905	23,165	22,032	21,715	23,100	22,697	22,445
Demonstration Population 9:	2,518	2,551	2,565	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
Demonstration Population 11:	8,553	8,814	9,077	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 MCO, 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 MCO Grievance and Appeal report. This report is based on data entered by grievance and appeal coordinators in various locations throughout the MCO (see Attachment 3). The unified MCO 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 submitted the initial PIP summary form to the External Quality Review Organization (EQRO) for review. This year's document focused on steps five and six of the CMS protocol (i.e., reviewing sampling methods and reviewing data collection methods). After an initial review, the EQRO provided the group with two points of clarification. The PIP work group decided to address these points of clarification, modify their initial submission, and resubmit the modified document to EQRO for review. It is anticipated that the EQRO will review the modified submission form and produce a final report during the next quarter. Also during this quarter, the MCO submitted Performance Measure (PM) source code and supporting documentation to help inform the EQRO PM Validation activities. After reviewing the documents, the EQRO conducted an on-site review of the MCO. During the visit, the EQRO conducted the following: opening meeting, evaluation of system compliance, review of ISCAT and supporting documentation, overview of data integration and control procedures, primary source verification, and a closing conference. It is anticipated that a final report will be produced by the EQRO during the next quarter. Also during this quarter, the MCO submitted documents demonstrating its compliance with Federal Medicaid MCO Measurement & Improvement standards. After reviewing the document, the EQRO conducted an on-site review of the MCO. During the visit, the EQRO conducted the following: opening conference, review of documents, interviews with key staff, and a closing conference. It is anticipated that a final report will be produced by the EQRO during the next quarter. Finally, the AHS QIM reviewed a draft copy of the EQRO annual technical report. This document combines the results of all three external quality review activities and identifies strengths and challenges associated with the three activities as well as making recommendations to improve the timeliness, access, and quality of services provided by the MCO. It is anticipated that this document will be produced by the EQRO by the end of next quarter.

Quality Assurance Performance Improvement Committee (QAPI): During this quarter, the Quality Assessment and Performance Improvement (QAPI) Committee began to discuss the scope of next year's MCO Compliance Review. This discussion focused on the four Access sub-standards contained in the Code of Federal Regulations (i.e., availability of services, assurances of adequate capacity and services, coordination and continuity of care, and coverage and authorization of services). The Committee reviewed the requirements associated with each sub-standard and discussed its role in helping OVHA to comply with them. Also during this quarter, the group discussed the importance of developing work plans associated with each of the activities contained in the MCO Quality Plan. This type of planning will help to ensure a timely completion of MCO quality assessment and performance improvement deliverables. During this quarter, the group discussed the committee structure. It was agreed that the current structure of the committee was adequate to address the monitoring/oversight needs of the Agency as well as the quality assessment and performance improvement needs of the MCO. It was agreed that other MCO staff would be invited to future meetings to present the results of their work. Also during this quarter, the committee discussed their role in assessing the performance of MCO investments. It was agreed that the committee was the appropriate forum, but clear expectations would need to be identified before the group could take further action. Finally, the group discussed the role that performance measures play in establishing a performance management system. The group agreed to recommend and discuss possible performance measures to be used in an Agency-wide dashboard. This approach appears to be in line with broader State-wide support for the use of Performance measures. During the next quarter, the group will continue to develop a list of sample measures to support an Agency-wide reporting mechanism.

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

During this quarter, the AHS Quality Improvement Manager (QIM) reviewed the interim evaluation report of the Global Commitment to Health 1115 Waiver prepared by Pacific Health Policy Group (PHPG). Feedback was given and modifications were made to the document. At the end of the quarter, the document accompanied the State's formal waiver extension request to CMS. Once the outcome of the waiver extension request is known, the AHS QIM 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 MCO 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 MCO Grievance and Appeal Reports
Attachment 5: Office of VT Health Access Ombudsman Report
Attachment 6: OVHA MCO 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
MCO:	Susan W. Besio, PhD, Director	
	VT Office of Health Access	802-879-5901 (P)
	312 Hurricane Lane, Suite 201	802-879-5952 (F)
	Williston, VT 05495	susan.besio@ahs.state.vt.us

Date Submitted to CMS: November 30, 2009

ATTACHMENTS

VERMONT

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

Office of Vermont Health Access
SFY 10 Catamount Health Actual Revenue and Expense Tracking
Tuesday, October 20, 2009

	SFY '10 Appropriated				Consensus Estimates for SFY to Date				Actuals thru 9/30/09				
	<=200%	>200% before 10/1/09	>200% after 10/1/09	Total	<=200%	>200% before 10/1/09	>200% after 10/1/09	Total	<=200%	>200% before 10/1/09	>200% after 10/1/09	Total	% of SFY to-Date
MONTH END ENROLLMENT DETAIL													
TOTAL PROGRAM EXPENDITURES													
Catamount Health	30,315,950	3,202,483	11,776,319	45,294,752	7,009,953	3,202,483	-	10,212,435	6,734,404	2,911,675	-	9,646,079	94.45%
Catamount Eligible Employer-Sponsored Insurance	1,061,694	116,345	427,831	1,605,870	245,394	116,345	-	361,738	233,421	108,793	-	342,214	94.60%
Subtotal New Program Spending	31,377,644	3,318,828	12,204,150	46,900,622	7,255,346	3,318,827	-	10,574,174	6,967,825	3,020,469	-	9,988,294	94.46%
Catamount and ESI Administrative Costs	1,523,958	242,689	899,587	2,666,234	380,990	242,689	-	623,679	380,990	242,689	-	623,679	100.00%
TOTAL GROSS PROGRAM SPENDING	32,901,602	3,561,517	13,103,737	49,566,856	7,636,336	3,561,516	-	11,197,852	7,348,814	3,263,158	-	10,611,972	94.77%
TOTAL STATE PROGRAM SPENDING	**9,883,641**	**3,561,517**	**3,936,363**	**17,381,521**	**2,293,955**	**3,561,516**	**-**	**5,855,472**	**2,207,584**	**3,263,158**	**-**	**5,470,742**	**93.43%**
TOTAL OTHER EXPENDITURES													
Immunizations Program	-	625,000	1,875,000	2,500,000	-	625,000	-	625,000	-	625,000	-	625,000	100.00%
VT Dept. of Labor Admin Costs Assoc. With Employer Assess.	-	98,518	295,554	394,072	-	98,518	-	98,518	-	98,518	-	98,518	100.00%
Marketing and Outreach	500,000	-	-	500,000	125,000	-	-	125,000	125,000	-	-	125,000	100.00%
Blueprint	-	461,678	1,385,035	1,846,713	-	461,678	-	461,678	-	461,678	-	461,678	100.00%
TOTAL OTHER SPENDING	500,000	1,185,196	3,555,589	5,240,785	125,000	1,185,196	-	1,310,196	125,000	1,185,196	-	1,310,196	100.00%
TOTAL STATE OTHER SPENDING	**150,200**	**1,185,196**	**3,555,589**	**4,890,985**	**37,550**	**1,185,196**	**-**	**1,222,746**	**37,550**	**1,185,196**	**-**	**1,222,746**	**100.00%**
TOTAL ALL STATE SPENDING	**10,033,841**	**4,746,713**	**7,491,951**	**22,272,506**	**2,331,505**	**4,746,713**	**-**	**7,078,218**	**2,245,134**	**4,448,354**	**-**	**6,693,488**	**94.56%**
TOTAL REVENUES													
Catamount Health Premiums	4,559,808	1,079,635	3,970,083	9,609,526	1,070,948	1,060,686	-	2,131,634	984,371	773,747	-	1,758,118	82.48%
Catamount Eligible Employer-Sponsored Insurance Premiums	300,889	82,026	301,629	684,544	73,130	83,739	-	156,869	71,746	51,710	-	123,456	78.70%
Subtotal Premiums	4,860,697	1,161,661	4,271,712	10,294,070	1,144,078	1,144,425	-	2,288,503	1,056,117	825,457	-	1,881,574	82.22%
Federal Share of Premiums	(3,400,544)	-	(2,988,490)	(6,389,034)	(800,397)	-	-	(800,397)	(738,859)	-	-	(738,859)	92.31%
TOTAL STATE PREMIUM SHARE	1,460,153	1,161,661	1,283,222	3,905,036	343,681	1,144,425	-	1,488,106	317,258	825,457	-	1,142,715	76.79%
Cigarette Tax Increase ($.60 / $.80)				9,315,500				2,328,875				2,771,235	118.99%
Floor Stock				-				-				340,064	0.00%
Employer Assessment				7,124,207				1,781,052				1,202,000	67.49%
Interest				-				-				3,434	0.00%
State Fund Transfer due to Enhanced ARRA				(5,083,590)				(843,815)				(534,579)	63.35%
TOTAL OTHER REVENUE				11,356,117				3,266,112				3,782,154	115.80%
TOTAL STATE REVENUE	**1,460,153**	**1,161,661**	**1,283,222**	**15,261,153**	**343,681**	**1,144,425**		**4,754,218**	**317,258**	**825,457**		**4,924,869**	**103.59%**
State-Only Balance				(7,011,352)				(2,324,000)				(1,768,619)	
Carryforward				7,311,891				7,311,891				7,311,891	
(DEFICIT)/SURPLUS				**300,538**				**4,987,890**				**5,543,272**	
Reserve Account Funding				-				-				-	
REVISED (DEFICIT)/SURPLUS WITH RESERVE FUNDING				**300,538**				**4,987,890**				**5,543,272**	

