

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
January 1, 2009 to March 31, 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 second quarterly report for waiver year four, covering the period from January 1, 2009 to March 31, 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.

Demonstration Population	Current Enrollees Last Day of Qtr 3/31/2009	Previously Reported Enrollees Last Day of Qtr 12/31/2008
Demonstration Population 1:	42,768	41,887
Demonstration Population 2:	42,394	40,838
Demonstration Population 3:	9,219	8,862
Demonstration Population 4:	N/A	N/A
Demonstration Population 5:	1,137	1,259
Demonstration Population 6:	2,372	2,856
Demonstration Population 7:	29,088	25,620
Demonstration Population 8:	7,609	7,301
Demonstration Population 9:	2,535	2,553
Demonstration Population 10:	N/A	N/A
Demonstration Population 11:	7,418	6,014

* 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 second quarter, the Office of Vermont Health Access, along with Blue Cross Blue Shield conducted group interviews with college students in preparation of third quarter outreach to college graduates. These interviews informed OVHA’s marketing messages, which will be used in April, May and June. The OVHA also secured a business partner through Vermont’s largest bank which will help us conduct outreach to college seniors next quarter.

During this quarter, the OVHA joined with the Vermont Department of Labor and provided information on Green Mountain Care at 29 lay offs, three job fairs, and two events built around America’s Recovery and Reinvest Act reaching a total of 3126 people about Green Mountain Care. Additionally, the OVHA sent information through the Burlington School District staff which in turn provided information to 1828 families. The OVHA provided training to four nursing homes, and to the Human Resource Directors of 12 Home Health Agencies which employ 2500 long-term care providers, most of whom do not have health insurance.

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. As of the end of March, there were 9671 individuals enrolled.

The Vermont legislature has been working on an omnibus health care reform bill that, if passed and signed by the Governor, will make 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.

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 March 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 March 31, 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.

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 will continue 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 will remain at \$195,000 for SFY 2009.

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 will be 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 will remain 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 is scheduled for Spring, 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 through SFY '09 and SFY '10.

Expenditure Containment Initiatives

Buprenorphine Program: Many physicians limit the number of opiate dependent patients because of the challenging nature of caring for this population (i.e., missed appointments, diversion, time spent by office staff). 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
Total	\$ 221,002.09

In 2009 OVHA started enrolling patients under the care of the providers who are capitated program participants 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 as phase two of the coordination of office based medication assisted therapies (COBMAT) evaluation process.

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. The program continues to be successful at increasing patient access to providers who are licensed to prescribe Buprenorphine in Vermont.

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.

The CCI supports and aligns with other State health care reform efforts, including the Blueprint for Health. 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 has been provided by the Center for Health Policy and Research (CHPR) at the University of Massachusetts Medical School. CHPR also stratifies beneficiaries into those at highest risk and most likely to benefit from intensive care coordination services, and those for whom less intensive disease management services are sufficient. Through targeting 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 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. Since then, some level of intervention services has been 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 nurse 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 share 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 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.

Highlights of the Chronic Care Initiative

- During the expanded CCI program's first full year of operation (7/1/07 to 6/30/08), after a six month claims run out period emergency room use declined by 6.02% and inpatient admissions declined by 10.66%. Data for Year 2 are not yet available.
- 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.
- During the second quarter of FFY 2009, the average monthly program caseload was 4,046. Monthly caseload includes beneficiaries in active outreach by CCI staff, as well as those successfully engaged and receiving services.
- 2,177 unique beneficiaries have been served by either OVHA care coordinators or APS disease management health coaches since the beginning of FFY 2009.

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.

Mental Health – Vermont Futures Planning

The Department of Mental Health is nearing full implementation of the community-based programs designed to reduce the need for state hospital level services. DMH is reviewing an application to develop a six-bed residential recovery program in the Brattleboro area, which if approved, would begin operation in September 2009. A development team to design a peer alternative crisis program is under contract, and a consulting team is working with Vermont's public mental health system to design a care management system.

The planning to develop the 15-bed secure (locked) adult psychiatric treatment and recovery residential program on the grounds of the State Office Complex in Waterbury first described in the Annual Report for FFY 08 is proceeding. The Douglas Administration proposed Capital Appropriation of \$500,000 to "continue the process of planning, designing and permitting for a 15-bed Secure Residential Recovery facility on the Waterbury Campus to provide a secure treatment program for patients who do not require psychiatric inpatient care, but do require additional intensive recovery and rehabilitation services in order to return to their home communities." (SFY 2010 Capital Request). 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.

The Rutland Regional Medical Center (RRMC) and the Department of Mental Health are exploring the viability of expanding the psychiatric inpatient program at RRMC to provide an estimated 12 acute, intensive inpatient beds. Legislative proposals to support the development of this option include \$250,000 for planning in the Capital bill and the development of a statutory framework for special hospital designation modeled after the Vermont framework for designated community mental health agencies.

Financial/Budget Neutrality Development/Issues

Effective January 1, 2009, AHS began paying OVHA the PMPM capitation payment prospectively; AHS has trueed up its capitation payment obligations to OVHA per the PMPM rates for FFY08 and FFY09 to-date. AHS is working to resubmit the CMS-64 forms to reflect actual PMPM costs reported by MEG buckets. CMS provided guidance pertaining to CRT reporting on February 6, 2009; accordingly, AHS will report CRT costs as a supplement to the CMS-64 system. CMS has extended the CMS-64 deadline for QE0309 from April 30, 2009 to May 15, 2009; as a result, budget neutrality information for QE0309 is not available at this time and is not included in this quarterly report summary.

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.

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.

<u>Consumer Issues</u>				Total for					
Demonstration Population	Month 1	Month 2	Month 3	Quarter	Quarter	Quarter	Quarter	Quarter	Quarter
	1/15/2009	2/15/2009	3/15/2009	Ending	Ending	Ending	Ending	Ending	Ending
				2nd Qtr	1st Qtr	4th Qtr	3rd Qtr	2nd Qtr	1st Qtr
				FFY '09	FFY '09	FFY '08	FFY '08	FFY '08	FFY '08
Demonstration Population 1:	42,688	42,763	42,727	128,178	125,825	123,997	122,281	121,926	120,113
Demonstration Population 2:	41,255	42,132	42,439	125,826	122,210	121,981	123,283	122,118	120,309
Demonstration Population 3:	9,104	9,154	9,290	27,548	26,555	26,452	25,723	24,676	24,821
Demonstration Population 4:	N/A								
Demonstration Population 5:	1,331	1,123	1,133	3,587	3,832	3,850	3,767	3,542	3,767
Demonstration Population 6:	2,466	2,255	2,248	6,969	8,208	7,428	7,357	6,208	6,084
Demonstration Population 7:	26,415	27,582	28,066	82,063	75,277	74,301	73,966	72,336	65,803
Demonstration Population 8:	7,349	7,466	7,540	22,355	22,032	21,715	23,100	22,697	22,445
Demonstration Population 9:	2,531	2,517	2,543	7,591	7,649	7,626	7,838	7,919	7,929
Demonstration Population 10:	N/A								
Demonstration Population 11:	6,893	7,174	7,539	21,606	19,465	16,136	12,525	7,997	1,641

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 3). 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 4). 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 5). 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 steps discussed included the following: use of sampling techniques, reliably collect data, implement intervention and improvement strategies, analyze data and interpret study results, and plan for real improvement. A work plan was developed and agreed upon by all members of the group. Data collection will start March 1, 2009 and run through the end of next quarter. The Agency of Human Services (AHS) Quality Improvement Manager (QIM) will continue to support the work group as they prepare this year's performance improvement project submission. During this quarter, the AHS QIM also met with Managed Care Organization (MCO) staff to identify the set of measures that will be used to monitor MCO performance during this year. It was agreed that the MCO would report on 4 of the 6 measures reported last year and calculate and report 10 additional measures. A work plan was developed and all measures will be reported to AHS by the end of next quarter. Finally during this quarter, the AHS QIM worked with the EQRO to develop a review tool that will be used by the EQRO to assess the MCO's ability to comply with Federal and State Medicaid MCO Measurement and Improvement standards (i.e., practice guidelines, quality assessment & performance improvement program, and health information systems). During the next quarter, the AHS QIM will use this document to help the MCO prepare for this year's compliance review.

