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
April 1, 2009 to June 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 third quarterly report for waiver year four, covering the period from April 1, 2009 to June 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 6/30/2009	Previously Reported Enrollees Last Day of Qtr 3/31/2009
Demonstration Population 1:	42,782	42,768
Demonstration Population 2:	42,841	42,394
Demonstration Population 3:	9,563	9,219
Demonstration Population 4:	N/A	N/A
Demonstration Population 5:	1,159	1,137
Demonstration Population 6:	2,757	2,372
Demonstration Population 7:	30,230	29,088
Demonstration Population 8:	7,821	7,609
Demonstration Population 9:	2,581	2,535
Demonstration Population 10:	N/A	N/A
Demonstration Population 11:	8,236	7,418

* Demonstration Population 11 represents the State's new Catamount Health Premium subsidy. Enrollment numbers are expected to grow throughout the year.

Green Mountain Care Outreach / Innovative Activities

During the third quarter, the Office of Vermont Health Access launched its second annual "Graduate Campaign" in efforts to reach college seniors about Green Mountain Care. To date the State has reached over 5541 seniors and 8778 faculty and staff at 18 of the 21 public and private colleges in Vermont. This was more than double the eight colleges that participated last year.

Joining this campaign was Vermont's largest bank, Chittenden Bank, which programmed all 47 of its Automatic Teller Machines with a message encouraging grads to check out Green Mountain Care. The bank prominently displayed brochures in their branches and featured Green Mountain Care in its member newsletter.

During the month of June all 74 Vermont State Liquor Stores followed suit by displaying brochures and programming store receipts with a Green Mountain Care message. The State of Vermont homepage also posted a widget with a "graduation image" that linked directly to the Green Mountain Care website.

Business associations assisted during the Graduate Campaign with electronic emails and newsletters that targeted members as parents of dependents who may have children aging off of coverage. In June, over 6400 members of the Vermont Businesses for Social Responsibility and the Lake Champlain Regional Chamber of Commerce helped OVHA promote Green Mountain Care to its members.

The State of Vermont as well as its largest city, Burlington, sent emails to over 3600 employees

informing them that children who may be aging off coverage are eligible for Green Mountain Care.

OVHA also partnered with the Vermont Department of Labor at eight layoffs, reaching 147 laid off workers with information about Green Mountain Care.

Enrollment and legislative action: Enrollment in the new premium assistance program components of Green Mountain Care (Catamount Health and Employer-Sponsored Insurance) has continued to grow over the quarter, although the rate of growth has decreased. As of the end of June there were 10,697 individuals enrolled.

During the 2009 session, the Vermont legislature passed and the governor signed H.444, an omnibus health care reform bill, that made two minor changes to the premium assistance eligibility determination process:

- 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.

Both of these changes will require a waiver amendment, which the bill directs OVHA to request no later than September 1, 2009.

Another bill, H.235, passed by the legislature this year charges OVHA with submitting a report by October 1, 2009, on the programmatic and cost implications of applying for a waiver amendment to provide Medicaid children with life-limiting illnesses with concurrent palliative and curative care. Several other states, including Colorado, Florida, and California, have approved waivers to implement similar programs.

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 June 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 June 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.

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.

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 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

Chronic Care Initiative

The OVHA's Chronic Care Initiative (CCI) is designed to fulfill the following mission: 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 goal is to improve health outcomes of Medicaid beneficiaries through addressing the increasing prevalence of chronic illness in this population. The CCI 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 CCI 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 CCI aims to improve health outcomes by supporting better self-care and lowering health care expenditures through appropriate utilization of health care services.

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The CCI supports and aligns with other State health care reform efforts, including the Blueprint for Health and Office-Based Medically Assisted Treatment for Opioid Dependence initiative (see below). CCI 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 CCI 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 CCI if they receive Medicare or other third party insurance. Those targeted for enrollment in the CCI 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, which previously was provided by the Center for Health Policy and Research (CHPR) at the University of Massachusetts Medical School. During the past quarter, internal OVHA Program Integrity staff began conducting the predictive modeling for case identification. During the predictive modeling process, beneficiaries are also stratified into those at highest risk and most likely to benefit from intensive care coordination case management services, and those for whom less intensive disease management services are sufficient. Through targeting these predicted high cost beneficiaries, resources can be allocated where there is the greatest cost savings opportunity. Especially among beneficiaries at highest risk, 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.

In 2006, the OVHA began providing face-to-face intensive care coordination services to the highest risk, medically complex beneficiaries, and progressed to a statewide field presence in early 2008. The OVHA care coordination staff, which includes nurse case managers and medical social workers, is now fully embedded in local communities, has strong relationships with local providers and hospital partners, and is co-located within the state's Agency of Human Services' district offices. 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 CCI 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. June 30, 2009, marked the end of the second year of expanded operations. During this time, some level of intervention services was provided to over 25,000 beneficiaries. The CCI 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.

Service level needs are determined through both predictive modeling and clinical assessment, in accordance with national evidence-based, disease-specific clinical guidelines. Beneficiaries assessed at moderate to high risk receive predominantly telephonic health education and coaching services provided through contracted APS Healthcare RN health coaches. Those at highest risk are provided intensive face-to-face outreach and support from OVHA care coordinators working in the field, who facilitate a medical home and effective communication among service providers, support the primary care provider in achieving the clinical plan of care, and work to increase beneficiaries' success by, for example, addressing barriers such as lack of transportation that interferes with keeping scheduled medical appointments. The CCI is designed to enable seamless transition between service tiers as a beneficiary's needs change.

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. 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 related to his or her plan of care (POC).

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, the OVHA negotiated a contract amendment with APS, which refocused resources and changed services for some beneficiaries effective October 1, 2008. Specifically, the CCI refocused efforts 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. If they express interest in speaking directly with a CCI staff member, they are immediately transferred to an RN health coach or a disease management coordinator at APS Healthcare**.** Concurrent with the APS funding reduction, two OVHA care coordination medical social worker positions were eliminated, requiring expansion of geographic coverage areas for remaining staff to assure critical services remain available statewide.

The CCI provides ongoing outreach, education and support to the primary care providers (PCPs) of participating beneficiaries. PCPs are notified whenever one of their patients decides to participate in care coordination or disease management services, as well as when their patients are selected but can't be reached or decline services. 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.

During the third quarter of FFY 2009, the OVHA contracted with the University of Vermont (UVM) for

CCI program monitoring, evaluation, and identification of quality improvement projects. UVM will conduct a thorough evaluation of CCI using administrative (claims) data, as well as information obtained during Medical Record Reviews (MRRs), and will identify quality measures amenable to performance improvement activities that also are likely to have the greatest impact on the CCI managed population. They will assist with implementing quality improvement activities and will evaluate the CCI's success at improving clinical and utilization outcomes.

Highlights of the 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.
- The ability to track and report results for the Buprenorphine program, which is being integrated with care coordination services, has been added to the APS CareConnection® system. OVHA Care Coordinators began providing case management for buprenorphine patients from four pilot provider practices.
- During the third quarter of FFY 2009, the average monthly program caseload was 3,405. The average monthly caseload for FFY 2009 to date is 3,772. Monthly caseload includes beneficiaries in active outreach by CCI staff, as well as those successfully engaged and receiving care coordination or health coaching services.
- 2,716 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 6/30/09). 1,344 of these members were served during the 3rd quarter of FFY 2009 (4/1/09 to 6/30/09). During the second full program year of enhanced services (7/1/08 to 6/30/09), the CCI provided care coordination and/or nurse health coaching services to 3,189 different beneficiaries.
- Evidence-based Clinical Guidelines, Touch Levels, and Action Plans are in place for all 11 chronic conditions to guide CCI staff interventions. Clinical content is coordinated with other state health improvement and chronic disease initiatives to ensure consistent information is used throughout the State.

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				
III.	Induction	$348.97	+	**BONUS**	=	**Final Capitated Rate (depends on the number of patients per level, per provider)**
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
Total	$ 351,080.98

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 $351,089.98 has been paid out to the 33 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 these Buprenorphine into case management services, which will be provided by OVHA's Chronic Care Initiative (CCI). Initially, the OVHA will assign case managers to four practice sites. 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. OVHA in collaboration with ADAP and UVM will evaluate the success of the program.

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. The six-bed community residential recovery program in the Brattleboro area is under contract and will open this fall. 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. The consultation to design a care management system has been completed. A representative steering committee of inpatient and community providers is being formed and three working groups are being commissioned to:

- Develop consensus medical clearance protocols for all hospital emergency departments to use when referring individuals for psychiatric inpatient care
- Create 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. 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.

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 responses will be used to develop a "Master Plan" to replace VSH as required by the Legislature.