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

Green Mountain Care Enrollment Report
September 2009

TOTAL ENROLLMENT BY MONTH

	Jul-07	Nov-07	Jul-08	Aug-08	Sep-08	Oct-08	Nov-08	Dec-08	Jan-09	Feb-09	Mar 09	Apr 09	May 09	Jun 09	Jul 09	Aug 09	Sep 09
Adults:																	
VHAP-ESIA	-	35	672	691	733	747	759	809	859	900	938	952	948	957	966	955	953
ESIA	-	21	336	358	413	447	499	569	504	489	519	542	577	578	586	589	633
CHAP	-	320	4,608	5,003	5,384	5,684	6,120	6,239	6,407	6,699	7,046	7,538	7,710	7,842	7,988	8,235	8,477
Catamount Health	-	120	697	701	785	853	932	991	1,011	1,103	1,168	1,220	1,243	1,320	1,339	1,404	1,455
Total	**-**	**376**	**6,313**	**6,753**	**7,315**	**7,731**	**8,310**	**8,608**	**8,781**	**9,191**	**9,671**	**10,252**	**10,478**	**10,697**	**10,879**	**11,183**	**11,518**

	Jul-07	Nov-07	Jul-08	Aug-08	Sep-08	Oct-08	Nov-08	Dec-08	Jan-09	Feb-09	Mar 09	Apr 09	May 09	Jun 09	Jul 09	Aug 09	Sep 09
Adults:																	
VHAP	23,725	24,849	26,441	26,721	26,622	26,900	26,860	27,198	28,038	28,957	29,451	30,064	30,747	30,997	31,270	31,605	31,629
Other Medicaid	69,764	69,969	70,947	70,846	71,638	71,403	35,601	35,610	36,893	37,019	37,290	37,331	37,663	37,857	37,930	38,117	38,207
Children:																	
Dr Dynasaur	19,738	19,733	19,960	20,061	20,251	20,481	20,511	20,468	20,630	20,717	20,649	20,636	20,675	20,798	20,705	20,466	20,525
SCHIP	3,097	3,428	3,396	3,363	3,415	3,504	3,527	3,482	3,606	3,105	3,140	3,264	3,290	3,330	3,398	3,412	3,430
Other Medicaid*	Included	Included	Included	Included	Included	Included	34,015	33,759	35,672	36,375	36,836	37,035	37,354	37,519	37,671	37,605	37,579
Total	**116,324**	**117,979**	**120,744**	**120,991**	**121,926**	**122,288**	**120,514**	**120,517**	**124,839**	**126,173**	**127,366**	**128,330**	**129,729**	**130,501**	**130,974**	**131,205**	**131,370**
TOTAL ALL	**116,324**	**118,355**	**127,057**	**127,744**	**129,241**	**130,019**	**128,824**	**129,125**	**133,620**	**135,364**	**137,037**	**138,582**	**140,207**	**141,198**	**141,853**	**142,388**	**142,888**

KEY:

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

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

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

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

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

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

Dr. Dynasaur = Enrolled in Dr. Dynasaur

SCHIP = Enrolled in SCHIP

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

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

Green Mountain Care Enrollment Report

Sep 2009 Demographics

Income	VHAP-ESIA*	ESIA*	CHAP*	TOTAL
0-50%	28	3	406	
50-75%	46	1	91	
75-100%	99	9	140	
100-150%	478	18	543	
150-185%	270	210	3,115	
185-200%	17	185	1,868	
200-225%	11	115	1,115	
225-250%	1	59	679	
250-275%	-	30	363	
275-300%	3	3	157	
Total	**953**	**633**	**8,477**	**10,063**

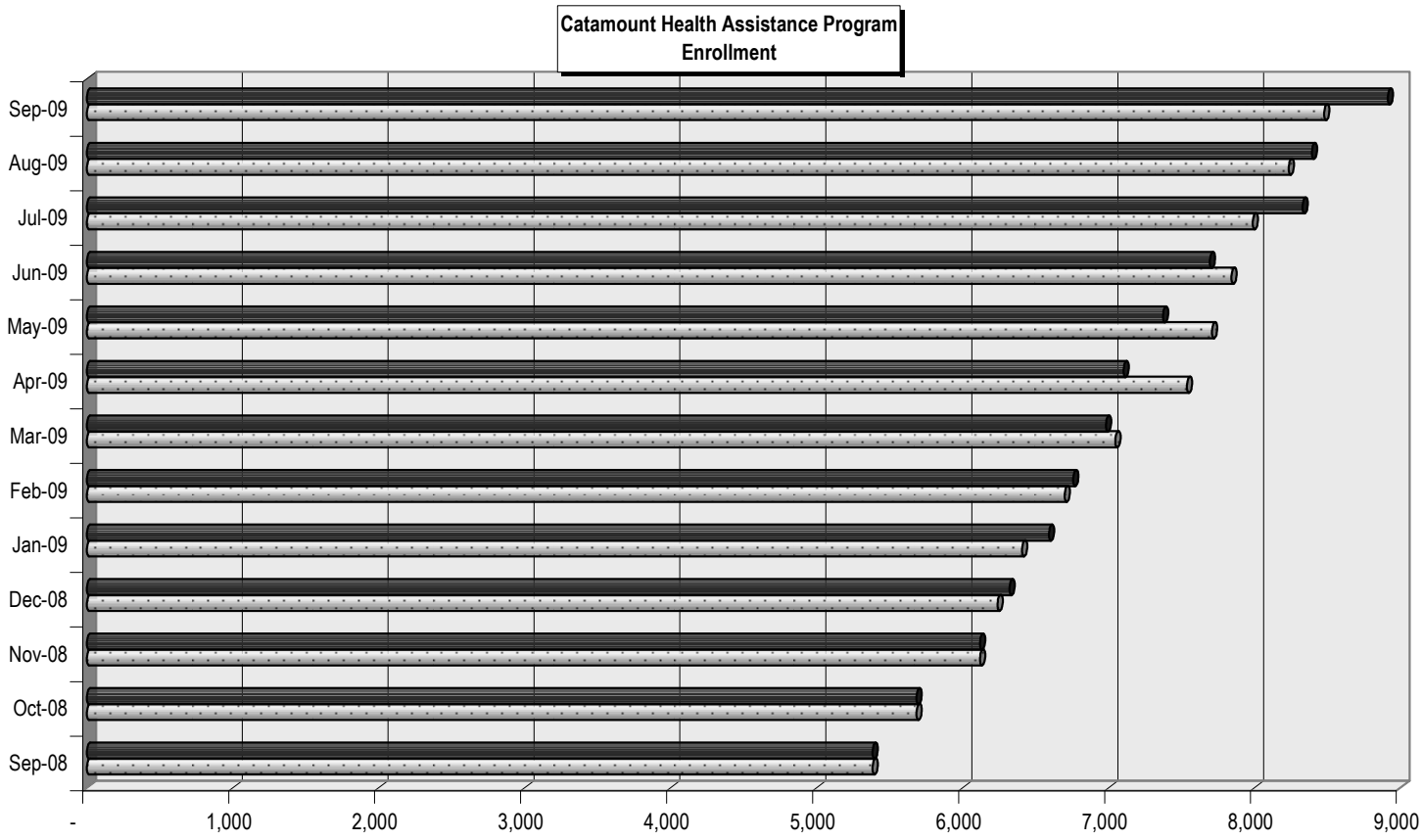
Age	VHAP-ESIA	ESIA	CHAP	TOTAL
18-24	60	66	1,679	
25-35	268	146	1,416	
36-45	357	185	1,402	
46-55	210	174	1,907	
56-64	58	62	2,068	
65+	-	-	5	
Total	**953**	**633**	**8,477**	**10,063**