Quality Assurance Performance Improvement Committee(QAPI): During this quarter, the Quality Assessment and Performance Improvement (QAPI) Committee reviewed the definitions of those Medicaid beneficiaries identified by the State as having special health needs (i.e., children enrolled in the community mental health system identified with severe emotional disturbance, adults enrolled in the Community Rehabilitation and Treatment Program, adults enrolled in developmental disability services, and adults enrolled in the Traumatic Brain Injury Program). The group also spent time discussing how the MCO conducts assessments and treatment/service planning for this group as well as how it assesses the appropriateness of services provided to them. Reports were identified to help the group monitor the MCO's ability to conduct these activities. During this quarter, the group discussed the mechanism that the MCO uses to detect under/over utilization of services. This discussion was followed up by a presentation by the MCO Program Integrity Manager. During the next quarter, utilization management reports that will be used by this group to help monitor over/underutilization of services will be identified. Also during this quarter, the group discussed MCO authorizations and the MCO's use of practice guidelines. This information was added to the MCO Quality Plan and reports will be developed and/or identified during the next quarter to help the group monitor these processes. The group also continued to develop a MCO Quality Plan and received an update on the status of the GC Evaluation activities. The group continues to integrate waiver evaluation activities into the quality assessment and performance improvement activities of the MCO. Also during this quarter, the group discussed the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey and how it would be used to obtain feedback on beneficiary's experience of care including timeliness of service delivery. The group also discussed the Office of Vermont Health Access's (OVHA) responsibility to monitor administrative MCO functions that it delegates to its Inter-Governmental Partners. The committee reviewed the MCO Monitoring Toolkit and agreed on a process for implementation. It was decided that the tool would be piloted during next quarter and feedback will be used to modify the toolkit before full implementation. Finally, during this quarter, the group discussed the current set of performance measures that OVHA calculates and reports to AHS. It was agreed that a total of fourteen measures would be calculated and reported for this year. During the same conversation, it was agreed

that the three utilization measures reported this year would not be carried over to next year due to their limited ability to help the Agency and the EQRO assess the quality, timeliness, and accessibility of services

Quality Strategy: The Quality Framework contained in the Quality Strategy continues to be used by the QAPI Committee to guide the development of the MCO Quality Plan (discussed above). The AHS QIM and the QAPI committee will review the Quality Strategy on a regular basis and recommend any necessary modifications.

Mapping and Network Analysis

The Office of Vermont Health Access (OVHA) maintains systematic analysis of the health care provider network to monitor and evaluate capacity. One component of this activity is geographic mapping of providers in order to evaluate and monitor access, to target licensed by not enrolled providers, and to evaluate providers in comparison to beneficiaries to ensure access. A series of maps for each provider type listed below depict data that includes, but is not limited to, the percentage of licensed providers enrolled, the percentage of enrolled providers accepting new patients, the percentage of beneficiaries receiving services from the provider type, etc.

Mapping allows for a visual representation of the provider network and helps to identify any access issues. Companion steps to mapping are targeted refinement, evaluation and provider outreach.

The analysis and monitoring is a continuous process, and year-to-year comparisons will be available as maps are updated to reflect subsequent state fiscal year data.

Demonstration Evaluation

During this quarter the revised Global Commitment to Health Waiver Evaluation Plan developed by Pacific Health Policy Group (PHPG) was submitted to CMS, after receiving input from AHS staff. A telephone survey of beneficiaries was initiated in January, with two PHPG staff member dedicated to this activity throughout the quarter. With approximately 200 household contacts and 60 completed surveys per month, this activity is on target to achieve 350-400 completed surveys by July 2009, in accordance with the evaluation plan timeline. In addition, the 2009 CAHPS survey was sent to beneficiaries in February, with follow-up to respondents in March. Finally, an online Provider Survey was prepared, and a secure database for responses has been created; primary care physicians who do not respond to the online survey will receive follow-up phone calls from PHPG staff.

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 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: Global Commitment 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)

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Policy/Program:	Suzanne Santarcangelo, Director AHS Health Care Operations, Compliance, and Improvement VT Agency of Human Services 103 South Main Street Waterbury, VT 05671-0203	802-241-3155 (P) 802-241-4461 (F) suzanne.santarcangelo@ahs.state.vt.us
MCO:	Susan W. Besio, PhD, Director VT Office of Health Access 312 Hurricane Lane, Suite 201 Williston, VT 05495	802-879-5901 (P) 802-879-5952 (F) susan.besio@ahs.state.vt.us

Date Submitted to CMS: May 19, 2009

ATTACHMENTS


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

	SFY '09 Revised Appropriated			Consensus Estimates for SFY to Date			Actuals thru 3/31/09			
	<=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	14,720,552	6,292,318	21,012,870	14,569,550	6,644,454	21,214,005	100.96%
Catamount Eligible Employer-Sponsored Insurance	803,144	406,981	1,210,125	564,003	285,800	849,803	514,969	257,458	772,427	90.89%
Subtotal New Program Spending	21,620,395	9,318,399	30,938,794	15,284,555	6,578,117	21,862,672	15,084,519	6,901,912	21,986,431	100.57%
Catamount and ESI Administrative Costs	1,658,945	1,297,834	2,956,780	1,244,209	973,376	2,217,585	1,244,209	973,376	2,217,585	100.00%
TOTAL GROSS PROGRAM SPENDING	23,279,340	10,616,233	33,895,573	16,528,764	7,551,493	24,080,257	16,328,728	7,875,288	24,204,016	100.51%
TOTAL STATE PROGRAM SPENDING	9,463,052	10,616,233	20,079,285	6,718,943	7,551,493	14,270,435	6,637,628	7,875,288	14,512,916	101.70%
TOTAL OTHER EXPENDITURES										
Immunizations Program	-	2,500,000	2,500,000	-	1,875,000	1,875,000	-	1,875,000	1,875,000	100.00%
VT Dept. of Labor Admin Costs Assoc. With Employer Assess.	-	394,072	394,072	-	295,554	295,554	-	295,554	295,554	100.00%
Marketing and Outreach	500,000	-	500,000	375,000	-	375,000	375,000	-	375,000	100.00%
Blueprint	-	1,846,713	1,846,713	-	1,385,035	1,385,035	-	1,385,035	1,385,035	100.00%
TOTAL OTHER SPENDING	500,000	4,740,785	5,240,785	375,000	3,555,589	3,930,589	375,000	3,555,589	3,930,589	100.00%
TOTAL STATE OTHER SPENDING	203,250	4,740,785	4,944,035	152,438	3,555,589	3,708,026	152,438	3,555,589	3,708,026	100.00%
TOTAL ALL STATE SPENDING	9,666,302	15,357,018	25,023,320	6,871,380	11,107,082	17,978,462	6,790,065	11,430,877	18,220,942	101.35%
TOTAL REVENUES										
Catamount Health Premiums	3,299,886	2,972,223	6,272,109	2,333,469	2,097,518	4,430,987	2,171,975	1,600,064	3,772,039	85.13%
Catamount Eligible Employer-Sponsored Insurance Premiums	246,580	269,856	516,436	173,159	189,505	362,664	162,514	123,890	286,404	78.97%
Subtotal Premiums	3,546,466	3,242,079	6,788,545	2,506,628	2,287,023	4,793,651	2,334,489	1,723,954	4,058,443	84.66%
Federal Share of Premiums	(2,104,828)	-	(2,104,828)	(1,487,684)	-	(1,487,684)	(1,385,519)	-	(1,385,519)	93.13%
TOTAL STATE PREMIUM SHARE	1,441,638	3,242,079	4,683,718	1,018,944	2,287,023	3,305,967	948,970	1,723,954	2,672,923	80.85%
Cigarette Tax Increase (\$.60 / \$.80)			9,207,000			6,905,250			7,083,828	102.59%
Floor Stock			500,000			375,000			347,785	92.74%
Employer Assessment			5,480,159			4,566,799			4,945,000	108.28%
Interest			-			-			102,035	0.00%
TOTAL OTHER REVENUE			15,187,159			11,847,049			12,478,648	105.33%
TOTAL STATE REVENUE	1,441,638	3,242,079	19,870,877	1,018,944	2,287,023	15,153,017	948,970	1,723,954	15,151,572	99.99%
State-Only Balance			(5,152,443)			(2,825,445)			(3,069,370)	
Carryforward			9,775,791			9,775,791			9,775,791	
(DEFICIT)/SURPLUS			4,623,348			6,950,346			6,706,420	
Reserve Account Funding			-			-			-	
REVISED (DEFICIT)/SURPLUS WITH RESERVE FUNDING			4,623,348			6,950,346			6,706,420	

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

Green Mountain Care Enrollment Report March 2009

TOTAL ENROLLMENT BY MONTH

	<u>Jul-07</u>	<u>Nov-07</u>	<u>Mar-08</u>	<u>Apr-08</u>	<u>May-08</u>	<u>Jun-08</u>	<u>Jul-08</u>	<u>Aug-08</u>	<u>Sep-08</u>	<u>Oct-08</u>	<u>Nov-08</u>	<u>Dec-08</u>	<u>Jan-09</u>	<u>Feb-09</u>	<u>Mar 09</u>
Adults:															
VHAP-ESIA	-	35	542	589	607	632	672	691	733	747	759	809	859	900	938
ESIA	-	21	242	273	304	324	336	358	413	447	499	569	504	489	519
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
Catamount Health	-	120	361	344	470	606	697	701	785	853	932	991	1,011	1,103	1,168
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
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
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
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
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
Other Medicaid*	Included	34,015	33,759	35,672	36,375	36,836									
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
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

KEY:

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

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

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

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

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

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

Dr. Dynasaur = Enrolled in Dr. Dynasaur

SCHIP = Enrolled in SCHIP

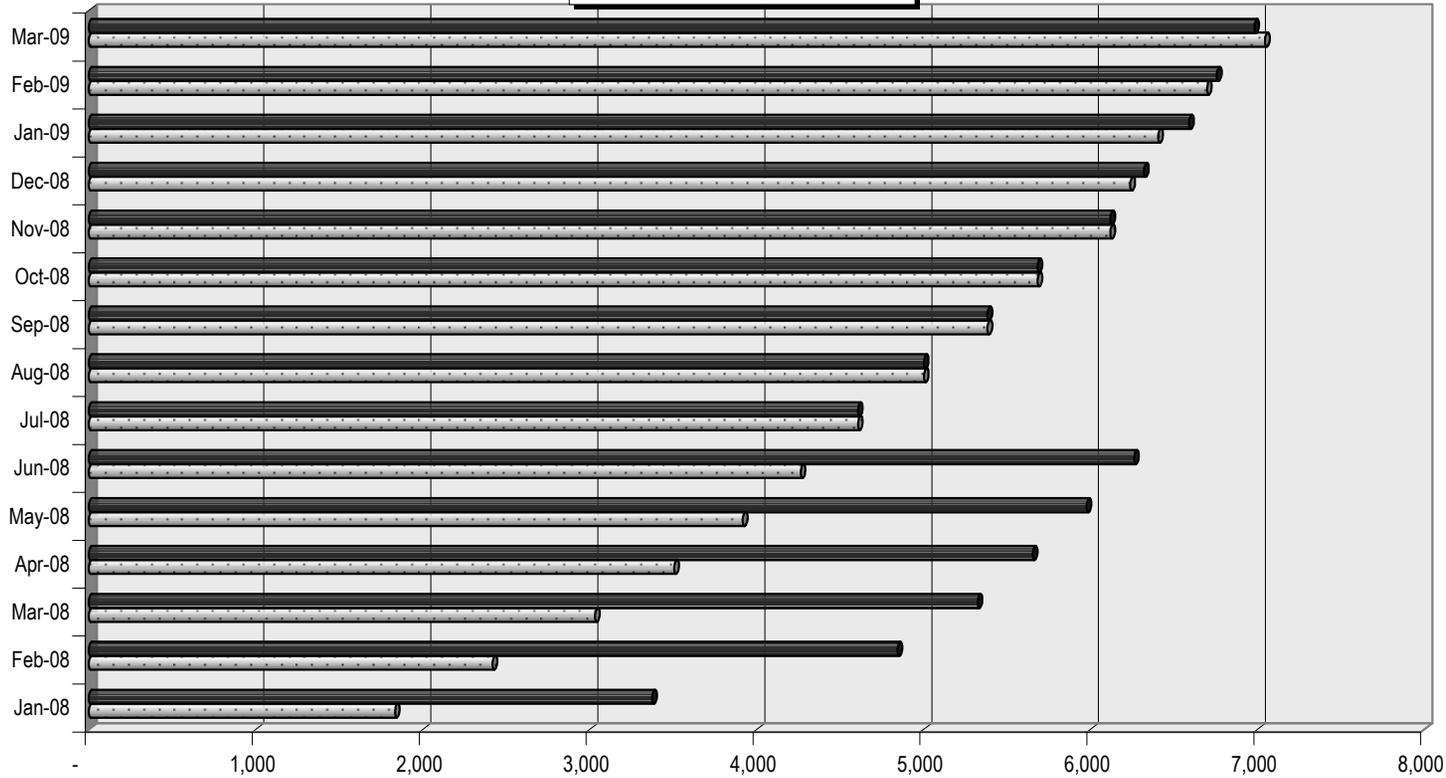
Totals do not include programs such as Pharmacy, Choices for Care, Medicare Buy-in

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

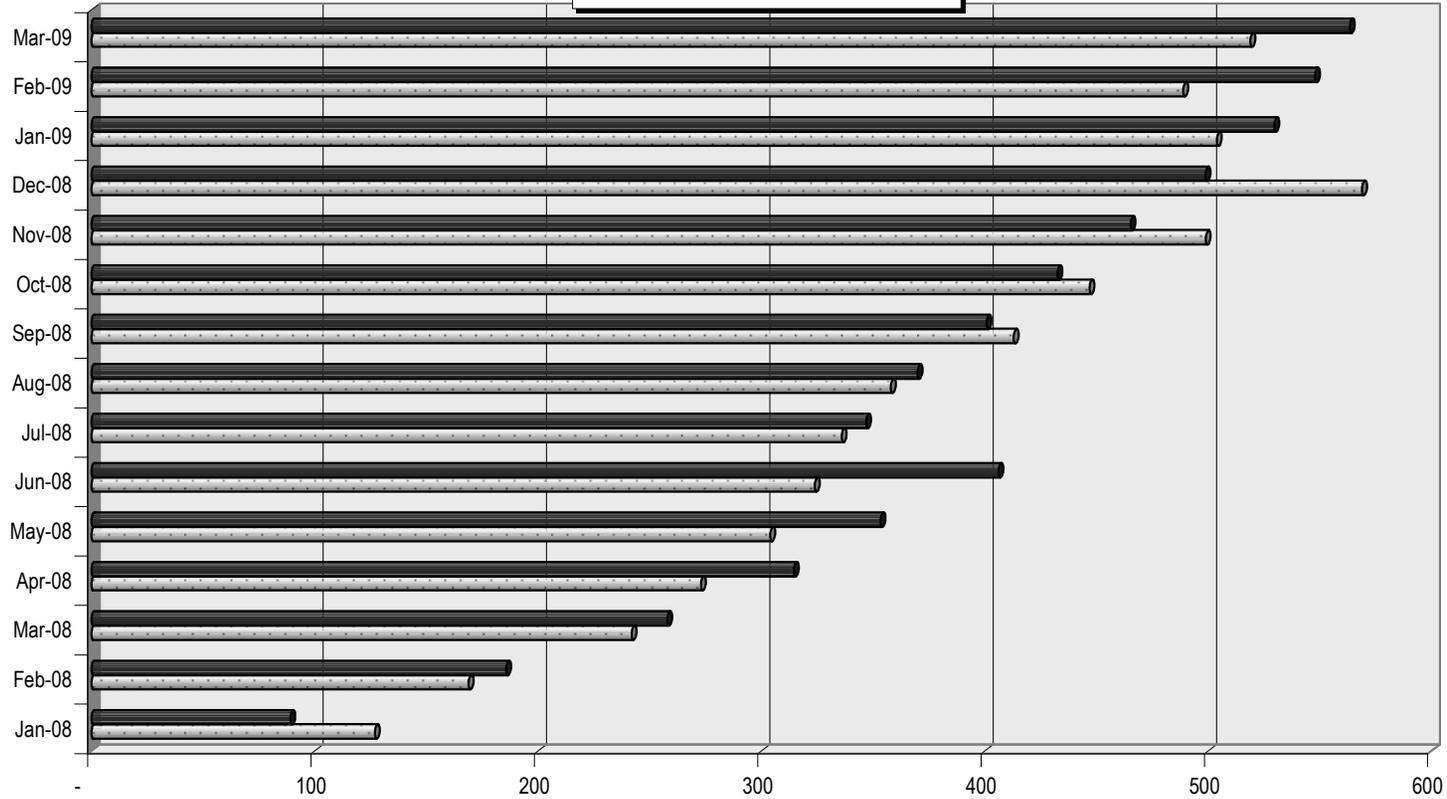
Green Mountain Care Enrollment Report				
March 2009 Demographics				
Income	VHAP-ESIA*	ESIA*	CHAP*	TOTAL
0-50%	43	36	1,232	
50-75%	49	5	100	
75-100%	92	4	130	
100-150%	414	26	479	
150-185%	260	151	1,953	
185-200%	68	120	1,276	
200-225%	9	85	869	
225-250%	3	54	551	
250-275%	-	23	310	
275-300%	-	15	146	
Total	938	519	7,046	8,503

Age	VHAP-ESIA	ESIA	CHAP	TOTAL
18-24	62	57	1,294	
25-35	253	122	1,204	
36-45	352	149	1,185	
46-55	202	150	1,612	
56-64	69	41	1,735	
65+	-	-	16	
Total	938	519	7,046	8,503