Concurrently, DMH and RRMC continue to work on expanding the current psychiatric inpatient program to provide an estimated 12 beds for the highest level of acuity (currently only provided at VSH). 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. If the approach receives favorable responses from the capital markets, then the Joint Fiscal Office and the Treasurer's office will prepare an analysis of the viability of the project for two Legislative Oversight Committees that will have until November 1, 2009 to object to the project (this would essentially stop further planning with RRMC).

Financial/Budget Neutrality Development/Issues

Effective January 1, 2009, AHS began paying OVHA the PMPM capitation payment prospectively; AHS has trued up its capitation payment obligations to OVHA per the PMPM rates for FFY07, FFY08 and FFY09 to-date. With the QE0309 report, AHS has resubmitted the CMS-64 forms for these periods to reflect actual PMPM costs reported by Medicaid Eligibility Groups.

Per guidance received from CMS on May 1, 2009, on May 4, 2009, AHS began drawing enhanced FMAP for Global Commitment, retroactive to October 1, 2008.

On April 10, 2009, the AHS computer system was hit with a disabling virus which resulted in network unavailability. Files were not fully restored until the first week of May. This network outage disrupted the monthly enrollment process, in addition to other business processes. As a result, AHS was unable to

follow its normal procedure of running enrollment numbers as of April 15th, on the first business day afterward; we ran enrollment numbers as of 4/15/09 on 4/22/09. This is in line with our PMPM Payment Process procedure. Similarly, on May 18, 2009 (the first business day after the 15th), issues relating to the Business Objects query function were discovered. These could not be resolved prior to preparation of the 6/1/09 capitation payment, so enrollment from the prior month, run on 4/22/09, was used for the 6/1 payment. This is also reflective of our procedure. We do not anticipate similar issues occurring in the future.

Vermont's State fiscal year begins on July 1st. The AHS Global Commitment appropriation provides the State match used to generate the monthly capitation payments to OVHA. For our June 1st capitation payment, the GC appropriation faced a State fund shortfall of $8,095,477, $25,972,014 gross that AHS could not pay OVHA on June 1st per its IGA obligation. On July 1st, AHS paid OVHA this $26M obligation out of its SFY10 appropriation, in addition to the funds due OVHA for the July 1st capitation payment and as a result OVHA has received full payment for its QE0609 PMPMs to-date.

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 4/15/2009	Month 2 5/15/2009	Month 3 6/15/2009	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:	42,722	42,746	42,735	128,203	125,825	123,997	122,281	121,926	120,113
Demonstration Population 2:	42,750	42,947	42,893	128,590	122,210	121,981	123,283	122,118	120,309
Demonstration Population 3:	9,465	9,557	9,606	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
Demonstration Population 5:	1,188	1,208	1,172	3,568	3,832	3,850	3,767	3,542	3,767
Demonstration Population 6:	2,355	2,471	2,654	7,480	8,208	7,428	7,357	6,208	6,084
Demonstration Population 7:	28,648	29,162	29,306	87,116	75,277	74,301	73,966	72,336	65,803
Demonstration Population 8:	7,633	7,736	7,796	23,165	22,032	21,715	23,100	22,697	22,445
Demonstration Population 9:	2,527	2,554	2,584	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
Demonstration Population 11:	8,058	8,262	8,397	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 met to discuss the remaining steps of the project and to prepare for this year's External Quality Review Organization (EQRO) PIP validation. The work plan was reviewed and anticipated barriers were discussed. Enrollment in the PIP ended on May 31, 2009, but due to a thirty day lag, data analysis can not begin until the beginning of next quarter. During this quarter, the AHS worked with the EQRO to finalize the Performance Improvement Project Validation documents and the Performance Measure Validation documents (e.g., MCO letter, summary form, etc). At the end of the quarter, these documents were sent to the MCO in anticipation of their submission. 2009 MCO Performance Measures were not submitted to AHS this quarter. Because some source code modifications were identified by the EQRO prior to their on site visit, the submission will be held until after the EQRO Performance Measure Validation work finishes. This will improve the validity of the measures. It is anticipated that the report will be submitted by the end of next quarter.

Quality Assurance Performance Improvement Committee(QAPI): During this quarter, the Quality Assessment and Performance Improvement (QAPI) Committee discussed the pending MCO Compliance Review. This discussion focused on the three Measurement & Improvement sub-standards (i.e., practice guideline, quality assessment and performance improvement program, and health information systems). 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 finalized the MCO Quality Plan. As a final step, the group cross-walked their quality plans with OVHA's quality plan to ensure that shared activities were consistent and that any unique activities were identified. During this quarter, the group discussed the committee purpose and evaluated its membership. Now that the Evaluation Plan, Quality Strategy, and Quality Plan are in place, the group discussed a need to focus more on MCO monitoring and oversight activities. The group agreed to review the aforementioned activities during the next quarter and prioritize their completion. As part of this process, the group also discussed how it might determine the impact and effectiveness of the MCO quality assessment and performance improvement program. In addition to reviewing results of performance measures and performance improvement projects, the group agreed to conduct a self assessment at least annually. This idea will be advanced further in subsequent quarters.

Quality Strategy: The AHS 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, Pacific Health Policy Group (PHPG) completed their telephone survey of beneficiaries. Of the 2,500 names provided, 1,537 were contacted with 383 completing the survey for a response rate of approximately 24.9 percent. PHPG also continued surveying primary care providers (PCPs) to assess their satisfaction with program policies and procedures, payment rates, specialist physician capacity and care coordination. PHPG selected approximately 326 PCP's, who have provided care to at least fifty Medicaid enrollees over the previous 12 months, to complete a mail survey. The survey will be mailed to PCP's during the next quarter. Finally, PHPG began preparing an interim evaluation report which must accompany the State's formal extension waiver request. It is anticipated that an interim waiver evaluation report will be completed during the next quarter.

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 5 for a summary of MCO Investments, with applicable category identified, for State fiscal year 2008.

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 - *"deadline for CMS-64 for QE0609 extended to 8/14; as such the budget neutrality sheet has not been updated at this time"*
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: August 13, 2009

ATTACHMENTS

VERMONT

Office of Vermont Health Access
SFY '09 Catamount Health Actual Revenue and Expense Tracking
Wednesday, July 22, 2009

	SFY '09 Revised Appropriated			Consensus Estimates for SFY to Date			Actuals thru 6/30/09			
	<=200%	*>200%*	*Total*	*<=200%*	*>200%*	*Total*	*<=200%*	*>200%*	*Total*	*% of SFY to-Date*
TOTAL PROGRAM EXPENDITURES										
Catamount Health	20,817,250	8,911,418	29,728,669	20,817,250	8,911,418	29,728,669	21,965,784	8,327,448	30,293,232	101.90%
Catamount Eligible Employer-Sponsored Insurance	803,162	406,989	1,210,151	803,162	406,989	1,210,151	720,889	354,566	1,075,455	88.87%
Subtotal New Program Spending	21,620,412	9,318,408	30,938,820	21,620,412	9,318,408	30,938,820	22,686,673	8,682,014	31,368,687	101.39%
Catamount and ESI Administrative Costs	1,278,217	905,626	2,183,843	1,278,217	905,626	2,183,843	1,278,217	905,626	2,183,843	100.00%
TOTAL GROSS PROGRAM SPENDING	22,898,629	10,224,034	33,122,663	22,898,629	10,224,034	33,122,663	23,964,890	9,587,640	33,552,530	101.30%
TOTAL STATE PROGRAM SPENDING	**7,826,751**	**10,224,034**	**18,050,785**	**7,826,751**	**10,224,034**	**18,050,785**	**8,191,199**	**9,587,640**	**17,778,839**	**98.49%**
TOTAL OTHER EXPENDITURES										
Immunizations Program	-	2,500,000	2,500,000	-	2,500,000	2,500,000	-	2,254,334	2,254,334	90.17%
VT Dept. of Labor Admin Costs Assoc. With Employer Assess.	-	394,072	394,072	-	394,072	394,072	-	384,046	384,046	97.46%
Marketing and Outreach	500,000	-	500,000	500,000	-	500,000	500,000	-	500,000	100.00%
Blueprint	-	1,846,713	1,846,713	-	1,846,713	1,846,713	-	2,092,381	2,092,381	113.30%
TOTAL OTHER SPENDING	500,000	4,740,785	5,240,785	500,000	4,740,785	5,240,785	500,000	4,730,761	5,230,761	99.81%
TOTAL STATE OTHER SPENDING	**170,900**	**4,740,785**	**4,911,685**	**170,900**	**4,740,785**	**4,911,685**	**170,900**	**4,730,761**	**4,901,661**	**99.80%**
TOTAL ALL STATE SPENDING	**7,997,651**	**14,964,819**	**22,962,470**	**7,997,651**	**14,964,819**	**22,962,470**	**8,362,099**	**14,318,401**	**22,680,501**	**98.77%**
TOTAL REVENUES										
Catamount Health Premiums	3,275,499	2,972,223	6,247,722	3,275,499	2,972,223	6,247,722	3,533,837	2,556,838	6,090,675	97.49%
Catamount Eligible Employer-Sponsored Insurance Premiums	244,395	269,856	514,251	244,395	269,856	514,251	225,965	160,898	386,863	75.23%
Subtotal Premiums	3,519,893	3,242,079	6,761,973	3,519,893	3,242,079	6,761,973	3,759,801	2,717,736	6,477,538	95.79%
Federal Share of Premiums	(2,316,794)	-	(2,316,794)	(2,316,794)	-	(2,316,794)	(2,474,701)	-	(2,474,701)	106.82%
TOTAL STATE PREMIUM SHARE	1,203,100	3,242,079	4,445,179	1,203,100	3,242,079	4,445,179	1,285,100	2,717,736	4,002,836	90.05%
Cigarette Tax Increase ($.60 / $.80)			9,207,000			9,207,000			9,361,695	101.68%
Floor Stock			500,000			500,000			348,117	69.62%
Employer Assessment			5,480,159			5,480,159			6,378,000	116.38%
Interest			-			-			125,951	0.00%
TOTAL OTHER REVENUE			15,187,159			15,187,159			16,213,764	106.76%
TOTAL STATE REVENUE	**1,203,100**	**3,242,079**	**19,632,338**	**1,203,100**	**3,242,079**	**19,632,338**	**1,285,100**	**2,717,736**	**20,216,600**	**102.98%**
State-Only Balance			(3,330,132)			(3,330,132)			(2,463,900)	
Carryforward			9,775,791			9,775,791			9,775,791	
(DEFICIT)/SURPLUS			**6,445,658**			**6,445,658**			**7,311,891**	
Reserve Account Funding			-			-			-	
REVISED (DEFICIT)/SURPLUS WITH RESERVE FUNDING			**6,445,658**			**6,445,658**			**7,311,891**	