Green Mountain Care Enrollment Report (continued)

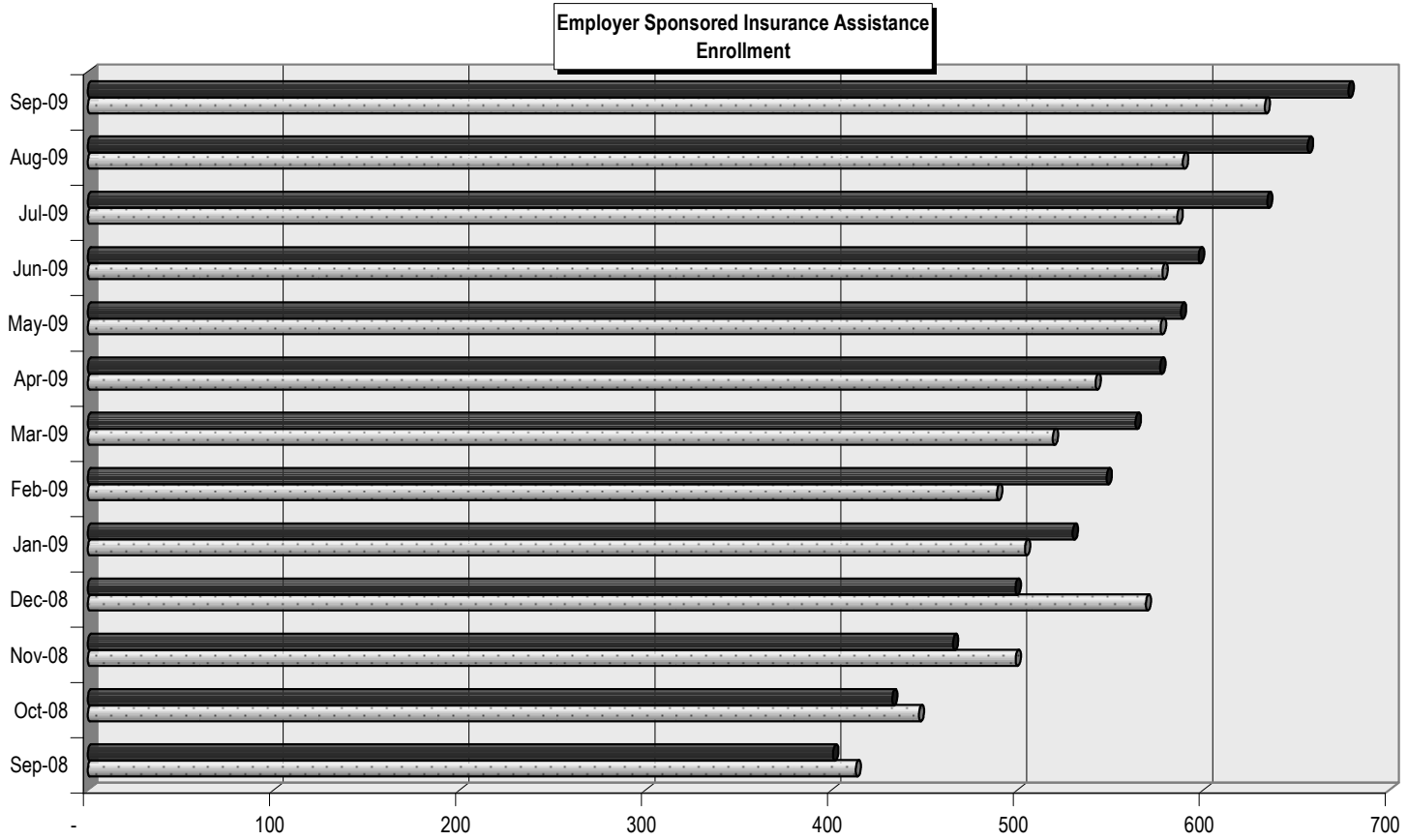
Sep 2009 Demographics

Gender	VHAP-ESIA	ESIA	CHAP	TOTAL
Male	340	231	3,725	
Female	613	402	4,752	
Total	**953**	**633**	**8,477**	**10,063**

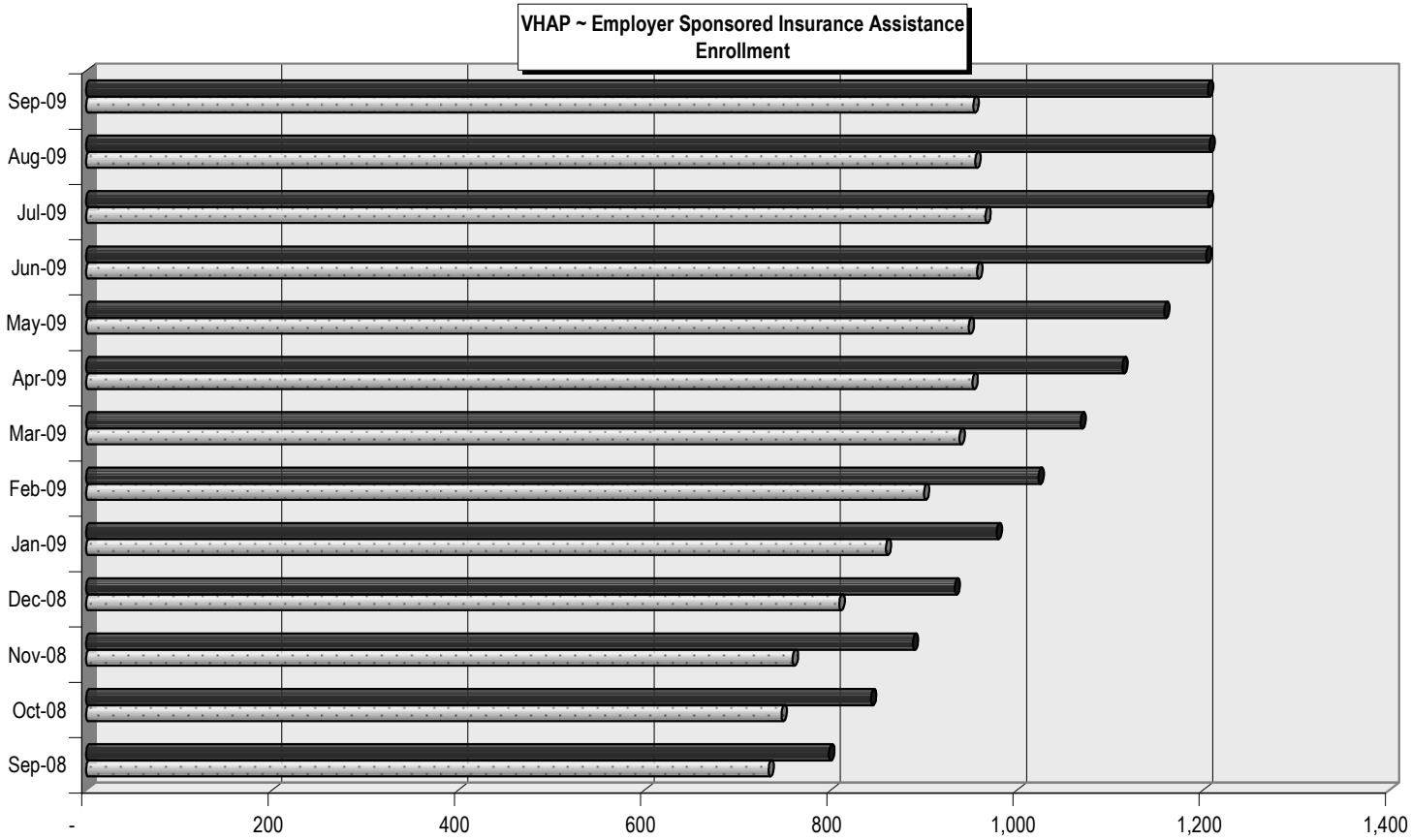
County	VHAP-ESIA	ESIA	CHAP	TOTAL
Addison	67	33	528	
Bennington	84	61	497	
Caledonia	41	16	514	
Chittenden	169	133	1,543	
Essex	11	4	102	
Franklin	107	46	580	
Grand Isle	9	9	95	
Lamoille	56	42	468	
Orange	33	32	414	
Orleans	73	29	518	
Other	2	-	23	
Rutland	101	87	890	
Washington	74	43	833	
Windham	53	47	683	
Windsor	73	51	789	
Total	**953**	**633**	**8,477**	**10,063**