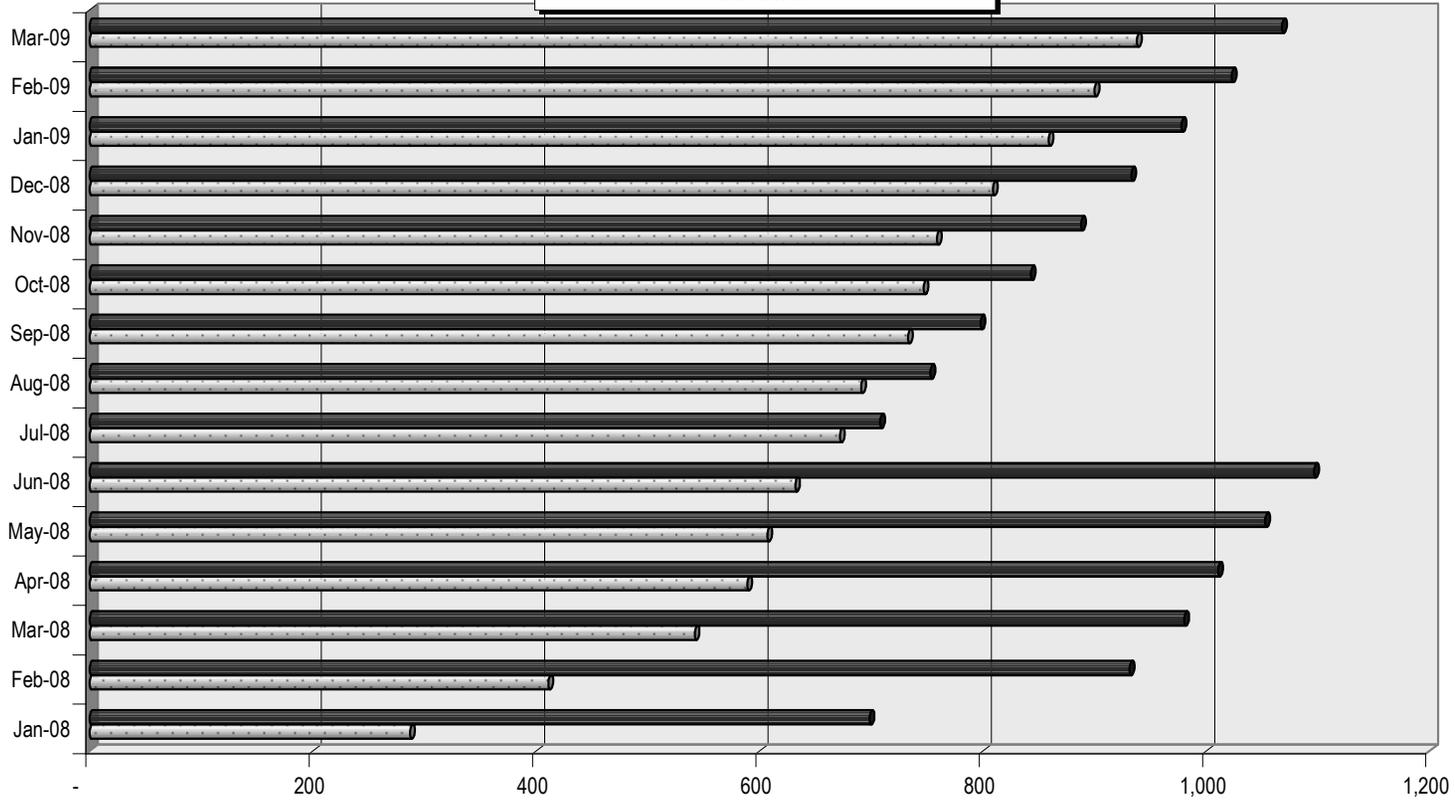
Green Mountain Care Enrollment Report (continued)				
March 2009 Demographics				
Gender	VHAP-ESIA	ESIA	CHAP	TOTAL
Male	336	183	3,032	
Female	602	336	4,014	
Total	938	519	7,046	8,503
County	VHAP-ESIA	ESIA	CHAP	TOTAL
Addison	57	30	459	
Bennington	95	39	391	
Caledonia	42	19	442	
Chittenden	176	115	1,288	
Essex	11	-	86	
Franklin	93	40	455	
Grand Isle	11	6	81	
Lamoille	50	29	375	
Orange	38	21	339	
Orleans	67	28	442	
Other	3	-	1	
Rutland	100	71	751	
Washington	71	32	683	
Windham	65	39	594	
Windsor	59	50	659	
Total	938	519	7,046	8,503

**Catamount Health Assistance Program
 Enrollment**


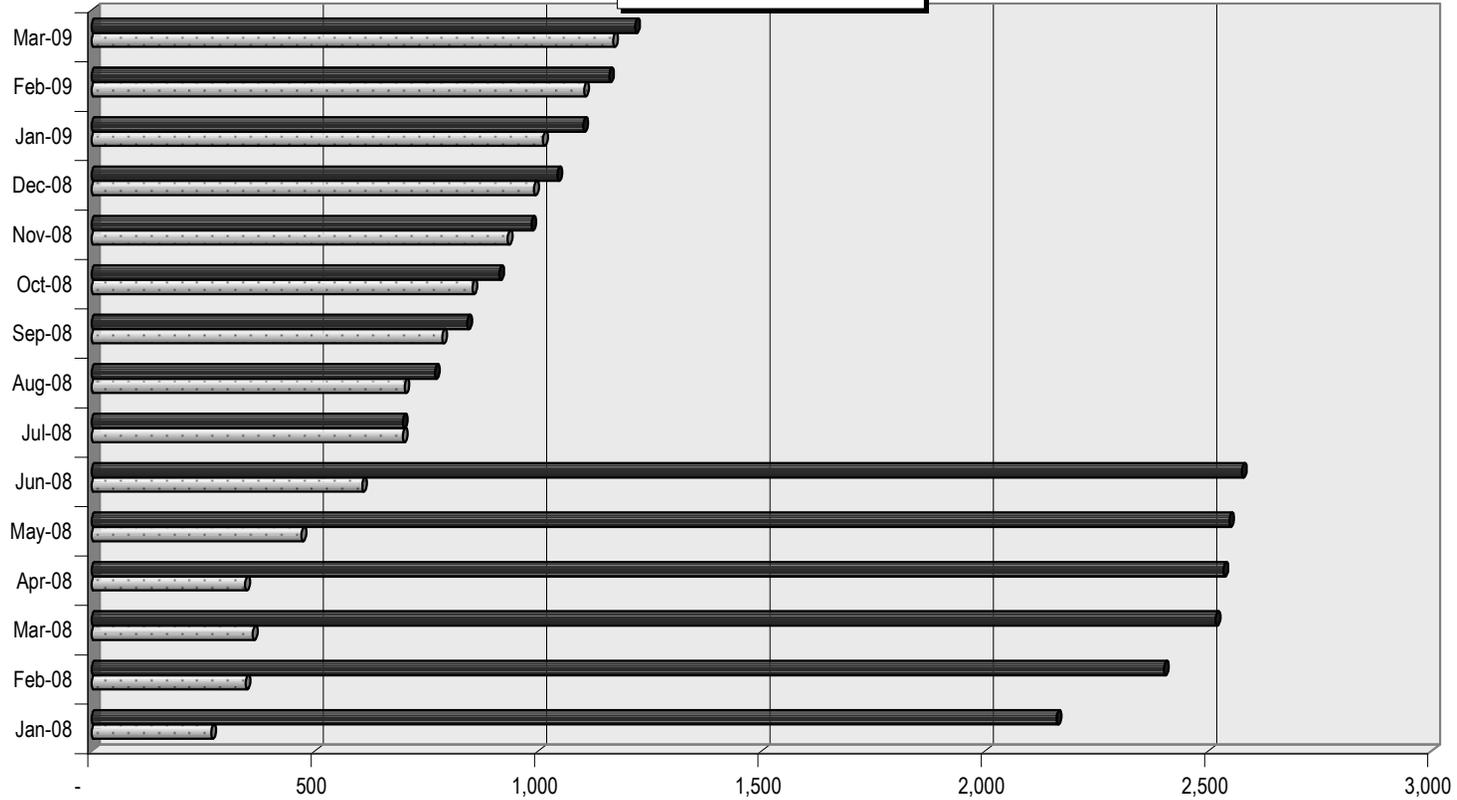
	Jan-08	Feb-08	Mar-08	Apr-08	May-08	Jun-08	Jul-08	Aug-08	Sep-08	Oct-08	Nov-08	Dec-08	Jan-09	Feb-09	Mar-09
■ Projected	3,375	4,845	5,324	5,655	5,978	6,262	4,608	5,003	5,384	5,684	6,120	6,321	6,592	6,758	6,983
▨ Actual	1,834	2,419	3,033	3,507	3,918	4,265	4,608	5,003	5,384	5,684	6,120	6,239	6,407	6,699	7,046

**Employer Sponsored Insurance Assistance
 Enrollment**


	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
■ Projected	89	186	258	315	353	406	347	370	401	433	465	499	530	548	564
▨ Actual	127	169	242	273	304	324	336	358	413	447	499	569	504	489	519

**VHAP ~ Employer Sponsored Insurance Assistance
 Enrollment**


	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
■ Projected	699	931	980	1,011	1,053	1,097	708	753	798	843	888	933	978	1,023	1,068
▨ Actual	287	411	542	589	607	632	672	691	733	747	759	809	859	900	938

Catamount Health ~ Unsubsidized Enrollment


	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
■ 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
□ Actual	268	345	361	344	470	606	697	701	785	853	932	991	1,011	1,103	1,168