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

Green Mountain Care Enrollment Report
June 2009
TOTAL ENROLLMENT BY MONTH

	Jul-07	Nov-07	Mar-08	Apr-08	May-08	Jun-08	Jul-08	Aug-08	Sep-08	Oct-08	Nov-08	Dec-08	Jan-09	Feb-09	Mar 09	Apr 09	May 09	Jun 09
Adults:																		
VHAP-ESIA	-	35	542	589	607	632	672	691	733	747	759	809	859	900	938	952	948	957
ESIA	-	21	242	273	304	324	336	358	413	447	499	569	504	489	519	542	577	578
CHAP	-	320	3,033	3,507	3,918	4,265	4,608	5,003	5,384	5,684	6,120	6,239	6,407	6,699	7,046	7,538	7,710	7,842
Catamount Health	-	120	361	344	470	606	697	701	785	853	932	991	1,011	1,103	1,168	1,220	1,243	1,320
Total	**-**	**376**	**4,178**	**4,713**	**5,299**	**5,827**	**6,313**	**6,753**	**7,315**	**7,731**	**8,310**	**8,608**	**8,781**	**9,191**	**9,671**	**10,252**	**10,478**	**10,697**

	Jul-07	Nov-07	Mar-08	Apr-08	May-08	Jun-08	Jul-08	Aug-08	Sep-08	Oct-08	Nov-08	Dec-08	Jan-09	Feb-09	Mar 09	Apr 09	May 09	Jun 09
Adults:																		
VHAP	23,725	24,849	26,301	26,670	26,516	26,650	26,441	26,721	26,622	26,900	26,860	27,198	28,038	28,957	29,451	30,064	30,747	30,997
Other Medicaid	69,764	69,969	70,851	70,789	70,766	70,754	70,947	70,846	71,638	71,403	35,601	35,610	36,893	37,019	37,290	37,331	37,663	37,857
Children:																		
Dr Dynasaur	19,738	19,733	20,210	20,227	20,297	20,410	19,960	20,061	20,251	20,481	20,511	20,468	20,630	20,717	20,649	20,636	20,675	20,798
SCHIP	3,097	3,428	3,166	3,200	3,231	3,215	3,396	3,363	3,415	3,504	3,527	3,482	3,606	3,105	3,140	3,264	3,290	3,330
Other Medicaid*	Included	Included	Included	Included	Included	Included	Included	Included	Included	Included	34,015	33,759	35,672	36,375	36,836	37,035	37,354	37,519
Total	**116,324**	**117,979**	**120,528**	**120,886**	**120,810**	**121,029**	**120,744**	**120,991**	**121,926**	**122,288**	**120,514**	**120,517**	**124,839**	**126,173**	**127,366**	**128,330**	**129,729**	**130,501**
TOTAL ALL	**116,324**	**118,355**	**124,706**	**125,599**	**126,109**	**126,856**	**127,057**	**127,744**	**129,241**	**130,019**	**128,824**	**129,125**	**133,620**	**135,364**	**137,037**	**138,582**	**140,207**	**141,198**

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

June 2009 Demographics

Income	VHAP-ESIA*	ESIA*	CHAP*	TOTAL
0-50%	27	4	361	
50-75%	54	2	88	
75-100%	101	3	129	
100-150%	487	11	549	
150-185%	253	206	2,807	
185-200%	17	178	1,694	
200-225%	12	95	1,085	
225-250%	4	54	672	
250-275%	-	21	306	
275-300%	2	4	151	
Total	**957**	**578**	**7,842**	**9,377**

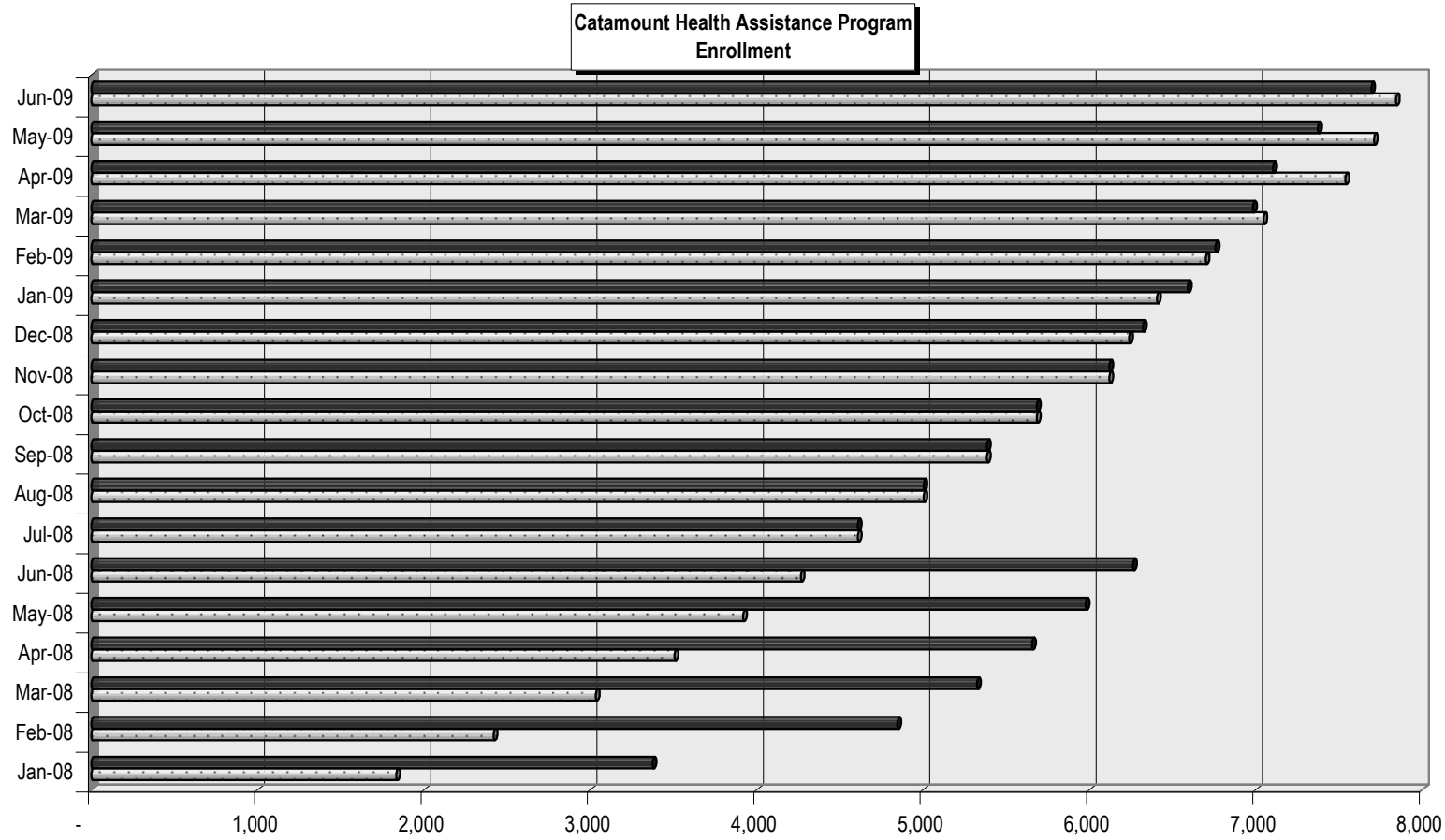
Age	VHAP-ESIA	ESIA	CHAP	TOTAL
18-24	66	53	1,492	
25-35	269	142	1,318	
36-45	361	158	1,271	
46-55	207	164	1,790	
56-64	54	61	1,962	
65+	-	-	9	
Total	**957**	**578**	**7,842**	**9,377**