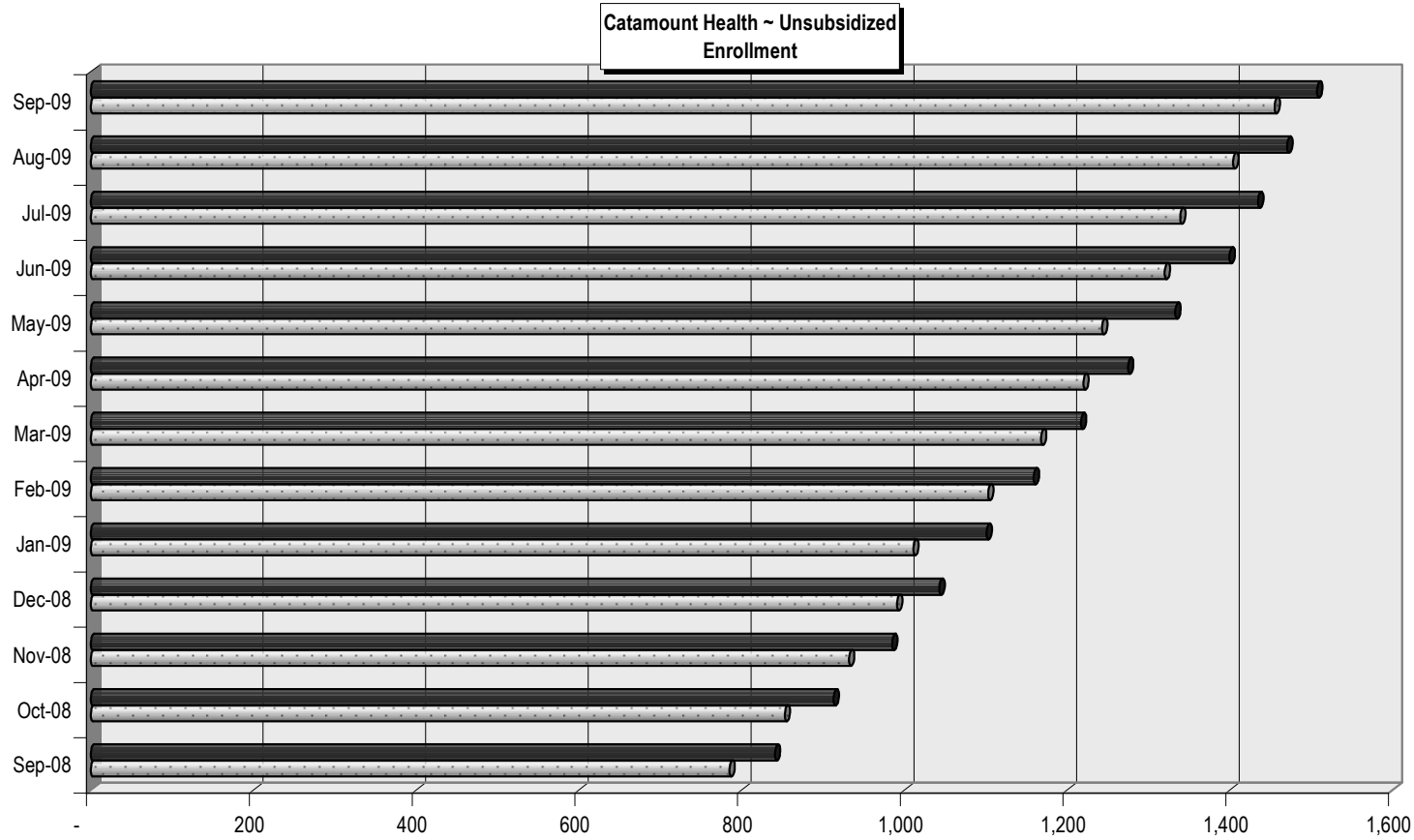
	Sep-08	Oct-08	Nov-08	Dec-08	Jan-09	Feb-09	Mar-09	Apr-09	May-09	Jun-09	Jul-09	Aug-09	Sep-09
Projected	5,384	5,684	6,120	6,321	6,592	6,758	6,983	7,103	7,374	7,694	8,329	8,394	8,914
Actual	5,384	5,684	6,120	6,239	6,407	6,699	7,046	7,538	7,710	7,842	7,988	8,235	8,477



	Sep-08	Oct-08	Nov-08	Dec-08	Jan-09	Feb-09	Mar-09	Apr-09	May-09	Jun-09	Jul-09	Aug-09	Sep-09
Projected	401	433	465	499	530	548	564	577	588	597	634	656	678
Actual	413	447	499	569	504	489	519	542	577	578	586	589	633



	Sep-08	Oct-08	Nov-08	Dec-08	Jan-09	Feb-09	Mar-09	Apr-09	May-09	Jun-09	Jul-09	Aug-09	Sep-09
Projected	798	843	888	933	978	1,023	1,068	1,113	1,158	1,203	1,205	1,207	1,205
Actual	733	747	759	809	859	900	938	952	948	957	966	955	953



	Sep-08	Oct-08	Nov-08	Dec-08	Jan-09	Feb-09	Mar-09	Apr-09	May-09	Jun-09	Jul-09	Aug-09	Sep-09
Projected	841	913	985	1,043	1,101	1,159	1,217	1,275	1,333	1,400	1,435	1,471	1,507
Actual	785	853	932	991	1,011	1,103	1,168	1,220	1,243	1,320	1,339	1,404	1,455