Global Commitment Expenditure Tracking

	Quarterly Expenditures	PQA: WY1	PQA: WY2	PQA: WY3	Net Program PQA	Net Program Expenditures as reported on 64	non-MCO Admin Expenses	Total columns J:K for Budget Neutrality calculation	Cumulative Waiver Cap	Variance to Cap under/(over)
QE	[REDACTED]									
1205	\$ 178,493,793					\$ 178,493,793				
0306	\$ 189,414,365	\$ 14,472,838			\$ 14,472,838	\$ 203,887,203				
0606	\$ 209,647,618	\$ (14,172,165)			\$ (14,172,165)	\$ 195,475,453				
0906	\$ 194,437,742	\$ 133,350			\$ 133,350	\$ 194,571,092				
WY1 SUM	\$ 771,993,518	\$ 434,023	\$ -		\$ 434,023	\$ 782,159,845	\$ 4,239,569	\$ 786,399,414	\$ 1,015,000,000	\$ 228,600,586
1206	\$ 203,444,640	\$ 8,903			\$ 8,903	\$ 203,453,543				
0307	\$ 203,804,330	\$ 8,894,097	\$ -		\$ 8,894,097	\$ 212,698,427				
0607	\$ 186,458,403	\$ 814,587	\$ (68,408)		\$ 746,179	\$ 187,204,582				
0907	\$ 225,219,267	\$ -	\$ -		\$ -	\$ 225,219,267				
WY2 SUM	\$ 818,926,640	\$ 9,717,587	\$ (68,408)		\$ 9,649,179	\$ 819,868,580	\$ 6,464,439	\$ 826,333,018	\$ 1,936,000,000	\$ 323,267,567
Cumulative								\$ 1,612,732,433	\$ 1,936,000,000	\$ 323,267,567
1207	\$ 213,871,059	\$ -	\$ 1,010,348		\$ 1,010,348	\$ 214,881,406				
0308	\$ 162,921,830	\$ -	\$ -	\$ -	\$ -	\$ 162,921,830				
0608	\$ 196,466,768	\$ 14,717		\$ 40,276,433	\$ 40,291,150	\$ 236,757,918				
0908	\$ 228,593,470				\$ -	\$ 228,593,470				
WY3 SUM	\$ 801,853,126	\$ 14,717	\$ 1,010,348	\$ 40,276,433	\$ 41,301,498	\$ 842,129,559	\$ 6,457,896	\$ 848,587,455	\$ 2,848,000,000	\$ 386,680,112
Cumulative								\$ 2,461,319,888	\$ 2,848,000,000	\$ 386,680,112
1208	\$ 228,768,784			\$ -	\$ -	\$ 228,768,784				
0309										
0609										
0909										
WY4 SUM	\$ 228,768,784	\$ -	\$ -		\$ -	\$ 228,768,784	\$ 1,746,469	\$ 230,515,253	\$ 3,779,000,000	\$ 1,087,164,859
Cumulative								\$ 2,691,835,141	\$ 3,779,000,000	\$ 1,087,164,859
1209										
0310										
0610										
0910										
WY5 SUM	\$ -	\$ -	\$ -		\$ -	\$ -	\$ -	\$ -	\$ 4,700,000,000	\$ 2,008,164,859
Cumulative								\$ 2,691,835,141	\$ 4,700,000,000	\$ 2,008,164,859
	\$ 2,621,542,068	\$ 10,166,327	\$ 941,940	\$ 40,276,433			\$ 18,908,373			

PQA = Prior Quarter Adjustments

Global Commitment Expenditure Tracking

from CMS-64 line:	LTC Admin Quarterly Expenditures							Net LTC Admin Expenditures as reported on 64	MMIS 90% Admin Quarterly Expenditures							Net MMIS 90% Admin Expenditures as reported on 64	AHSCO Admin Quarterly Expenditures: includes 50% & 75%							Net AHSCO Admin Expenditures as reported on 64	
	PQA: WY1	PQA: WY2	PQA: WY3	PQA: WY4	PQA: WY5	Net Admin	PQA: WY1		PQA: WY2	PQA: WY3	PQA: WY4	PQA: WY5	Net Admin	PQA: WY1	PQA: WY2		PQA: WY3	PQA: WY4	PQA: WY5	Net Admin					
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						\$ 2,272,141						\$ 668,742													\$ 1,967,428
1206	\$ 346,732					\$ -	\$ 376,007					\$ -							\$ 713,940						\$ -
0307	\$ 972,273					\$ -						\$ -							\$ 1,159,770						\$ -
0607	\$ 947,875	\$ (166,924)				\$ -	\$ 1,300,509					\$ -							\$ 591,699						\$ -
0907	\$ 328,298					\$ -	\$ 453,894					\$ -							\$ 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						\$ -						\$ -													\$ -
0609						\$ -						\$ -													\$ -
0909						\$ -						\$ -													\$ -
WY4 SUM						\$ 360,286						\$ -													\$ 1,386,183
1209						\$ -						\$ -													\$ -
0310						\$ -						\$ -													\$ -
0610						\$ -						\$ -													\$ -
0910						\$ -						\$ -													\$ -
WY5 SUM						\$ -						\$ -													\$ -
	\$ (166,924)	\$ (560)	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ (14,063,614)	\$ 534,199	\$ 206,109	\$ -	\$ -	\$ -	\$ -

PQA = Prior Quarter Adjustments

PQA = Prior Quarter Adjustments

PQA = Prior Quarter Adjustments



Office of Vermont Health Access
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 Williston, VT 05495-2086
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 [phone] 802-879-5900

Agency of Human Services

**Complaints Received by Health Access Member Services
 January 1, 2009 – March 31, 2009**

Eligibility forms, notices, or process	12
Catamount Health Assistance Program premiums, process, ads, plans	5
Use of social security numbers as identifiers	10
General premium complaints	9
Green Mountain Care website	1
Provider issues (perceived rudeness, refusal to provide service, prices) (variety of provider types)	1
Member services	2
Eligibility rules	1
Eligibility local office	6
Prescription drug plan issues	1
Pharmacy coverage	6
Coverage rules	2
Chiropractic coverage change	1
Copays/service limit	1
Provider enrollment issues	1
<hr/> Total	<hr/> 59



**Grievance and Appeal Quarterly Report
Medicaid MCO All Departments Combined Data
January 1, 2009 – March 31, 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 April 1, 2009, from the centralized database for grievances and appeals that were filed from January 1, 2009 through March 31, 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 eleven grievances filed with the MCO. Five of them were addressed during the quarter, none were withdrawn and six were still pending at the end of the quarter. Grievances must be addressed within 90 days of filing, so having pending cases at the end of the quarter is to be expected. The grievances that were addressed were addressed in an average of thirty-nine 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 one of those letters was sent late. Of the grievances filed, 55% were filed by beneficiaries, 45% were filed by a representative of the beneficiary, and none were filed by someone else on the beneficiary's behalf. Of the eleven grievances filed, DAIL had 18% and DMH had 82%. There were no grievances filed for the Department of Disabilities, Aging and Independent Living; the Department of Health; Department for Children and Families; or the Office of Vermont Health Access during this quarter.

At the end of the last quarter there was one case pending (OVHA). It was addressed this quarter, and within the required 90-day time frame.

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.

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 twenty-eight appeals filed with the MCO, of which five requested an expedited decision, and none met the criteria. Of these 28 appeals, thirteen were resolved (46% of filed appeals), three

were withdrawn (11%), and twelve appeals were still pending (43%). In nine cases (70% of those resolved), the original decision was upheld by the person hearing the appeal, two cases (15% of those resolved) were reversed, none were modified, and two were approved by the department/DA/SSA before the appeal meeting (15% of those resolved).

All thirteen appeals that were resolved this quarter were resolved within the statutory time frame of 45 days. In addition, 54% of the resolved appeals were resolved within 30 days. The average number of days it took to resolve these 13 cases was 27 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 28 appeals filed, thirteen were filed by beneficiaries (46%), fourteen were filed by a representative of the beneficiary (50%), none were filed by a provider, and one was filed by someone else at the request of the beneficiary (4%). Of the 28 appeals filed, OVHA had 43%, DAIL had 50%, and DMH had 7%. 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 M180.1 (see above). There were 21 appeals for a denial or limitation of authorization of a requested service or eligibility for service (75%), six were for a reduction/suspension/termination of a previously authorized covered service or service plan (21%), and one was left blank (4%).

There were six cases filed between October 1, 2008 and December 31, 2008 that were still pending at the beginning of this quarter. In addition, there were three DAIL cases that were still pending from before October 1, 2008 [On the last report there were five cases pending from before 10/01/08. Two of these cases had actually been resolved prior to December 31, 2009, but the information was not entered until after the quarterly reports were compiled on January 22, 2009.] Of those nine cases, five were resolved this quarter. 80% of these cases were upheld (three for DAIL & one for OVHA), none were reversed; none were modified, 20% was withdrawn (one for DAIL), and none were approved before the appeal hearing. 20% of the cases were resolved within thirty days, 40% in forty-five days, and 60% within fifty-nine days. The OVHA case had been extended, and was decided within correct timeframes. The other two cases were DAIL cases took 106 and 203 days to be resolved. On March 31, 2009 there were four cases still pending; one for DAIL's Children's Personal Care program for 201 days, one for DAIL's DS program through HCRS for 173 days, one for DAIL's DS program through LCMH for 392 days, and the last for the DMH's CRT program at LCMH for 125 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 seven fair hearings filed this quarter; three for DAIL and four for OVHA. Five were filed concurrently with the appeal, while the other two were filed subsequent to the appeal decision. Two cases were withdrawn, one case was upheld, and the other four are still pending. There were nine fair hearings that were pending from previous quarters. Two of them were upheld this quarter, with resolution in an average of 190 days. There are now eleven fair hearings pending, four for DAIL and seven 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.