Green Mountain Care Enrollment Report (continued)

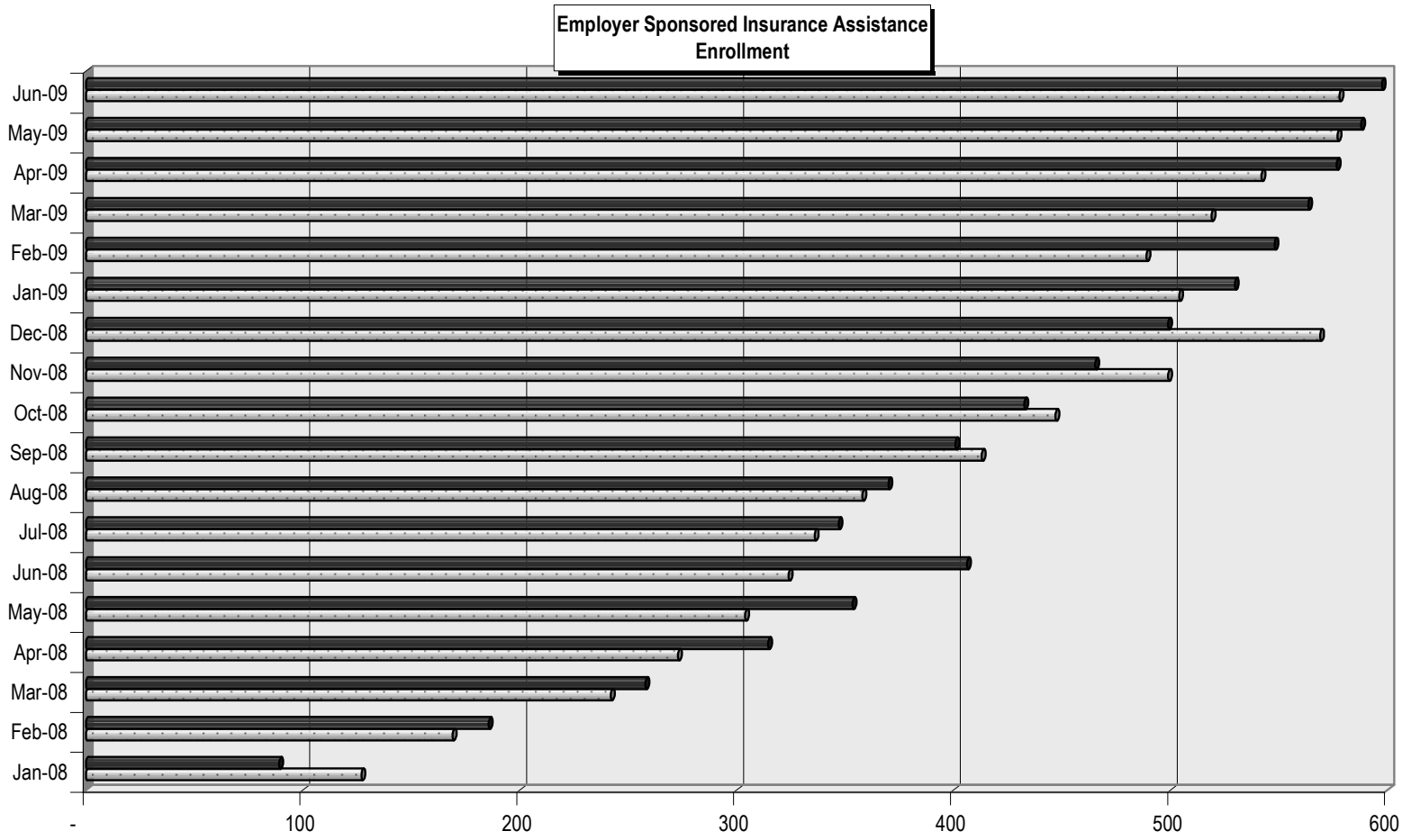
June 2009 Demographics

Gender	VHAP-ESIA	ESIA	CHAP	TOTAL
Male	346	200	3,399	
Female	611	378	4,443	
Total	**957**	**578**	**7,842**	**9,377**

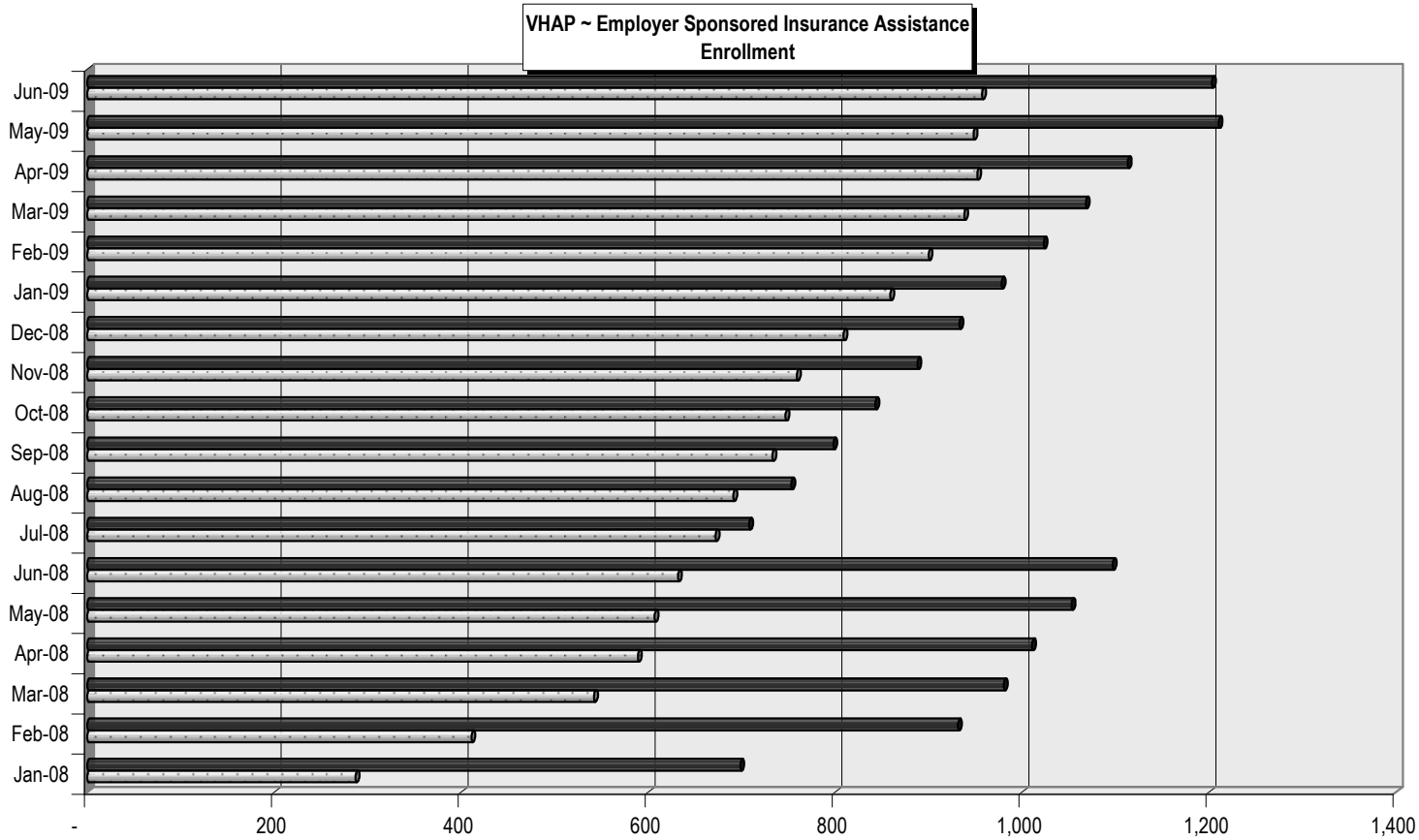
County	VHAP-ESIA	ESIA	CHAP	TOTAL
Addison	60	31	501	
Bennington	90	43	479	
Caledonia	47	19	463	
Chittenden	174	117	1,394	
Essex	10	2	101	
Franklin	97	44	514	
Grand Isle	11	10	94	
Lamoille	51	32	409	
Orange	41	29	376	
Orleans	66	30	475	
Other	2	1	19	
Rutland	102	88	863	
Washington	75	39	779	
Windham	62	38	645	
Windsor	69	55	730	
Total	**957**	**578**	**7,842**	**9,377**