Attachment 2
Global Commitment Expenditure Tracking

from CMS-64 line:	LTC Admin Quarterly Expenditures	PQA: WY1	PQA: WY2	PQA: WY3	PQA: WY4	PQA: WY5	Net Admin PQA	Net LTC Admin Expenditures as reported on 64	MMIS 90% Admin Quarterly Expenditures	PQA: WY1	PQA: WY2	PQA: WY3	PQA: WY4	PQA: WY5	Net Admin PQA	Net MMIS 90% Admin Expenditures as reported on 64	AHSCO Admin Quarterly Expenditures: includes 50% & 75%	PQA: WY1	PQA: WY2	PQA: WY3	PQA: WY4	PQA: WY5	Net Admin PQA	Net AHSCO Admin Expenditures as reported on 64
	LTC Admin	*LTC Admin*	*LTC Admin*	*LTC Admin*	*LTC Admin*	*LTC Admin*	*LTC Admin*		*MMIS 90% Admin*	*MMIS 90% Admin*	*MMIS 90% Admin*	*MMIS 90% Admin*	*MMIS 90% Admin*	*MMIS 90% Admin*	*MMIS 90% Admin*		*AHSCO Admin*	*AHSCO Admin*	*AHSCO Admin*	*AHSCO Admin*	*AHSCO Admin*	*AHSCO Admin*	*AHSCO Admin*	
QE																								
1205	$ 572,438						$ -								$ -		$ 14,580,556						$ -	
0306	$ 618,636						$ -		$ 668,742						$ -		$ -	$ (14,306,555)					$ (14,306,555)	
0606	$ 718,078						$ -								$ -		$ 833,644						$ -	
0906	$ 529,913						$ -								$ -		$ 616,842						$ -	
WY1 SUM								$ 2,652,874								$ 668,742								$ 1,967,428
1206	$ 346,732								$ 376,007								$ 713,940							
0307	$ 972,273	$ 380,733							$ 1,300,509								$ 1,159,770							
0607	$ 947,875	$ (166,924)							$ 453,894								$ 591,699							
0907	$ 328,298																$ 870,212							
WY2 SUM								$ 2,594,618								$ 2,130,410								$ 3,869,820
1207	$ 301,255								$ 171,297								$ 932,757							
0308	$ 344,759		$ (560)						$ -								$ 1,343,619	$ 242,941	$ 534,199	$ 171,279				
0608	$ 420,377																$ 1,223,320			$ 15,823				
0908	$ 351,308																$ 1,334,391							
WY3 SUM								$ 1,417,699								$ 171,297								$ 5,040,197
1208	$ 360,286								$ -								$ 1,386,183			$ 19,008				
0309	$ 317,458				$ 10				$ 8,564								$ 1,007,008				$ 400			
0609	$ 318,959								$ 13,187								$ 786,343				$ 888			
0909	$ 373,581								$ 19,756								$ 927,673							
WY4 SUM								$ 1,370,294								$ 41,507								$ 4,108,495
1209																								
0310																								
0610																								
0910																								
WY5 SUM								$ -								$ -								$ -
		$ 213,809	$ (560)	$ -	$ 10	$ -				$ -	$ -	$ -	$ -	$ -				$ (14,063,614)	$ 534,199	$ 206,109	$ 1,288	$ -		
		PQA = Prior Quarter Adjustments								PQA = Prior Quarter Adjustments								PQA = Prior Quarter Adjustments						

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
July 1, 2009 – September 30, 2009

Eligibility forms, notices, or process	20
Catamount Health/Premium Assistance Programs premiums, process, ads, plans	8
Use of social security numbers as identifiers	10
General premium complaints	12
Green Mountain Care website	1
Provider issues (perceived rudeness, refusal to provide service, prices) (variety of provider types)	6
Member services	2
Eligibility rules	16
Eligibility local office	33
Prescription drug plan issues	0
Pharmacy coverage	4
Coverage rules	1
Chiropractic coverage change	0
Copays/service limit	2
Provider enrollment issues	0
OVHA	0
Total	**115**

Attachment 4

VERMONT

Agency of Human Services

Grievance and Appeal Quarterly Report
Medicaid MCO All Departments Combined Data
July 1, 2009 – September 30, 2009

The MCO is composed of various administrative areas within the Agency of Human Services (AHS). These include: the Office of Vermont Health Access (OVHA), the Department for Children and Families (DCF), the Department of Mental Health (DMH), the Department of Disabilities, Aging and Independent Living (DAIL), and the Department of Health (VDH). Also included in the MCO are the Designated Agencies (DA) and Specialized Service Agencies (SSA) that provide service authorizations for DMH and DAIL. Each entity should have at least one assigned grievance and appeal coordinator who enters data into the MCO database. This report is based on data compiled on October 16, 2009, from the centralized database for grievances and appeals that were filed from July 1, 2009 through September 30, 2009.

Grievances: A grievance is an expression of dissatisfaction about any matter that is not an action taken by the MCO. It includes a request for a written response.

During this quarter, there were seventeen grievances filed with the MCO. Four were addressed during the quarter, one was withdrawn and twelve 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 28 days. Acknowledgement letters of the receipt of a grievance must be sent within five days, and as the MCO, we averaged only two days, although four of those letters were sent late. Of the grievances filed, 94% were filed by beneficiaries, and 6% were filed by a representative of the beneficiary. Of the seventeen grievances filed, DAIL had 6%, DMH had 76%, and OVHA had 18%. There were no grievances filed for the Department for Children and Families or the Department of Health during this quarter.

On the last quarterly report, it was reported that there were sixteen grievances pending. In actuality, there were only fifteen. The DAIL case had been addressed, but that information had not been entered into the database in time to be accurately reflected in the last quarterly report. Of the fifteen actual cases that were pending at the end of the last quarter, ten were resolved this quarter, with 90% addressed within the required timeframes. The other case had exceeded the timelines. There are still five grievances outstanding, and all five are from the HowardCenter. As of September 30, 2009, two cases have been pending for 99 days, one for 139 days, one for 154 days and the last for 210 days.

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

Appeals: Medicaid rule 7110 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 thirty-one appeals filed with the MCO, of which eight requested an expedited decision, and one met the criteria. Of these 31 appeals, twenty-four were resolved (78% of filed appeals), one was withdrawn (3%), and six appeals were still pending (19%). In seventeen cases (71% of those resolved), the original decision was upheld by the person hearing the appeal, two cases (8% of those resolved) were reversed, one was modified (4% of those resolved), and four were approved by the department/DA/SSA before the appeal meeting (17% of those resolved).

Of the twenty-four appeals that were resolved this quarter 92% were resolved within the statutory time frame of 45 days. In addition, 83% of the resolved appeals were resolved within 30 days. All 24 cases were resolved within 59 days, with both of the cases exceeding the required 45-day timeframe being extended at the beneficiary's request. The average number of days it took to resolve these 24 cases was 19 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 two of those letters were sent late.

Of the 31 appeals filed, twenty were filed by beneficiaries (65%), ten were filed by a representative of the beneficiary (32%), one was filed by a provider (3%), and none were filed by someone else at the request of the beneficiary. Of the 31 appeals filed, OVHA had 77%, DAIL had 13%, and DMH had 10%. There were no appeals filed for the Department of Health (neither ADAP nor CSHN), or the Department for Children and Families during this quarter.

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 26 appeals for a denial or limitation of authorization of a requested service or eligibility for service (84%), four were for a reduction/suspension/termination of a previously authorized covered service or service plan (13%), and one was left blank (3%).

There were four DAIL and three OVHA cases filed between April 1, 2009, and June 30, 2009 that were still pending at the beginning of this quarter. In addition, there were four DAIL cases that were still pending from before April 1, 2009 [On the last report there were nine cases pending from between 4/1/09 and 6/30/09. The additional case had been resolved prior to June 30, 2009, but the information was not entered until after the quarterly reports were compiled on July 21, 2009.] Of those eleven pending cases, seven were resolved this quarter. 57% of these cases were upheld (two each for DAIL & OVHA), 29% were reversed (one each for DAIL & OVHA); none were modified, 14% were withdrawn (one for DAIL), and none were approved before the appeal hearing. 57% of the cases were resolved within thirty days, 86% in forty-five days, and 86% within fifty-nine days. The other case was a DAIL Attendant Services case that took 60 days to be resolved.