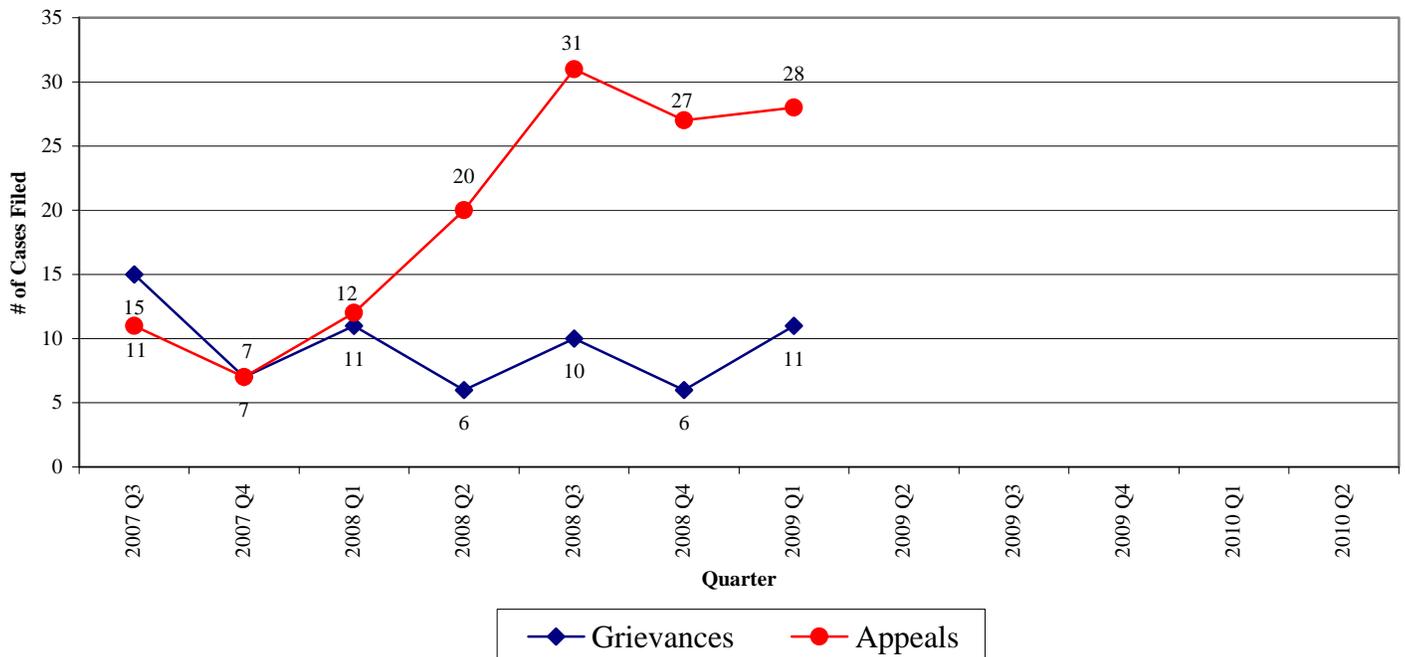
DCF was supposed to identify and have trained, program specific individuals, and that has not happened yet. In addition, to date, there are no known Grievance & Appeal procedures being used by the DCF. The MCO Grievance and Appeal Coordinator has agreed to provide all the necessary training to the Department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

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

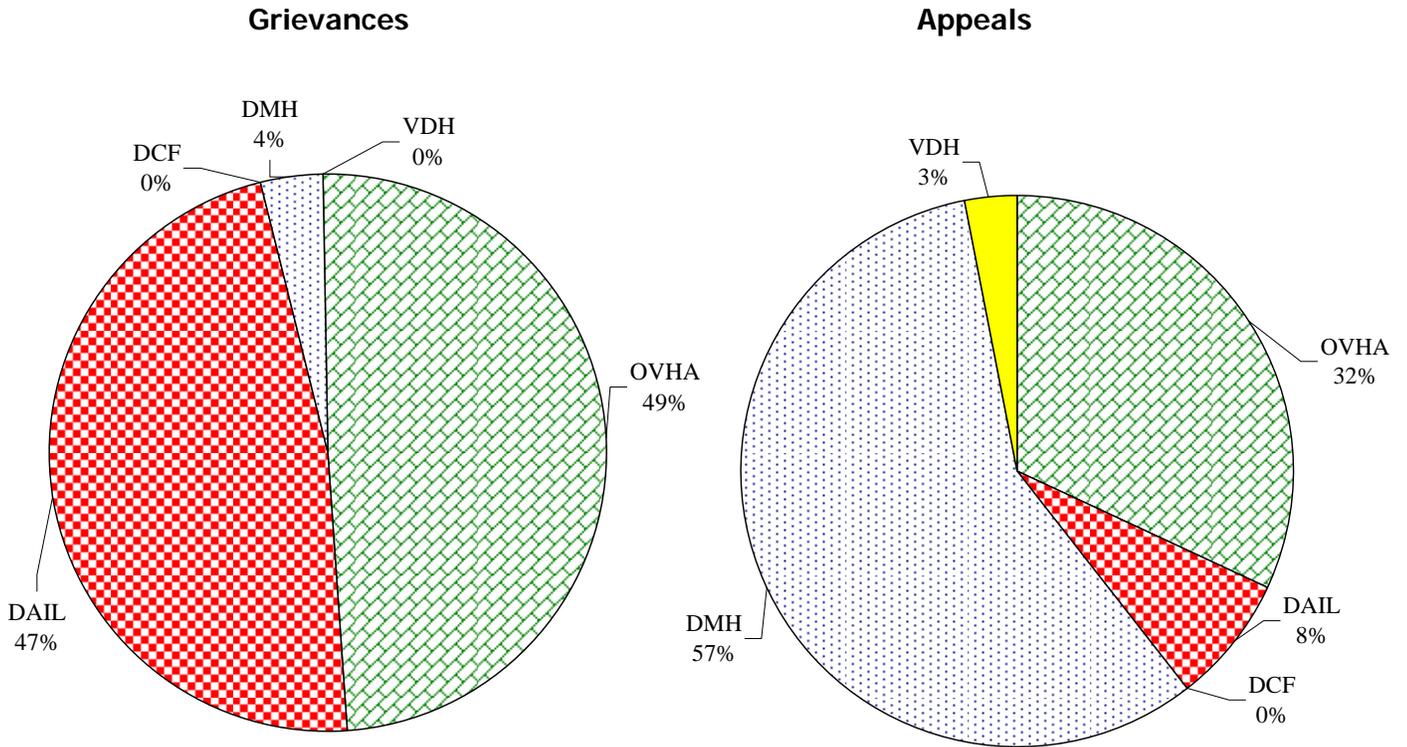
For this reporting quarter, QI reports were sent out on March 26th and were due back on April 9th. The following agencies/DAs/SSAs did not respond:

- DAIL - Attendant Services/Developmental Services
- DAIL - Outpatient/Emergency
- DOC
- Lincoln Street
- Sterling Area Services
- Upper Valley Services

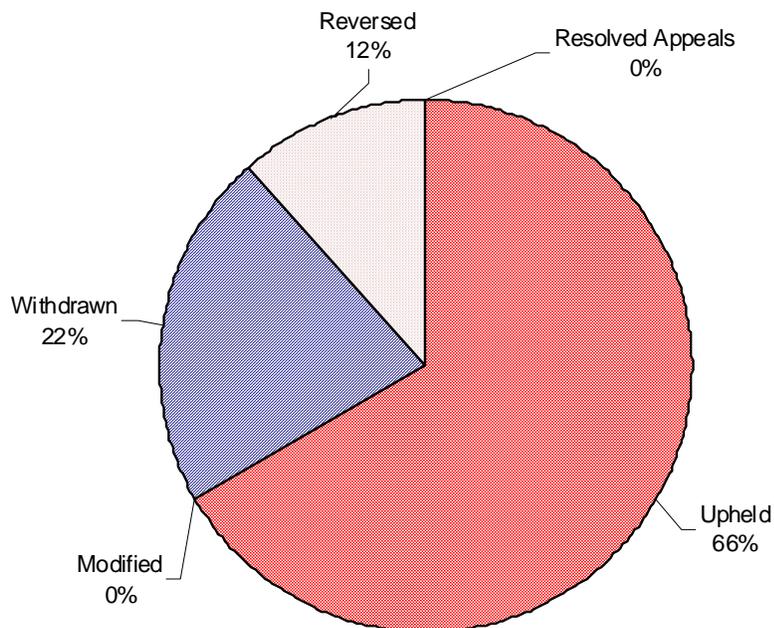
Medicaid MCO Grievances & Appeals



MCO Grievance & Appeals by Department from July 1, 2007 through March 31, 2009



MCO Appeal Resolutions from July 1, 2007 through March 31, 2009



Grievance and Appeal Quarterly Report
 Medicaid MCO All Departments Combined Data
 for the period: January 1, 2009 – March 31, 2009

Grievances

Total number of grievances filed: 11

Number pending: 6 [DAIL-1; DMH-5]

Number withdrawn: 0

Number addressed: 5 [DAIL-1; DMH-4]

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: 4

Average number of days from filing to being addressed: 39

Average number of days to send acknowledgement letter: 2

Number of late acknowledgement letters: 1 [DMH]

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:	6	55%
Beneficiary Representative:	5	45%
Other:	0	0%

Number related to:

OVHA:	0	0%
DAIL:	2	18%
DCF:	0	0%
DMH:	9	82%
VDH:	0	0%

Top services grieved:

1. Mental Health Services	(8)
2. Case Management	(1)
3. Community/Social Supports	(1)
4. Employment Services	(1)

Number by category: [Check ALL that apply]

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

* * * * *

Number pending from all previous quarters: 1
 [OVHA}

Number that were pending in previous quarters and addressed this quarter: 1

Within 90 days:	100%
Exceeding 90 days:	0%

Number of grievance reviews pending from all previous quarters: 0

Appeals

Number of appeals filed: 28

Number pending: 12 [DAIL-7; DMH-2; OVHA-3]

Number withdrawn: 3 [OVHA]

Number resolved: 13

Number upheld: 9 70% [DAIL-6; OVHA-3]

Number reversed: 2 15% [DAIL-1; OVHA-1]

Number modified: 0 0%

Number approved by Dept/DA/SSA:
2 15% [OVHA-2]

Number of cases extended: 0

Resolved time frames

Within 30 days: 54% [DAIL-5; OVHA-2]

Within 45 days: 100% [DAIL-7; OVHA-6]

Number of appeals filed too late: 3

Average number of days from NOA to filing appeal: 16

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

Average number of days from filing to resolution: 27

Average number of days to send acknowledgement letter: 2

Number of late acknowledgement letters: 2 [DAIL]

Average number of days from filing to withdrawing: 9

Number by category:

1. Denial or limitation of authorization of a requested service or eligibility for service: 21
2. Reduction/suspension/termination of a previously authorized covered service or service plan: 6
3. Denial, in whole or in part, of payment for a covered service: 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

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

Number of late withdrawal letters: 0

Source of appeal request:

Beneficiary: 13 46%

Beneficiary Representative: 14 50%

Provider: 0 0%

Other: 1 4%

Number related to:

OVHA: 12 43%

DAIL: 14 50%

DCF: 0 0%

DMH: 2 7%

VDH: 0 0%

Top services appealed:

1. Personal Care Services (9)

2. Prescriptions (6)

3. Orthodontics (3)

4. Transportation (2)

5. Employment Services (2)

Number of beneficiaries that requested that their services be continued: 3 11%

Of those that requested their services be continued:

Number that met criteria: 1 33%

Number that did not meet criteria: 2 67%

Expedited Appeals

Number of expedited appeals filed: 5 [OVHA}

Number of expedited appeals that:

Met criteria: 0

Did not meet criteria: 5

NOT meeting criteria:

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

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

Number late letters: 0

* * * * *

Number pending from last quarter: 6 [DAIL-4; DMH-1; OVHA-1]

Number pending from previous quarters: 3 [DAIL 3 (2 additional DAIL cases were listed as pending before the end of last quarter, but they were actually resolved between 10/1/08-12/31/08, but not entered until after 1/1/09)]

Total pending from ALL quarters: 9 [DAIL-7; DMH-1; OVHA-1]

Number of total pending that were resolved this quarter: 5

Number upheld: 4 80% [DAIL-3; OVHA-1]

Number reversed: 0 0%

Number modified: 0 0%

Number approved by Dept/DA/SSA: 0 0%

Number withdrawn: 1 20% [DAIL-1]

Resolution time frames for resolving above cases:

Within 30 days: 20% [DAIL-1]

Within 45 days: 40% [DAIL-2]

Within 59 days: 60% [DAIL-2; OVHA-1]

Extended (1) vs. Late (0)

Over 59 days: 40% [DAIL-2]

Number of appeals still pending from all previous quarters: 4 [DAIL-3; DMH-1]

Fair Hearings

Total number of Fair Hearings filed: 7 *[DAIL-3; OVHA-4]*

Number of Fair Hearings filed with a concurrent appeal: 5 *[DAIL-3; OVHA-2]*

Number of Fair Hearings filed after appeal resolution: 2 *[OVHA-2]*

Number pending: 4 *[DAIL-1; OVHA-3]*

Number resolved: 3

 Number upheld: 1 *[DAIL]*

 Number reversed: 0

 Number modified: 0

 Number dismissed: 0

 Number withdrawn: 2 *[DAIL-1; OVHA-1]*

Average number of days for resolution: 28

* * * * *

Number of pending Fair Hearings from previous quarters: 9 *[DAIL-4; OVHA-5]*

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

 Number upheld: 2 *[DAIL-1; OVHA-1]*

 Number reversed: 0

 Number modified: 0

 Number dismissed: 0

 Number withdrawn: 0

Average number of days for resolution for pending Fair Hearings from previous quarters: 190

Number of pending Fair Hearings from previous quarters still pending at the end of this quarter: 11 *[DAIL-4; OVHA-7]*

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QUARTERLY REPORT January 1, 2009 - March 31, 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 January 1, 2009 through March 31, 2009. The total number of all cases/all coverages that we opened this quarter was 751, our second busiest quarter ever, and a 16.7% increase over the previous quarter. We received 643 calls last quarter and 503 the previous quarter. This quarter's total is slightly less than the same quarter in 2008, in which we received 770 calls, which was our all time highest volume quarter.

We received 312 calls from individuals on OVHA programs this quarter, up from 248 last quarter, and 218 the previous quarter. This was 41% of the total call volume, compared to 39% last quarter, and 43% the previous quarter. Last year we received 322 calls for this quarter.

The total all-coverages call volume for January 2009 was quite a bit lower than it was last January: 240 as compared to 311 in 2008. This appears to be due in part to a drop in the Medicare Part D calls. Historically, January is our busiest month for Medicare Part D and VPharm calls. The open enrollment period for Part D is November 15 through December 31st every year and the Part D plans change their payment structures and their formularies annually, effective January 1. These changes can create problems for beneficiaries so our call volume has typically increased each January. However, since January 2006 when Medicare Part D began, our Part D complaints have steadily dropped in each subsequent January. There were 116 Part D calls in 2006, 64 in 2007, 32 in 2008, and just 21 this year. Presumably this is because the Part D plans have improved their enrollment and transition systems.

Nevertheless, although January's total call volume was on the low side, February and March made up for it. February 2009 was the busiest February ever at 255 calls, and March 2009 tied for the busiest March at 257. Calls regarding Access to Care and Eligibility for state programs in particular increased this quarter, probably as a result of the severe economic downturn.

We received 192 Access to Care calls this quarter, the highest number ever. The previous quarter we received 176 calls in this category, the second highest ever. Of the 192 calls this quarter, 110, or 57%, were from OVHA beneficiaries. Since OVHA beneficiaries made up 41% of our calls, this high percentage of Access calls is of some concern.

Likewise, Eligibility calls were the highest they've ever been at 195; the previous quarter's Eligibility calls were the third highest ever, at 163. Eligibility-related calls have jumped significantly since Catamount Health went into effect in October 2007. In all of 2005 there were just 328 Eligibility calls. In 2006 there were 398. In 2007 the yearly call volume for this issue category jumped 28.6%, to 512, with the rate almost doubling between the second and third quarters. This increase was clearly a result of the start of Catamount Health. Last year Eligibility calls increased an additional 16% to 593. That upward trend is continuing.

Prescription Drugs has consistently been our largest category of calls within the Access to Care code and remains so. The total number of Prescription Drug calls this quarter, including access to medications generally, Medicare Part D, VPharm and VScript, went up to 106 from 74 last quarter. Viewed together, the issue categories involving prescription drugs represented 14% of all calls received. Last quarter they made up 12% of all calls. Half of the prescription calls were about Medicare Part D this quarter.

We had 57 OVHA calls regarding prescription drugs and Medicare Part D this quarter, which is 54% of the total of all medication calls (106). This percentage is similar to last quarter's. This compares to 38 OVHA prescription calls the previous quarter. Of the 57 OVHA calls, 33 involved Part D, or 58%. This was the same as last quarter's percentage.

The calls about medications discussed above do not include the Pain Management calls that we received. Six 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 rose to 30 this quarter, compared to 21 last quarter. Of the 30 calls, 21 were from OVHA program beneficiaries, which means that 70% of our pain cases involved Medicaid programs. Last quarter the percentage was 43%. Only four of the individuals calling about pain management problems had commercial insurance. The fact that such a large percentage of our Pain Management cases are from OVHA beneficiaries greatly concerns us.

We received 64 calls regarding Catamount Health and the Premium Assistance programs, which was the same as last quarter. Catamount calls were 8.5 % of our total calls, slightly down from last quarter's 10%. Catamount and Premium Assistance calls are usually related to eligibility for those programs, but we also had three billing cases and six 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 314 OVHA cases this quarter, compared to 266 last quarter:

- 7% (22 calls) of the OVHA calls were resolved in the initial call;

- 56% (177 calls) were resolved by advice or referral, after an analysis of the problem. Last quarter 53% (141 calls) were resolved in this manner;
- 29% (91 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 28% (75 calls) were resolved in this manner.

III. Issues

We opened 312 OVHA cases, compared to 247 last quarter. Of these:

- 35% (110 calls) involved Access to Care, compared to 37% (91 calls) last quarter;
- 24% (74 calls) involved Eligibility issues, compared to 23% (58) last quarter;
- 23% (73 calls) involved Other issues, compared to 21% (53). "Other" includes Medicare Part D calls;
- 15% (46 calls) involved Billing or Coverage problems, compared to 15% (36); and
- 2% (7 calls) were coded as OVHA Consumer Education, compared to 4% (9).