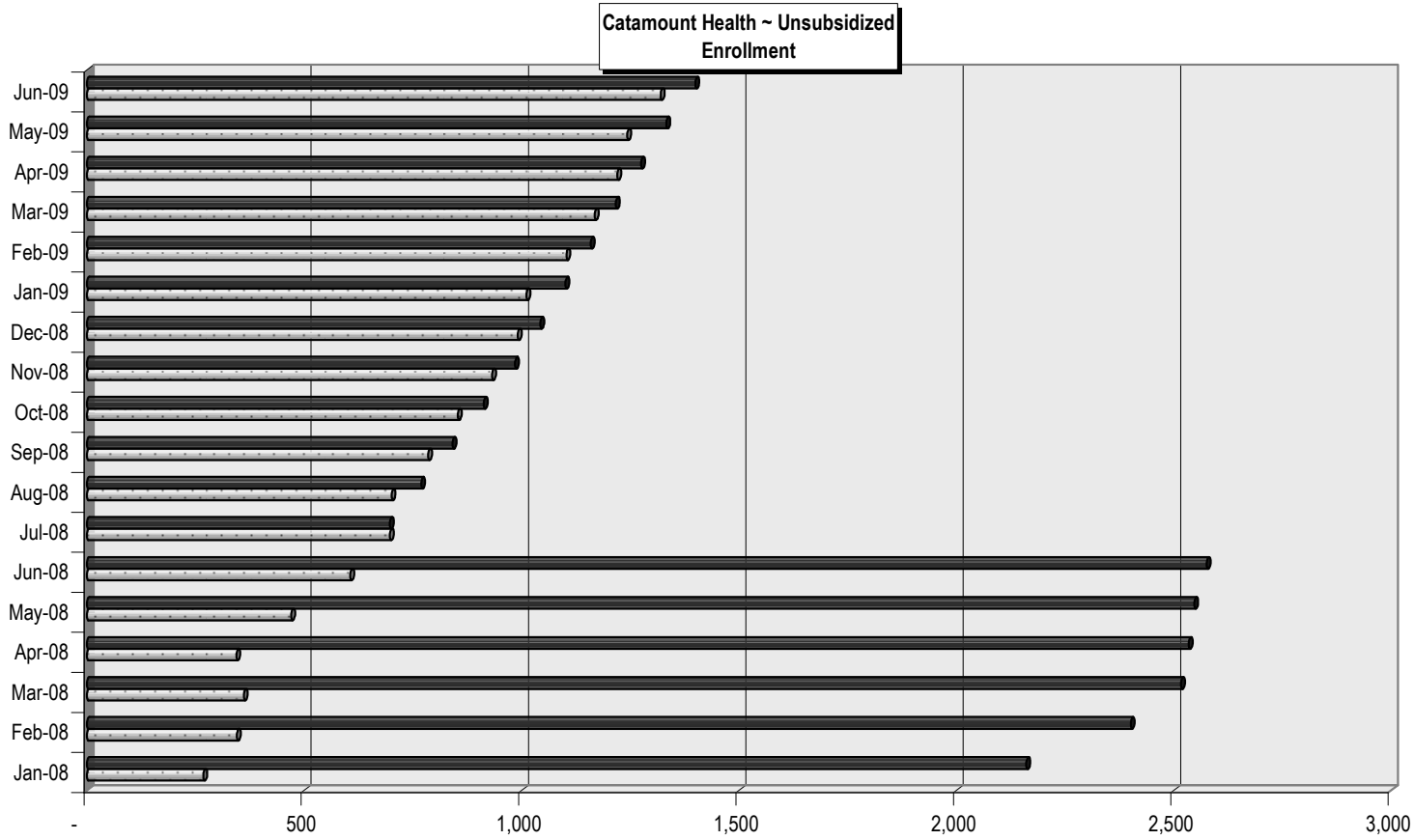
	Jan-08	Feb-08	Mar-08	Apr-08	May-08	Jun-08	Jul-08	Aug-08	Sep-08	Oct-08	Nov-08	Dec-08	Jan-09	Feb-09	Mar-09	Apr-09	May-09	Jun-09
Actual	3,375	4,845	5,324	5,655	5,978	6,262	4,608	5,003	5,384	5,684	6,120	6,321	6,592	6,758	6,983	7,103	7,374	7,694
Projected	1,834	2,419	3,033	3,507	3,918	4,265	4,608	5,003	5,384	5,684	6,120	6,239	6,407	6,699	7,046	7,538	7,710	7,842



	Jan-08	Feb-08	Mar-08	Apr-08	May-08	Jun-08	Jul-08	Aug-08	Sep-08	Oct-08	Nov-08	Dec-08	Jan-09	Feb-09	Mar-09	Apr-09	May-09	Jun-09
Projected	89	186	258	315	353	406	347	370	401	433	465	499	530	548	564	577	588	597
Actual	127	169	242	273	304	324	336	358	413	447	499	569	504	489	519	542	577	578



	Jan-08	Feb-08	Mar-08	Apr-08	May-08	Jun-08	Jul-08	Aug-08	Sep-08	Oct-08	Nov-08	Dec-08	Jan-09	Feb-09	Mar-09	Apr-09	May-09	Jun-09
Projected	699	931	980	1,011	1,053	1,097	708	753	798	843	888	933	978	1,023	1,068	1,113	1,210	1,203
Actual	287	411	542	589	607	632	672	691	733	747	759	809	859	900	938	952	948	957



	Jan-08	Feb-08	Mar-08	Apr-08	May-08	Jun-08	Jul-08	Aug-08	Sep-08	Oct-08	Nov-08	Dec-08	Jan-09	Feb-09	Mar-09	Apr-09	May-09	Jun-09
Projected	2,161	2,401	2,517	2,535	2,547	2,576	697	769	841	913	985	1,043	1,101	1,159	1,217	1,275	1,333	1,400
Actual	268	345	361	344	470	606	697	701	785	853	932	991	1,011	1,103	1,168	1,220	1,243	1,320

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, 2009 – June 30, 2009

Eligibility forms, notices, or process	10
Catamount Health/Premium Assistance Programs premiums, process, ads, plans	9
Use of social security numbers as identifiers	6
General premium complaints	7
Green Mountain Care website	1
Provider issues (perceived rudeness, refusal to provide service, prices) (variety of provider types)	4
Member services	3
Eligibility rules	2
Eligibility local office	7
Prescription drug plan issues	0
Pharmacy coverage	0
Coverage rules	3
Chiropractic coverage change	0
Copays/service limit	0
Provider enrollment issues	0
OVHA	1
Total	**53**

VERMONT

Agency of Human Services

Grievance and Appeal Quarterly Report
Medicaid MCO All Departments Combined Data
April 1, 2009 – June 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 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 has at least one assigned grievance and appeal coordinator who enters data into the MCO database. This report is based on data compiled on July21, 2009, from the centralized database for grievances and appeals that were filed from April 1, 2009 through June 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. Only one was addressed during the quarter, one was withdrawn and fifteen 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 grievance that was addressed was addressed in forty-four days. Acknowledgement letters of the receipt of a grievance must be sent within five days, and as the MCO, we averaged only three days, although four of those letters were sent late. Of the grievances filed, 71% were filed by beneficiaries, 18% were filed by a representative of the beneficiary, and 11% were filed by someone else on the beneficiary's behalf. Of the seventeen grievances filed, DAIL had 6%, DMH had 64%, OVHA had 24%, and VDH had 6%. There were no grievances filed for the Department for Children and Families during this quarter.

On the last quarterly report, it was reported that there were six grievances pending. In actuality, there were only four. Two of the cases 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 four DMH cases that were pending at the end of the last quarter, three were resolved this quarter, and within the required timeframes. The other case had exceeded the timelines.

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 one day. The Grievance Review that was filed last quarter has not been addressed yet.

Appeals: Medicaid rule M180.1 defines actions that an 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-nine appeals filed with the MCO, of which twelve requested an expedited decision, and none met the criteria. Of these 39 appeals, twenty-eight were resolved (72% of filed appeals), two were withdrawn (5%), and nine appeals were still pending (23%). In nineteen cases (68% of those resolved), the original decision was upheld by the person hearing the appeal, four cases (14% of those resolved) were reversed, none were modified, and five were approved by the department/DA/SSA before the appeal meeting (18% of those resolved).

Of the twenty-eight appeals that were resolved this quarter 93% were resolved within the statutory time frame of 45 days. In addition, 86% of the resolved appeals were resolved within 30 days. All 28 cases were resolved within 59 days, although one of these cases exceeded the required 45-day timeframe without an extension. The average number of days it took to resolve these 28 cases was 17 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 five of those letters were sent late.