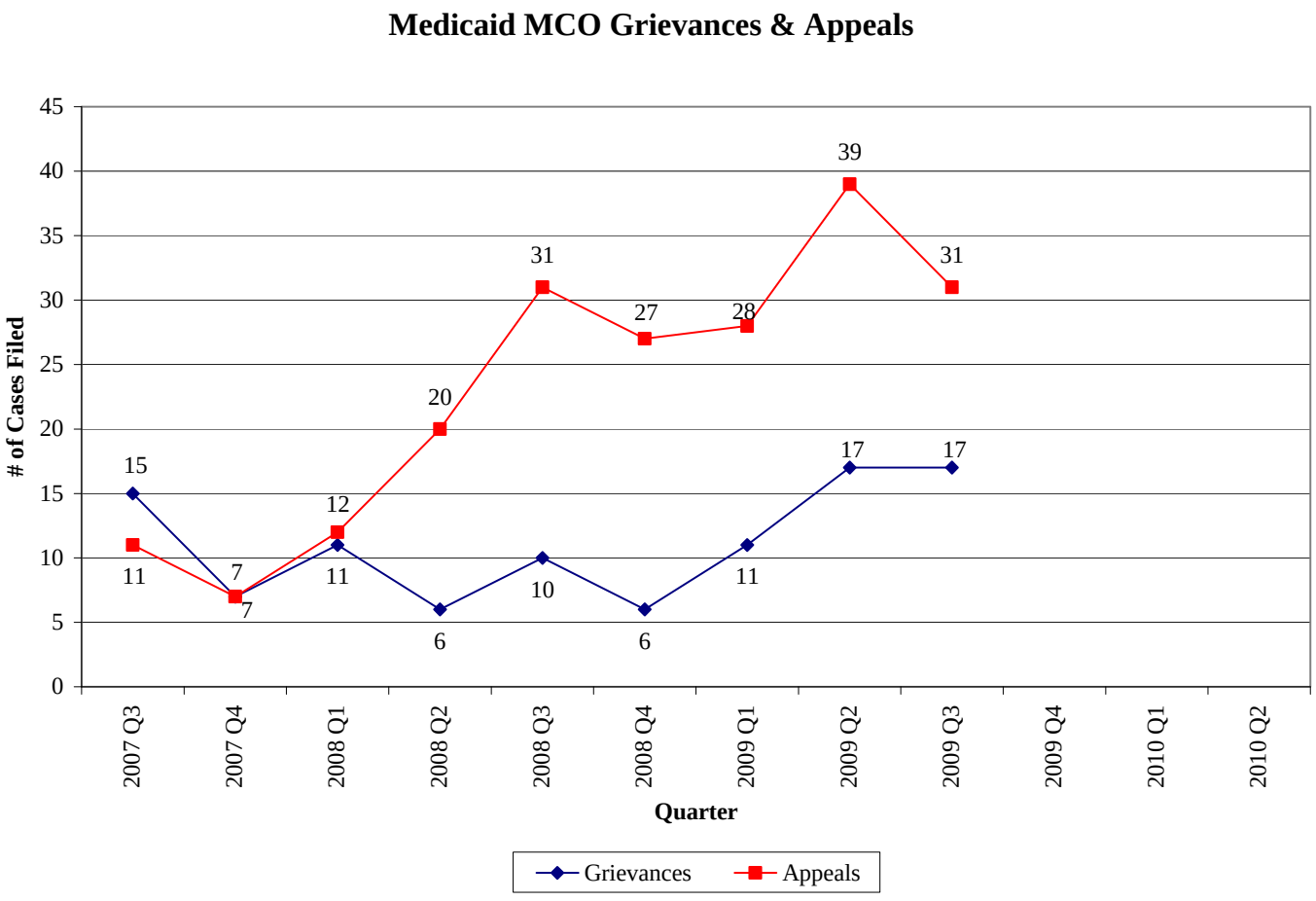
On September 30, 2009 there were four cases still pending; two for DAIL's Children's Personal Care program for 233 & 384 days, and two for DAIL's DS program through NKHS for 253 days.

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; two for DAIL, one for DMH, and three for OVHA. Two were filed concurrently with the appeal, while the other four were filed subsequent to the appeal decision. Five cases are still pending, with the DMH case being dismissed. There were fifteen fair hearings that were pending from previous quarters. Only one of them was resolved (an OVHA case was withdrawn) so there are a total of nineteen fair hearings still pending, seven for DAIL and twelve for OVHA.

Other Information:

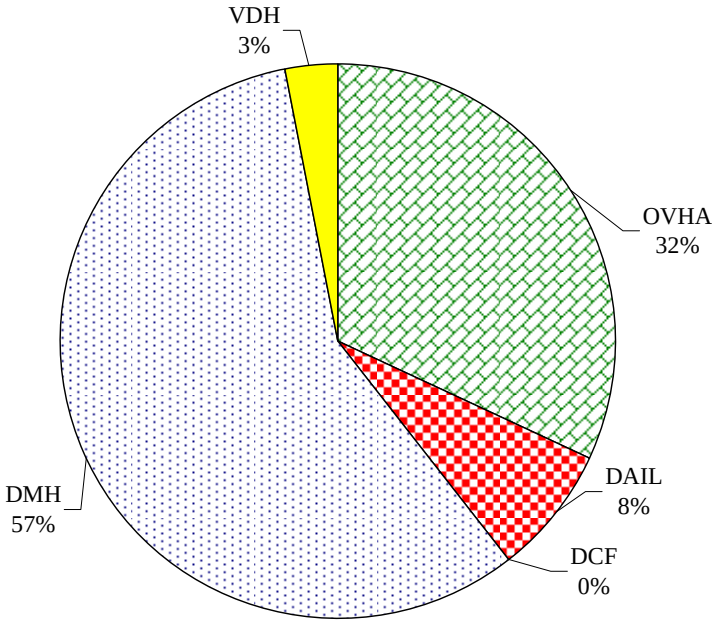
There is one SSA that has refused to be trained in the G&A process (Sterling Area Services) and that DAIL was going to contact them to ensure that an individual was identified and trained. That has still not happened after two years.

Two years ago, DCF was supposed to have identified and had program specific individuals trained in the process, and that has not happened yet. In addition, to date, there are no known Grievance & Appeal procedures being used by the DCF. The MCO Grievance and Appeal Coordinator has agreed to provide all the necessary training to the Department of Children & Families.

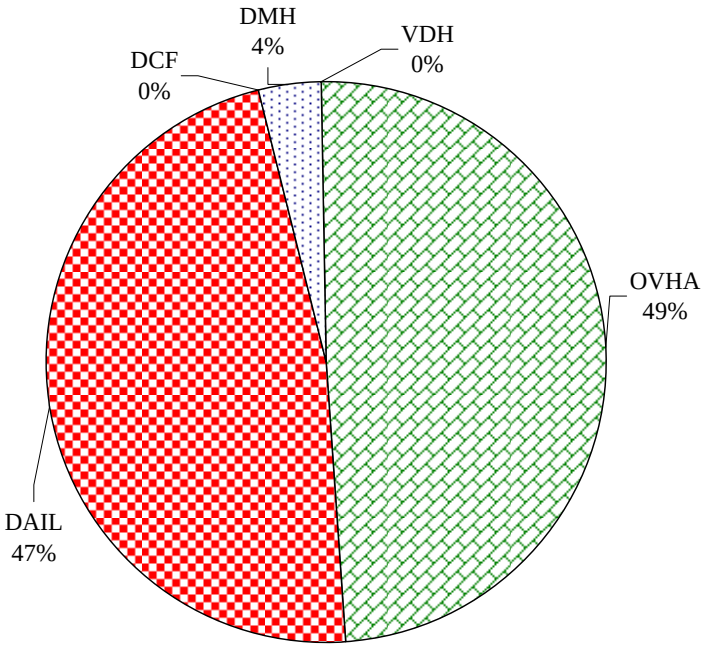


MCO Grievance & Appeals by Department from July 1, 2007 through September 30, 2009