A. Access to Care

We received 110 OVHA Access to Care calls, up from 91 last quarter. Of the 17 subcategories in this issue code, the top call volume ones were:

- 24 calls on access to Prescription Drugs, not including Medicare Part D, up from 16 calls last quarter;
- 21 calls involved Pain Management, up from 9 last quarter, which is a huge jump as mentioned above;
- 14 involved Dental care or Orthodontia, up from 12;
- 9 involved Specialty Care, down from 12;
- 9 involved Transportation, down from 11; and
- Behavior Health dropped off the list of top volume-getters, at 4 calls down from 9 last quarter.

B. Billing/Coverage

We received 46 calls in this category, up from 36 last quarter.

- 16 involved Medicaid/VHAP managed care billing, compared to 11 last quarter;
- 18 involved hospital billing, compared to 7 last quarter.

C. Eligibility

We received 74 calls in this category, up from 58 last quarter:

- 32 involved Medicaid eligibility, compared to 26 last quarter;
- 18 involved VHAP, compared to 16 last quarter;

- 7 involved Catamount Health and Premium Assistance, same as last quarter. However, we had 64 calls total in these categories. The reason only seven 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

- 33 calls involved Medicare Part D or VPharm in the OVHA statistics, compared to 22 last quarter;
- 57 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 38 last quarter;
- 54% of all calls related to prescriptions involved OVHA beneficiaries, compared to 51% last quarter.

V. Uninsured Callers

We received 67 calls from uninsured Vermonters that were not otherwise coded as covered by state or commercial insurance, which is about the same as 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.

OFFICE OF HEALTH CARE OMBUDSMAN

TOTAL CASES - Office of Vermont Health Access

Total Number of Cases by Issue Category

Calendar Years 2008 and 2009

Issue Category	Calendar Year 2008						Calendar Year 2009					
	Jan 1-Mar 31	Apr 1-June 30	July 1-Sept 30	Oct 1-Dec 31	2008 Total	2008 Total	Jan 1-Mar 31	Apr 1-June 30	July 1-Sept 30	Oct 1-Dec 31	2009 Total	2009 Total
Access to Care	85	81	67	91	324	324	110					
Billing /Coverage	74	66	43	36	219	219	46					
Buying Insurance	0	1	1	0	2	2	2					
Consumer Education	13	9	6	9	37	37	7					
Eligibility	67	78	62	58	265	265	74					
Other	83	81	39	53	256	256	73					
Grand Total	322	316	218	247	1103	1103	312					

Percentage of Cases by Issue Category

Issue Category	Calendar Year 2008						Calendar Year 2009					
	Jan 1-Mar 31	Apr 1-June 30	July 1-Sept 30	Oct 1-Dec 31	2008 Total	2008 Total	Jan 1-Mar 31	Apr 1-June 30	July 1-Sept 30	Oct 1-Dec 31	2009 Total	2009 Total
Access to Care	26.40%	25.62%	30.73%	36.84%	29.37%	29.37%	35.26%					
Billing /Coverage	22.98%	20.88%	19.73%	14.57%	19.86%	19.86%	14.74%					
Buying Insurance	0.00%	0.30%	0.45%	0.00%	0.18%	0.18%	0.64%					
Consumer Education	4.04%	2.94%	2.75%	3.64%	3.35%	3.35%	2.24%					
Eligibility	20.81%	24.66%	28.45%	23.48%	24.03%	24.03%	23.72%					
Other	25.78%	25.60%	17.89%	21.47%	23.21%	23.21%	23.40%					
Grand Total	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%					

Caseload Report
1/1/2009 TO 3/31/2009
OVHA only Coverage Types

	Carried Cases	Opened Cases	Closed Cases	Open at End Cases
1. Jan	35	93	93	35
2. Feb	35	121	96	60
3. Mar	60	98	125	33
Grand Totals:		312	314	

OVHA Quarterly Report

Quarter Ending 03/31/2009

Types of Callers

Applicant	5
Insured	216
Provider	3
Advocate	22
Other	63
Unknown	3
Totals	<hr/> 312

OVHA Quarterly Report

Quarter Ending 03/31/2009

How did the Caller Hear about HCO?

BISHCA	1
Provider	6
Called Before	98
State Agency	33
HCO Materials	1
Other	41
DSW	9
Maximus	19
Consumer Group	7
Outreach	3
Unknown	83
Legislator	11
Totals	<hr/> 312

OVHA Quarterly Report

Quarter Ending 03/31/2009

Distribution by County

Addison	7
Bennington	9
Caledonia	7
Chittenden	80
Essex	3
Franklin	17
Grand Isle	6
Lamoille	8
Orange	8
Orleans	5
Rutland	54
Unknown	37
Washington	27
Windham	20
Windsor	24

312

OVHA Quarterly Report

Quarter Ending 03/31/2009

Plan Type

Choices For Care	7
Dual eligible	76
PCCM	196
VHAP Limited	4
VPharm	29
	<hr/>
	312

OVHA Quarterly Report

Quarter Ending 03/31/2009

Coverage Summary

Dual Eligible	76
Medicaid Managed Care	126
VHAP	81
VPHARM	29
	<hr/>
Totals	312

OVHA Quarterly Report

Quarter Ending 03/31/2009

Who Is the Problem With?

EDS	2
Hospital	23
Insurance Company/Plan	12
Not Specified	1
OVHA	161
Other	10
Other Agency	15
PBM	1
PDP	29
Provider	56
Unknown	2
	<hr/>
	312

OVHA Quarterly Report

Quarter Ending 03/31/2009

Disposition Summary

Inquiry Answered During Initial Call	22
Brief Analysis and/or Referral	69
Brief Analysis and/or Advice	108
Direct Intervention	62
Complex Intervention	29
Client Withdrew	10
Other	14
Totals	<hr/> 314

OVHA Quarterly Report

Quarter Ending 03/31/2009

ISSUE Summary

Access to Care

Affordability	1
Behavioral Health	4
Chiropractic	4
Clinical Denial Of Care	1
DME, Supplies	4
Dental	12
Emergency Care	1
Eye Care	4
Home Health	5
Orthodontics	2
Pain Management	21
Prescription Drugs/Pharmacy	24
Routine Care/PCP	3
Speciality Care	9
Transition/Continuity Of Care	4
Transportation	9
Urgent Care	2

Access to Care

110

Billing/Coverage

Behavioral Health	1
Claim Denials	2

OVHA Quarterly Report

Quarter Ending 03/31/2009

ISSUE Summary

Billing/Coverage

Dr. Dynasaur Premiums	1
General Billing Questions	1
Hosp Financial Assistance	2
Hospital billing	18
Insurance Coverage/Contract Questions	1
ME Rx	2
Medicaid Fee-For-Service Billing	1
Medicaid/VHAP Managed Care Billing	16
Medicare Billing	1

Billing/Coverage 46

Buying Insurance

Insurance In Another State	1
Medicare Supplemental Insurance	1

Buying Insurance 2

Consumer Education

Cancer Law	1
Catamount	1
Fair Hearing	2
General Questions About Insurance	1
Info/Applying For OVHA Programs	2

Consumer Education 7

Eligibility

OVHA Quarterly Report

Quarter Ending 03/31/2009

ISSUE Summary

Eligibility

Buy In Programs	6
Catamount Health	1
Medicaid	32
Medicare	2
Other OVHA Programs	2
Premium Assistance	6
VHAP	18
VPharm	7

Eligibility

74

Other

Access To Medical Records	1
Communication Problems: DSW/HAEU	1
Communication/Complaint: Provider	21
Coordination Of Benefits	2
DSW ID Card Problems	1
MMA	26
Medicare Part C	2
OVHA Policy Issues	1
Other	11
Termination	6
Unknown	1

Other

73

Totals

16

OVHA Quarterly Report

Quarter Ending 03/31/2009

ISSUE Summary

312

Office of Health Care Ombudsman

Quarter Ending 03/31/2009

Report of Outcomes and Disposition OVHA

Outcome	Complex Intervention	Direct Intervention			
Client Not Eligible for Benefit		1			
Client Responsible For Bill		1			
Estimated Eligibility For Insurance	1	1			
Obtained Coverage For Services	3	7			
Other Access/Eligibility Outcome	5	17			
Other Billing Assistance		2			
Patient Assistance Provided	1	4			
Prevented Termination or Reduction in Coverage	3	7			
Service Excluded Under Contract		1			

Office of Health Care Ombudsman

Quarter Ending 03/31/2009

OVHA Coverages

Report of Outcomes and Issues

Outcome	Access to Care	Billing/Coverage	Eligibility
Client Not Eligible for Benefit			1
Client Responsible For Bill			1
Estimated Eligibility For Insurance			2
Obtained Coverage For Services	8		2
Other Access/Eligibility Outcome	12	1	9
Other Billing Assistance		2	
Patient Assistance Provided	4	1	
Prevented Termination or Reduction in Coverage			10
Service Excluded Under Contract	1		

Office of Health Care Ombudsman

Quarter Ending 03/31/2009

Report of Outcomes and Issues Prescription Drugs OVHA Only

Outcome	Access to Care
Obtained Coverage For Services	5
Other Access/Eligibility Outcome	1

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