Of the 39 appeals filed, nineteen were filed by beneficiaries (49%), eighteen were filed by a representative of the beneficiary (46%), two were filed by a provider (5%), and none were filed by someone else at the request of the beneficiary. Of the 39 appeals filed, OVHA had 62%, and DAIL had 38%. There were no appeals filed for the Department of Health (neither ADAP nor CSHN), The Department of Mental Health, 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 M180.1 (see above). There were 25 appeals for a denial or limitation of authorization of a requested service or eligibility for service (64%), 13 were for a reduction/suspension/termination of a previously authorized covered service or service plan (33%), and one was left blank (3%).

There were thirteen cases filed between January 1, 2009, and March 31, 2009 that were still pending at the beginning of this quarter. In addition, there were two DAIL cases that were still pending from before January 1, 2009 [On the last report there were twelve cases pending from between 1/1/09 and 3/31/09. The additional case had been received prior to March 31, 2009, but the information was not entered until after the quarterly reports were compiled on July 1, 2009.] Of those fifteen cases, eleven were resolved this quarter. 846% of these cases were upheld (three for DAIL & two for OVHA), 18% were reversed (tone for DAIL & one for OVHA); 9% were modified (DMH), 27% was withdrawn (one for DAIL, one for DMH & one for OVHA), and none were approved before the appeal hearing. 27% of the cases were resolved within thirty days, 73% in forty-five days, and 91% within fifty-nine days. One DAIL case had been extended, and was decided within correct timeframes. The other cases were DAIL cases which took 54 and 426 days to be resolved. On June 30, 2009 there were four cases still pending; two for DAIL's Children's Personal Care program for 292 & 141 days, one for DAIL's DS program through NKHS for 161 days, and one for DAIL's DS program through WCMH for 173 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 three fair hearings filed this quarter; one for DAIL and two for OVHA. One was filed concurrently with the appeal, while the other two were filed subsequent to the appeal decision. All three cases are still pending. There were twelve fair hearings that were pending from previous quarters. Since none of them were resolved, there are fifteen total fair hearings still pending, five for DAIL and ten for OVHA.

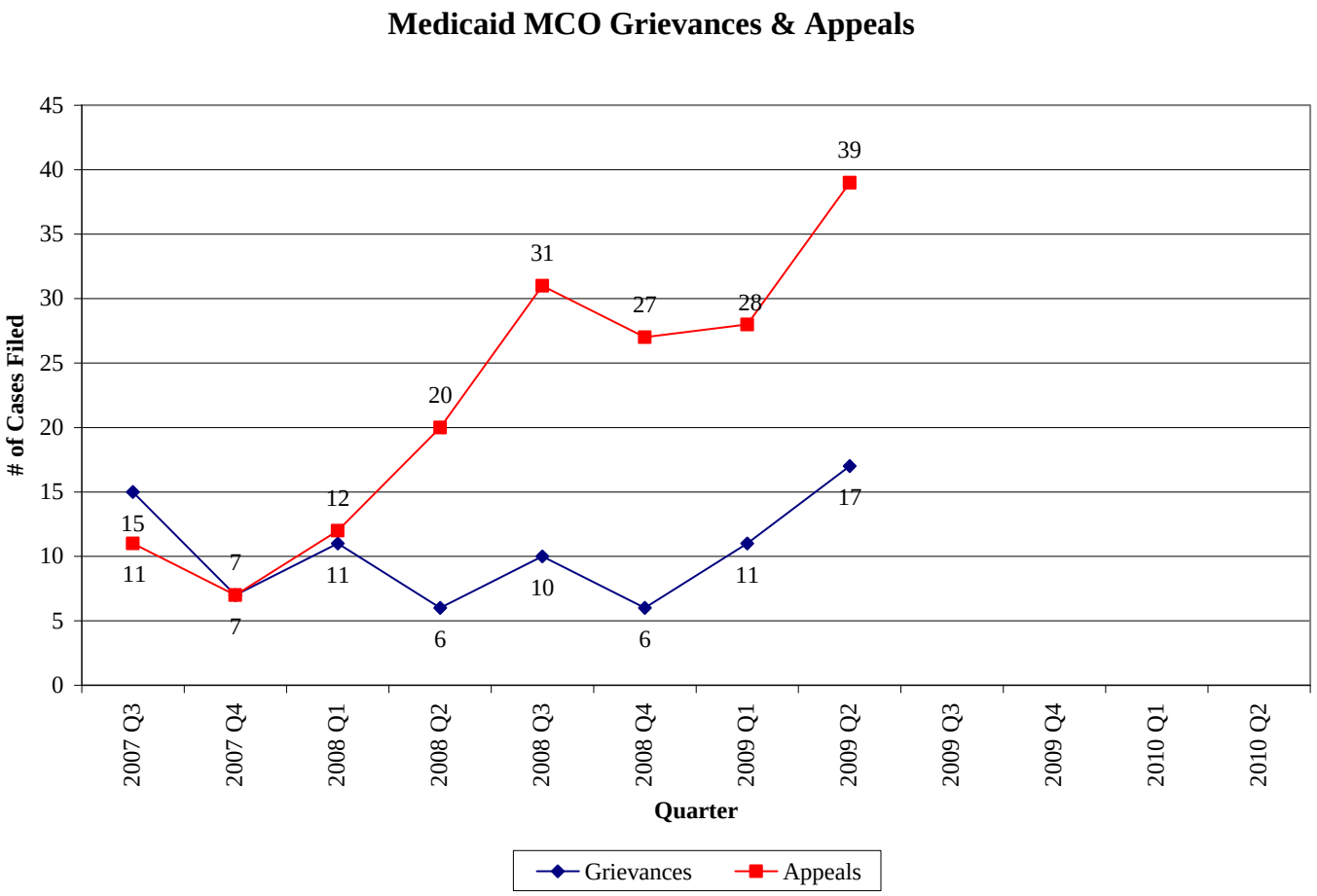
Other Information:

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.

DCF was supposed to identify and have trained, program specific individuals, 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.

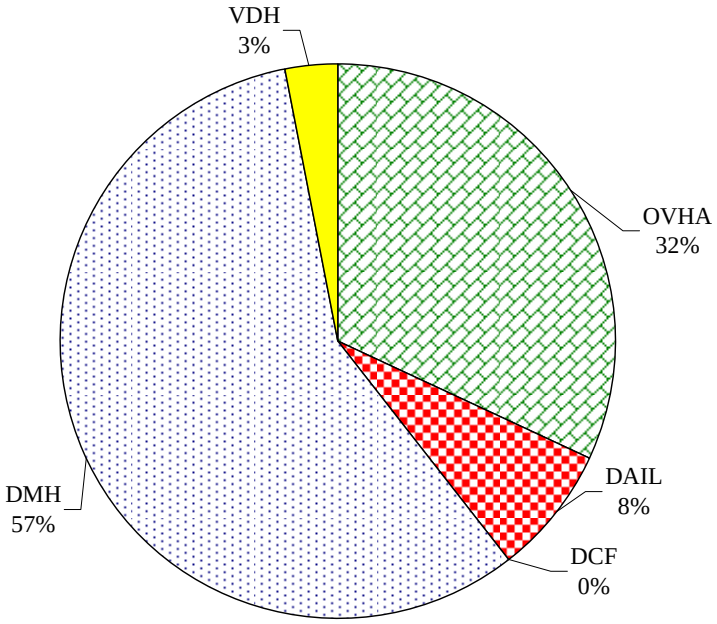
One requirement was for each entity/grievance and appeal coordinator to complete a quarterly Quality Improvement (QI) Report.

For this reporting quarter, QI reports have not been sent out yet.