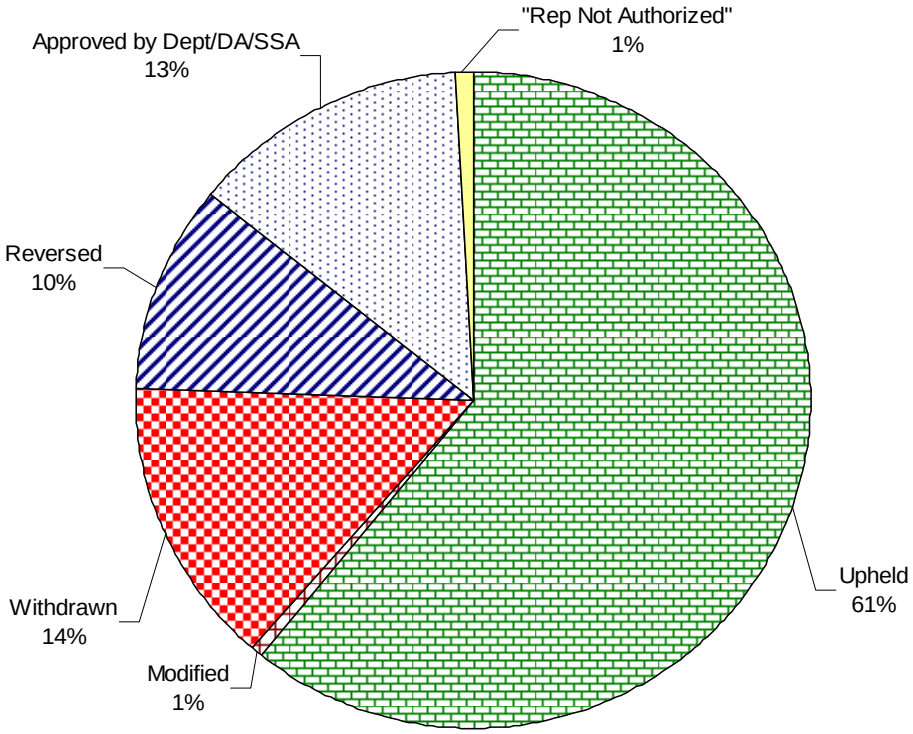
Grievances



Appeals



MCO Appeal Resolutions from July 1, 2007 through September 30, 2009



Grievance and Appeal Quarterly Report
Medicaid MCO All Departments Combined Data
for the period: July 1, 2009 – September 30, 2009

Grievances

Total number of grievances filed: 17

Number pending: 12 *DAIL-1; DMH-8; OVHA 3*

Number withdrawn: 1 *DMH*

Number addressed: 4 *DMH*
- Within 90 days: 100%
- Exceeding 90 days: 0%

Number of grievances filed too late: 1

Average number of days from "pertinent issue" to filing grievance: 4

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

Average number of days from filing to being addressed: 28

Average number of days to send acknowledgement letter: 2

Number of late acknowledgement letters: 4 *DAIL-1; DMH-1*

Average number of days from filing to withdrawing: 2

Average number of days to send withdrawal letter: If a letter was sent it was not entered in the database.

Number of late withdrawal letters: 1 *DMH*

Number of grievance reviews requested: 1 *DMH*

Average number of days to send grievance review acknowledgement letter: 5

Number of late grievance review acknowledgement letters: 0

Number of grievance reviews addressed: 0

Source of grievance request:

Beneficiary:	16	94%
Beneficiary Representative:	1	6%
Other:	0	0%

Number related to:

OVHA:	3	18%
DAIL:	1	6%
DCF:	0	0%
DMH:	13	76%
VDH:	0	0%

Top services grieved:
1. Mental Health Services (9)
2. Case Management (2)
3. Transportation (2)

Number by category: [Check ALL that apply]

Staff/Contractor:	5
Program Concern:	1
Management:	0
Policy or Rule Issue:	3
Quality of Service:	5
Service Accessibility:	2
Timeliness of Service Response:	3
Service Not Offered/Available:	1
Other:	4
Enrollee Rights:	1
Adverse Effect/Exercising Rights:	0

* * * * * *

Number pending from all previous quarters: 15 *DMH-11; OVHA-3; VDH - 1*

Number that were, this quarter:
- Withdrawn: 0 0%
- Addressed within 90 days: 9 90%
  DMH-5; OVHA-3, VDH-1
- Addressed, but exceeded 90 days: 1 10%
  DMH-1

Number of grievance reviews pending from all previous quarters: 2 *DMH - 2*

Number of pending grievance reviews addressed this quarter: 0

Number of grievances from all previous quarters that are still pending at the end of this quarter: 5 *DMH-5: all 5 with HowardCenter (days pending: 99, 99, 139, 154, & 210)*

Appeals

Number of appeals filed: 31

Number pending: 6 *DAIL-1; DMH-2; OVHA-3*

Number withdrawn: 1 *OVHA*

Number resolved: 24
- Upheld: 17 71% *DAIL-3; DMH-1; OVHA 13*
- Reversed: 2 8% *OVHA*
- Modified: 1 4% *OVHA*
- Approved by Dept/DA/SSA: 4 17% *OVHA*

Number of cases extended: 2
- by beneficiary: 2
- by MCO: 0

Resolved time frames
- Within 30 days: 83% *DAIL-2; DMH-1; OVHA-17*
- Within 45 days: 92% *DAIL-2; DMH-1; OVHA-19*
- Within 59 days: 100% *DAIL-3; DMH-1; OVHA-20*
- Extended (2) vs. Late (0)

Number of appeals filed too late: 1

Average number of days from NOA to filing appeal: 19

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

Average number of days from filing to resolution: 19

Average number of days from filing to resolution when extended: 54

Average number of days to send acknowledgement letter: 2

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

Average number of days from filing to withdrawing: 22

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

Source of appeal request:

Beneficiary:	20	65%
Beneficiary Representative:	10	32%
Provider:	1	3%
Other:	0	0%

Number related to:

OVHA:	24	77%
DAIL:	4	13%
DCF:	0	0%
DMH:	3	10%
VDH:	0	0%

Top services appealed:
1. Orthodontics (7)
2. Prescriptions (7)
3. Transportation (5)
4. Personal Care (4)

Number of beneficiaries that requested that their services be continued: 1 4%

Of those that requested their services be continued:

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

Number by category:

1. Denial or limitation of authorization of a requested service or eligibility for service:	26
2. Reduction/suspension/termination of a previously authorized covered service or service plan:	4
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

Was not entered by date data run: 1

Expedited Appeals

Number of expedited appeals filed: 8

Number of expedited appeals that:
- Met criteria: 1
- Did not meet criteria: 7

For those MEETING criteria

Number pending:0

Number of expedited appeals filed too late: 0

Number resolved: 1

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

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

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

Average number of days from filing to resolution: 3

Source of appeal:

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

Service appealed: Prescriptions (1)

Number related to:

OVHA:	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: 1

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

Number late letters: 0

* * * * * *

Number pending from last quarter: 7 *DAIL-4; OVHA-3*

Number pending from previous quarters: 4 *DAIL-4*

Total pending from ALL quarters: 11 *DAIL-8; OVHA-3*

Number of total pending that were resolved this quarter: 7

Number upheld:	4	57%	*DAIL-2; OVHA-2*
Number reversed:	2	29%	*DAIL-1; OVHA-1*
Number withdrawn:	1	14%	*DAIL-1*

Resolution time frames for resolving above cases:

Within 30 days:	57%	*DAIL-2; OVHA-2*
Within 45 days:	86%	*DAIL-3; OVHA-3*
Within 59 days:	86%	*DAIL-3; OVHA-3*
Over 59 days:	14%	*DAIL- 1*

Number of appeals still pending from all previous quarters: 4 *DAIL-4: CPC - 2 (233 days & 384 days); DS-NKHS - 2 (both 253 days)*

Fair Hearings

Total number of Fair Hearings filed: 6 ***DAIL-2; DMH-1; OVHA-3***

Number of Fair Hearings filed with a concurrent appeal: 2 *DMH-1; OVHA-1*

Number of Fair Hearings filed after appeal resolution: 4 *DAIL-2; OVHA-2*

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

Number resolved: 1

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

* * * * *

Number of pending Fair Hearings from previous quarters: 15 *DAIL-5; OVHA-10*

Number of pending Fair Hearings from previous quarters resolved this quarter: 1

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

Average number of days for resolution for pending Fair Hearings from previous quarters: 42

Number of pending Fair Hearings from previous quarters still pending at the end of this quarter: 19 *DAIL-7; OVHA-12*

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
July 1, 2009 – September 30, 2009

OFFICE OF VERMONT HEALTH ACCESS

I. Overview

This is the Office of Health Care Ombudsman's (HCO) report to the Office of Vermont Health Access (OVHA) for the quarter July 1, 2009 through September 30, 2009. This is our first report using our new database. This case management system will eventually allow us to track more issues and create different reports.

The total number of all cases/all coverages that we opened this quarter was 615, compared to 702 last quarter. Although this was a significant decrease in call volume, it is not surprising because typically the summer is our slowest time of year. In 2008 we had 504 calls, in 2007 we had 627 and in 2006 we had 580 for the months of July, August and September.