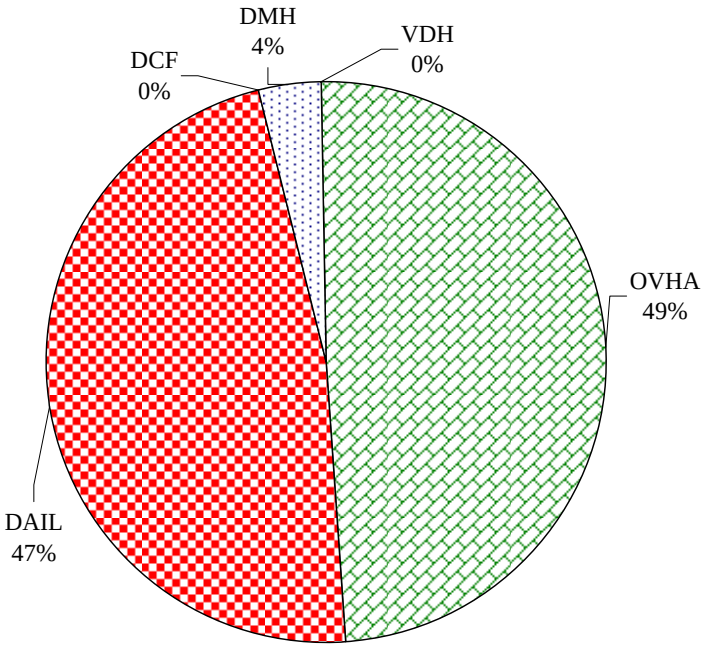


MCO Grievance & Appeals by Department from July 1, 2007 through June 30, 2009

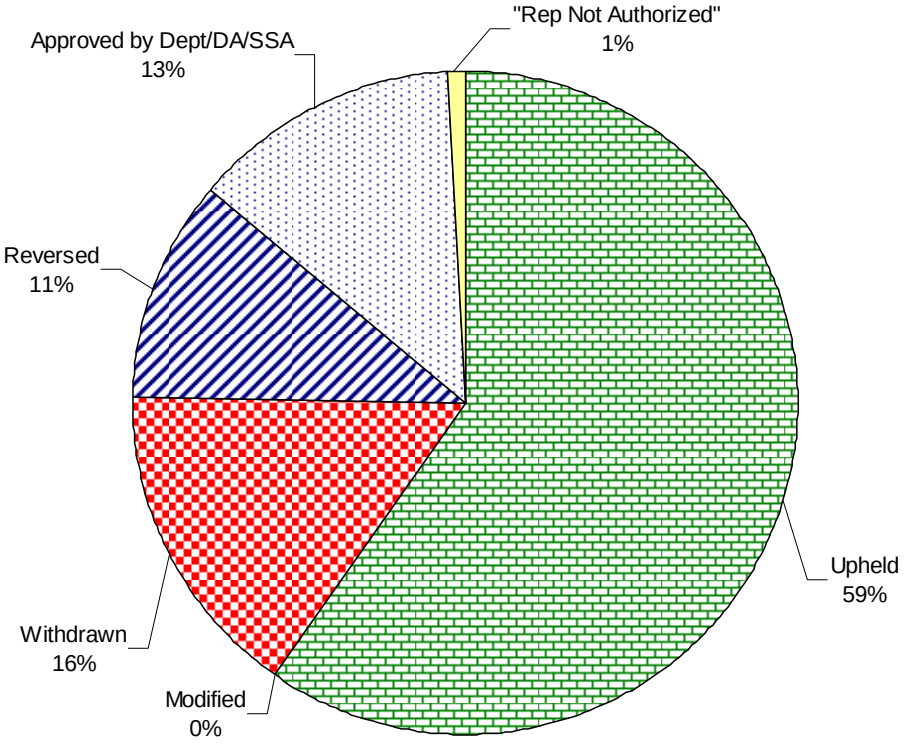
Grievances



Appeals



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



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

Grievances

Total number of grievances filed: 17

Number pending: 15 *Dail-1; DMH-10; OVHA-3; VDH-1*

Number withdrawn: 1 *OVHA*

Number addressed: 1 *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: 10

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

Average number of days from filing to being addressed: 44

Average number of days to send acknowledgement letter: 3

Number of late acknowledgement letters: 4 *DMH-3; VDH-1*

Average number of days from filing to withdrawing: 2

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

Number of late withdrawal letters: 0

Number of grievance reviews requested: 1 *DMH*

Average number of days to send grievance review acknowledgement letter: 1

Number of late grievance review acknowledgement letters: 0

Number of grievance reviews addressed: 0

Source of grievance request:

Beneficiary:	12	71%
Beneficiary Representative:	3	18%
Other:	2	11%

Number related to:

OVHA:	4	24%
DAIL:	1	6%
DCF:	0	0%
DMH:	11	64%
VDH:	1	6%

Top services grieved:
1. Mental Health Services (4)
2. Other (3)
3. Prescriptions (2)
4. Communtiy/Social Supports (2)

Number by category: [Check ALL that apply]

Staff/Contractor:	5
Program Concern:	2
Management:	1
Policy or Rule Issue:	3
Quality of Service:	5
Service Accessibility:	4
Timeliness of Service Response:	3
Service Not Offered/Available:	2
Other:	6
Enrollee Rights:	3

* * * * * *

Number pending from all previous quarters: 4 *DMH*

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

Number that were pending in previous quarters and addressed this quarter: 3
- Within 90 days: 100%

Number of grievance reviews pending from all previous quarters: 1 *DMH [still pending]*

There were 6 pending grievances at the end of last quarter. This report only shows 4 as the other 2 (DAIL & DMH) were addressed last quarter but the information was not entered until too late. One grievance that was filed last quarter is still pending as of 6/30/09.

Data as of: 7/21/09

Appeals

Number of appeals filed: 39

Number pending: 9 *DAIL-6; OVHA-3*

Number withdrawn: 2 *OVHA*

Number resolved: 28
- Number upheld: 19 68% *DAIL-7; OVHA-12*
- Number reversed: 4 14% *DAIL-2; OVHA-2*
- Number modified: 0 0%
- Number approved by Dept/DA/SSA: 5 18% *OVHA*

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

Resolved time frames
- Within 30 days: 86% *DAIL-7; OVHA-17*
- Within 45 days: 93% *DAIL-8; OVHA-18*
- Within 59 days: 100% *DAIL-9; OVHA-19*
  - Extended (1) vs. Late (1) *DAIL-late*
- Over 59 days: 0%

Number of appeals filed too late: 0

Average number of days from NOA to filing appeal: 17

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

Average number of days from filing to resolution: 17

Average number of days from filing to resolution when extended: 47

Average number of days to send acknowledgement letter: 2

Number of late acknowledgement letters: 5 *DAIL*

Average number of days from filing to withdrawing: 9

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

Number of late withdrawal letters: 0

Source of appeal request:

Beneficiary:	19	49%
Beneficiary Representative:	18	46%
Provider:	2	5%
Other:	0	0%

Number related to:

OVHA:	24	62%
DAIL:	15	38%
DCF:	0	0%
DMH:	0	0%
VDH:	0	0%

Top services appealed:
1. Personal Care (15)
2. Prescriptions (9)
3. Orthodontic (9)
4. Transportation (3)
5. Surgical Services (2)

Number of beneficiaries that requested that their services be continued: 4 10% *DAIL-2; OVHA-2)*

Of those that requested their services be continued:
- Number that met criteria: 3 75% *DAIL-2, OVHA-1*
- Number that did not meet criteria: 1 25% *OVHA-1*

Number by category:
1. Denial or limitation of authorization of a requested service or eligibility for service: 25
2. Reduction/suspension/termination of a previously authorized covered service or service plan: 13
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: 12 *OVHA-12*

Number of expedited appeals that:
Met criteria: 0
Did not meet criteria: 12

Of those that did not meet 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: 13
DAIL-8; DMH-1; OVHA-4 [Last report said 12. DAIL entered 1 case late from last quarter.

Number pending from previous quarters: 2
DAIL-2 [Last report said 4. One case each from DAIL & DMH had their resolution information entered late.

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

Number of total pending that were resolved this quarter: 11

Number upheld:	5	46%	*DAIL-3; OVHA-2*
Number reversed:	2	18%	*DAIL-1; OVHA-1*
Number modified:	1	9%	*DMH-1*
Number approved by Dept/DA/SSA:	0	0%	
Number withdrawn:	3	27%	*DAIL-1; DMH-1, OVHA-1*

Resolution time frames for resolving above cases:

Within 30 days:	27%	*OVHA-3*
Within 45 days:	73%	*DAIL-2; DMH-2; OVHA-4*
Within 59 days:	91%	*DAIL-4; DMH-2; OVHA-4*
Extended (1) vs. Late (1)		
Over 59 days:	9%	*DAIL-1*

Number of appeals still pending from all previous quarters: 4*DAIL-4: Children's Personal Care-2 (292 & 141 days), Developmental Services-NKHS (161 days), Developmental Services-WCMH (173 days)*

Fair Hearings

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

Number of Fair Hearings filed with a concurrent appeal: 1 *OVHA*

Number of Fair Hearings filed after appeal resolution: 2 *DAIL-1; OVHA-1*

Number pending: 3

Number of pending Fair Hearings from previous quarters: 12 DAIL-4; OVHA-8 (Last report said 11. OVHA received notification of a fair hearing after the last report was done.)

Number of pending Fair Hearings from previous quarters resolved this quarter: 0

Number of pending Fair Hearings from previous quarters still pending at the end of this quarter: 15
DAIL-5; OVHA-10

ATTACHMENT 5

Office of Health Care Ombudsman

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QUARTERLY REPORT
April 1, 2009 - June 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 April 1, 2009 through June 30, 2009. The total number of all cases/all coverages that we opened this quarter was 702, the highest volume yet for the second quarter of the calendar year. We received 751 total calls last quarter and 643 the previous quarter.

January and June are typically our busiest months. This year's total call volume in June was the highest ever for that month, at 276. This was also our busiest month to date in 2009, outstripping January in which we received 240 calls. The reason for the June increase is not completely clear from our data.

We received 320 calls from individuals on OVHA programs this quarter, up from 312 last quarter, and 248 the previous quarter. This was 46% of the total call volume, compared to 41% last quarter, and 39% the previous quarter. Last year we received 316 calls from OVHA beneficiaries for this quarter.

About 14% of our total (all coverages) calls were related to the hybrid programs involving government and private insurance, i.e. Medicare Part C, Medicare Part D, VPharm and the Catamount Health-related programs. We received 49 calls related to the federal Medicare Modernization Act (Medicare Part C, Medicare Part D and VPharm), compared to 60 calls last quarter, and 51 Catamount Health calls compared to 64 last quarter.

As has been the pattern lately, the highest call volume was for Access to Care (28%) and Eligibility (24%) issues. That more than half of all our calls are now related to Access to Care and Eligibility issues is most likely related to the current recession.

We received 196 total Access to Care calls this quarter, the highest number ever. This category has steadily increased over the last three quarters. The majority of Access calls were from OVHA beneficiaries: of the 196 calls, 111 (57%) were from OVHA beneficiaries. Last quarter, coincidentally, the same percentage, 57%, were from individuals on OVHA programs. Since OVHA beneficiaries made up 46% of our callers this quarter, this comparatively high percentage of Access calls from individuals on state programs continues to be of some concern.

Eligibility calls increased when Catamount Health went into effect in October 2007 and have remained high. This quarter we received 171 (24% of all calls) about Eligibility for government health insurance programs, down from 195 last quarter, which is somewhat surprising, given the economy and the increase in unemployment.

Prescription Drugs has consistently been our largest category of calls when general access to medications, Medicare Part D, Medicare Part B, and VPharm are counted together. The total number of Prescription Drug calls this quarter went down to 81 from 106 last quarter. Viewed together, the issue categories involving prescription drugs represented 12 % of all calls received. Last quarter they made up 14% of all calls. About 41% of the prescription calls were about Medicare Part D this quarter, down from about 50% last quarter. Interestingly, an additional 16% were about Medicare Part B drugs, which are medications administered in a medical setting. Thus, 57% of the prescription drug cases involved Medicare this quarter.

We had 34 OVHA calls regarding prescription drugs, Medicare Part B, Medicare Part D and VPharm. Thus, OVHA beneficiaries had 42 % of all prescription-related calls. This compares to 57 calls last quarter, and 38 the previous quarter.

The calls about medications discussed above do not include the Pain Management calls that we received. Nine months ago we began tracking pain management cases as a separate issue category because we had a noticeable increase in calls connected to pain. Some Pain Management cases involve access to prescription drugs, but many involve access to primary care doctors or other issues. The number of Pain Management cases we handled decreased to 23, down from 30 last quarter, but that is still more than the 21 received the previous quarter. Of the 23 pain-related calls, 14 (61%) were from OVHA program beneficiaries, compared to 70% of the 30 calls received last quarter. In the previous quarter 43% of the pain management cases were from OVHA program beneficiaries. Only three of the individuals calling about pain management problems had commercial insurance this quarter, down from four the last quarter. Clearly Medicaid beneficiaries are having more problems in this area.

We received 51 calls regarding Catamount Health and the Premium Assistance programs, which was down from 64 last quarter. Catamount calls were 7 % of our total calls, down from last quarter's 8.5%. Catamount and Premium Assistance calls are usually related to eligibility for

those programs, but we also had five billing cases and five consumer education cases. Few calls from OVHA beneficiaries were coded as Catamount and Premium Assistance because typically people calling us about these programs are either uninsured or on commercial insurance which they are about to lose or can't afford.

II. Disposition of cases

We closed 308 OVHA cases this quarter, compared to 312 last quarter:

- 7% (21 calls) of the OVHA calls were resolved in the initial call;
- 57% (182 calls) were resolved by advice or referral, after an analysis of the problem. Last quarter 56% (177 calls) were resolved in this manner;
- 25% (81 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 29% (91 calls) were resolved in this manner.

III. Issues

We opened 320 OVHA cases, compared to 312 last quarter. Of these:

- 35% (111 calls) involved Access to Care, compared to 35% (110 calls) last quarter;
- 27% (85 calls) involved Eligibility issues, compared to 24% (74) last quarter;
- 20% (65 calls) involved Billing or Coverage problems, compared to 15% (46);
- 16% (51 calls) involved Other issues, compared to 23% (73). "Other" includes Medicare Part D calls; and
- 2% (6 calls) were coded as OVHA Consumer Education, compared to 2% (7).

A. Access to Care

We received 111 OVHA Access to Care calls, up from 110 last quarter. Of the 17 subcategories in this issue code, the top call volume ones were:

- 17 involved Dental care or Orthodontia, up from 14;
- 15 involved Specialty Care, up from 9;
- 14 calls involved Pain Management, down from 21 last quarter;
- 11 calls on access to Prescription Drugs, not including Medicare Part D, significantly down from 24 calls last quarter;
- 8 involved Transportation, down from 9; and
- 8 involved Behavior Health or Mental Health, putting it back on the higher volume list.

B. Billing/Coverage

We received 65 calls in this category, up from 46 last quarter.

- 23 involved Medicaid/VHAP managed care billing, compared to 16 last quarter;
- 11 involved hospital billing, compared to 18 last quarter.

C. Eligibility

We received 85 calls in this category, up from 74 last quarter:

- 32 involved Medicaid eligibility, compared to 32 last quarter;
- 18 involved VHAP, compared to 18 last quarter;
- 11 involved Catamount Health and Premium Assistance, up from 7 last quarter. However, we had 51 calls total in these categories. The reason only 11 showed up here, is that our "OVHA-related" calls are categorized that way because the caller is on an OVHA insurance program when they call. Many callers who call about Catamount are either uninsured or on commercial insurance plans.
-

D. Medicare Part D/Prescription Drug Problems

- 18 calls involved Medicare Part D or VPharm in the OVHA statistics, compared to 33 last quarter;
- 34 of the OVHA calls dealt with prescription coverage, if the Part D calls are considered together with the calls coded as access to Prescription Drugs, compared to 57 last quarter;
- 42% of all calls related to prescriptions involved OVHA beneficiaries, compared to 54% last quarter.

V. Uninsured Callers

We received 59 calls from uninsured Vermonters that were not otherwise coded as covered by state or commercial insurance, which is down from 67 calls last quarter. However, some of the calls coded as OVHA coverage were from individuals who were uninsured at the time they called due to termination from state programs.

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.

2008 Final MCO Investments

Investment Criteria #	Department	Investment Description
2	Department of Education	School Health Services
4	AOA	Blueprint Director
2	BISHCA	Health Care Administration
4	DII	Vermont Information Technology Leaders
2	VVH	Vermont Veterans Home
2	Vermont State Colleges	Health Professional Training
2	University of Vermont Medical School	Vermont Physician Training
2	VDH	Emergency Medical Services
2	VDH	TB Medical Services
3	VDH	Epidemiology
3	VDH	Health Research and Statistics
3	VDH	Health Laboratory
3	VDH	Tobacco Cessation
2	VDH	Family Planning
4	VDH	Physician/Dentist Loan Repayment Program
2	VDH	Renal Disease
3	VDH	Newborn Screening
3	VDH	WIC Coverage
4	VDH	Vermont Blueprint for Health
4	VDH	Area Health Education Centers (AHEC)
4	VDH	FQHC Lookalike
4	VDH	Patient Safety - Adverse Events
4	VDH	Coalition of Health Activity Movement Prevention Program (CHAMPPS)
2	VDH - Alcohol and Drug Abuse	Substance Abuse Treatment
4	VDH - Alcohol and Drug Abuse	Recovery Centers
2	DMH	Special Payments for Medical Services
2	DMH	MH Outpatient Services for Adults
2	DMH	Mental Health Elder Care
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	CRT Staff Secure Transportation
2	DMH	Recovery Housing
1	OVHA	Buy-In
1	OVHA	HIV Drug Coverage
1	OVHA	Civil Union
4	OVHA	Hospital Safety Net Services
2	DCF	Family Infant Toddler Program
2	DCF	Medical Services
2	DCF	Residential Care for Youth/Substitute Care
2	DCF	Aid to the Aged, Blind and Disabled CCL Level III
2	DCF	Aid to the Aged, Blind and Disabled Res Care Level III
2	DCF	Aid to the Aged, Blind and Disabled Res Care Level IV
2	DCF	Essential Person Program
2	DCF	GA Medical Expenses
2	DCF	CUPS
2	DCF	VCRHYP
2	DCF	HBKF
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