We received 244 calls from individuals on OVHA programs this quarter, down from 320 calls last quarter, and 312 the quarter before that. This was 40% of the total call volume, compared to 46% last quarter, and 41% for the previous one. Last year we received 218 calls from OVHA beneficiaries for the months of July, August and September.

As has been the norm for awhile, about 14% of our total calls were related to the hybrid programs involving both government and commercial insurance. We received 30 calls about federal Medicare Modernization Act (Medicare Part C, Medicare Part D and VPharm) issues, compared to 49 calls last quarter and 60 the previous quarter. For the state hybrid programs (Catamount Health and the Premium Assistance programs), we received 58 calls this quarter, compared to 51 last quarter and 64 the previous quarter.

Once again more than half of the total calls (all coverages) we took were related to Access to Care and Eligibility for state programs. This quarter 25% of our total calls were regarding Access to Care and 27% were regarding Eligibility issues. We received 157 Access to Care calls, compared to 196 last quarter, and 169 Eligibility calls, compared to 172 last quarter.

Of the 157 Access to Care calls, 84 (54%) were from OVHA beneficiaries. In the previous quarter we had 196 total Access calls, with 111 (57%) coming from OVHA beneficiaries. Since only 40% of our total calls are from OVHA callers, this is a comparatively high percentage of calls regarding access issues, and remains a cause of some concern.

Calls about Eligibility issues increased markedly when Catamount Health went into effect in October 2007, and have remained high. This quarter we received 169 (27.48% of all calls) about Eligibility for government health insurance programs, compared to 171 (24%) last quarter. Of those 169, 69 were from current OVHA beneficiaries. In the future, with the new database, we should be able to track some specific issues within the category of eligibility to see whether there are particular recurring problems.

Prescription drugs have consistently generated a high call volume and continue to do so, including calls involving access to medications, eligibility for prescription programs, or questions, problems and confusion about the various prescription programs. If we count general access to medications, Medicare Part D, Medicare Part B, and VPharm calls together, the total number of prescription-related calls this quarter was 62, down from 81 the previous quarter and 106 the quarter before that. These calls, for all coverages, constituted 10% of our calls, down from 12% the previous quarter and 14% for the quarter before that. Of the 30 Access to Prescription Drug calls, 15 (50%) were from OVHA beneficiaries. The new rules requiring 90 day supplies of maintenance drugs and the VPharm pilot program for statins and proton pump inhibitors generated just one call where that was the primary issue.

The number of calls related to Pain Management has dropped somewhat. This quarter we received 16 calls involving Pain Management. With the new database we can now see that although Pain Management was the primary problem cited by 15 callers, one other call also involved Pain Management as at least a secondary issue. Last quarter we received 23 pain calls, down from 30 the previous quarter. Of the 15 primary issue pain cases this quarter, 12 were from individuals on OVHA programs. This means 80% of the Pain Management calls were from OVHA beneficiaries, compared to 14 calls (61%) last quarter and 30 calls (70%) the previous quarter. Only one caller on commercial insurance called about Pain Management. Last quarter only three individuals in this category had commercial insurance, and just four did in the previous quarter. Thus, pain management mainly continues to be a problem for individuals on OVHA programs.

In addition to tracking these issues, I'd like to report more frequently about Mental Health and Substance Abuse calls. This quarter we had 17 such calls for all coverages: 11 involved access to care (just 4 involved OVHA beneficiaries) and 6 involved problems after care was received related to billing and coverage (none of these involved OVHA beneficiaries). We had one coded as Substance Abuse, but this is a very new issue code. Anecdotally we seem to be getting more calls related to substance abuse (especially, for OVHA beneficiaries, regarding transportation to substance abuse facilities and waiting lists at facilities) and residential treatment for eating disorders. In the future we will be able to provide better data on these calls. In the past we had to code problems as either Mental Health or Transportation (we had 9 calls from OVHA beneficiaries regarding transportation problems this quarter). With the new database, we can now code one case as having more than one issue, e.g. Mental Health, Substance Abuse and Transportation. We will designate one issue as the "primary issue", so that we aren't double counting when determining the total number of calls. Thus, we'll be able to see how many cases that involved access to substance abuse treatment also involved transportation problems.

II. Disposition of cases

We closed 266 OVHA cases this quarter, compared to 308 last quarter:

- 6% (15 calls) of the OVHA calls were resolved in the initial call;
- 54% (143 calls) were resolved by advice or referral, after an analysis of the problem. Last quarter 57% (182 calls) were resolved in this manner;
- 20% (52 calls) were resolved by direct intervention on the caller's behalf, including advocacy with OVHA and providers, writing letters, gathering medical information, and representation at fair hearings. Last quarter 25% (81 calls) were resolved in this manner;
- 7% (19 calls) were considered complex intervention, which involves complex analysis and more than two hours of an advocate's time.

III. Issues

We opened 244 OVHA cases, compared to 320 last quarter. Of these:

- 34.43% (84 calls) involved Access to Care, compared to 35% (111 calls) last quarter;
- 28.28% (69 calls) involved Eligibility, compared to 27% (85 calls) last quarter;
- 12.70% (31 calls) involved Billing/Coverage, compared to 20% (65 calls) last quarter;
- 18.44% (45 calls) involved Other issues, compared to 16% (51 calls) last quarter. Other includes Medicare Part D calls; and
- 5.33% (13 calls) were coded as OVHA Consumer Education, compared to 2% (6 calls) last quarter.

A. Access to Care

We received 84 OVHA Access to Care calls, compared to 111 last quarter. The top call volume issues within this category were:

- 16 involved access to Prescription Drugs (including VPharm Therapeutic Substitution), up from 11 last quarter;
- 12 involved Pain Management, compared to 14 last quarter;
- 10 involved Specialty Care, compared to 15 last quarter;
- 10 involved Durable Medical Equipment, Supplies or Wheelchairs;
- 9 involved Transportation, compared to 8; and
- 6 involved Dental or Orthodontics, compared to 17.

B. Billing/Coverage

We received 31 OVHA calls in this category, compared to 65 last quarter:

- 15 involved Medicaid/VHAP Managed Care, compared to 23 last quarter; and
- 9 involved Hospital Billing, compared to 11 last quarter.

C. Eligibility

We received 69 OVHA calls in this category, compared to 85 last quarter:

- 23 involved Medicaid eligibility, compared to 32 last quarter;
- 19 involved VHAP, compared to 18;
- 15 involved Catamount Health and Premium Assistance, compared to 11. This count only includes callers who were already on OVHA plans when they called us. Many callers who call about Catamount are either uninsured or on commercial plans.

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.

ATTACHMENT 6

SFY09 Final MCO Investments

Investment Criteria #	Department	Investment Description
2	DOE	School Health Services
2	AOA	Blueprint Director
4	BISHCA	Health Care Administration
2	DII	Vermont Information Technology Leaders
2	VVH	Vermont Veterans Home
4	VSC	Health Professional Training
4	UVM	Vermont Physician Training
4	AHSCO	2-1-1 Grant
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
3	VDH	WIC Coverage
4	VDH	Vermont Blueprint for Health
4	VDH	Area Health Education Centers (AHEC)
4	VDH	Community Clinics
4	VDH	FQHC Lookalike
4	VDH	Patient Safety - Adverse Events
4	VDH	Coalition of Health Activity Movement Prevention Program (CHAMPPS)
2	VDH	Substance Abuse Treatment
4	VDH	Recovery Centers
2	VDH	Immunization
2	VDH	DMH Investment Cost in CAP
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
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 Mental Health
2	DCF	HBKF/Healthy Babies, Kids & Families
1	DCF	Catamount Administrative Services
2	DCF	Therapeutic Child Care
2	DCF	Lund Home
2	DDAIL	Mobility Training/Other Svcs.-Elderly Visually Impaired
2	DDAIL	DS Special Payments for Medical Services
2	DDAIL	Flexible Family/Respite Funding
4	DDAIL	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	Women's Health Program (Tapestry)
2	DOC	Community Rehabilitative Care
2	DOC	Return House