

*State of Vermont*  
*Agency of Human Services*

**Global Commitment to Health**  
**11-W-00194/1**

**Section 1115**  
**Demonstration Year: 3**  
**(10/1/2007 – 9/30/2008)**

**Quarterly Report for the period**  
**July 1, 2008 to September 30, 2008**

**Submitted Via Email on**  
**November 4, 2008**

## **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 31<sup>st</sup> 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 forth quarterly report for waiver year three, covering the period from July 1, 2008 to September 30, 2008.***

## **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	Previously Reported Enrollees
	Last Day of Qtr	Last Day of Qtr
	9/30/2008	6/30/2008
Demonstration Population 1:	41,496	40,712
Demonstration Population 2:	40,487	40,818
Demonstration Population 3:	8,665	8,591
Demonstration Population 4:	N/A	N/A
Demonstration Population 5:	1,274	1,280
Demonstration Population 6:	2,574	2,477
Demonstration Population 7:	25,570	25,434
Demonstration Population 8:	7,327	7,877
Demonstration Population 9:	2,563	2,601
Demonstration Population 10:	N/A	N/A
Demonstration Population 11:	5,698	4,496

- \* 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 fourth quarter, a Green Mountain Care application and the web site were updated in accordance with newly passed legislation impacting Catamount Health; namely that all preexisting conditions would be covered without a waiting period for those who apply before November 1. This legislation created an imperative to notify the public about this time-sensitive offering. The Green Mountain Care web button was coded in a way that allowed us to change the web button image on all sites with a timely message about amnesty for preexisting conditions. The Green Mountain Care website also added web links to sites that provided information on long-term care.

Outreach efforts included an email campaign via many of our partner organizations that reached close to 3,000 people in community agencies. Leadership within State government was also asked to prominently display materials for employees and the public. Additionally, OVHA and the Vermont Department of Labor (VDOL) developed a postcard mailing to all 22,000 private-sector employers in the State of Vermont.

OVHA has partnered with VDOL at seven company layoffs reaching over 250 people. We verified citizenship and identity at the site of a large layoff in order to expedite eligibility for health care programs. Additionally, OVHA and the VDOL develop a day-long workshop for 115 members of the Vermont Human Resource Association.

OVHA also worked with the Vermont Department of Health to re-brand their health care material under Green Mountain Care and disseminate them to every public school before the start of the school year.

Green Mountain Care was a sponsor at a three-day outdoor event which attracted 20,000 people to downtown Burlington. In addition to publicity generated by advertising and web promotion, we distributed materials to approximately 200 people, many of whom were working but lacked health insurance. Additionally, we outreached to over 800 people through various clubs, organizations and fairs.

*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 September, there were 7315 individuals enrolled.

OVHA continues to work with the new staff position (funded by OVHA) at Bi-State Primary Care Association on assisting applicants and tracking applications via the new online tracking tool. The staffer completed a phone survey of people who applied for premium assistance over the course of the last several months, but who did not follow through and actually enroll in either Catamount Health or their ESI plan. Half the people reached by telephone are currently on some form of health care assistance, so although they failed to follow through on their first attempt, they did reapply and complete the process. Of the remaining half who did not reapply, 14% said the cost of the premium was too high, and 12% obtained private insurance elsewhere. Only 3% said they didn't follow through because they didn't understand what to do.

The Bi-State Primary Care Association staffer also has been traveling around the state training health care providers on how to use the tracking tool to enter information on patients who do not have insurance. Once a patient's identifying information is entered, OVHA's Member Services Unit follows up with a phone call and an application form. If the person does not submit the completed application within 45 days, Member Services will call again to ask if the person needs help with the application process. If so, Member Services refers the person to Bi-State for further one-on-one assistance.

### **Operational/Policy Developments/Issues**

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

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

The OVHA, in conjunction with the Vermont Department of Health (VDH), has implemented 12 targeted initiatives listed below to provide a comprehensive, balanced approach to improve oral health and oral health access for all Vermonters. Updates as of September 30, 2008 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. School outreach efforts introduced a campaign for the fall of 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. In SFY 2009, an action plan will educate/train physicians on performing OHRA's, including online web links.

Initiative #4: Place Dental Hygienists in Each of the 12 District Health Offices - Successful pilot project will result in the start of placement of part-time dental hygienists in District Health Offices.

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; more than 4500 enrollees have selected 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. In SFY 2009, the OVHA will evaluate the resulting data to explore processes to reduce missed appointments and late cancellations.

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. In SFY 2009, 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 - 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, distributions of \$146,418 each will be made in October 2008 and April 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.

Chiropractic: Chiropractic coverage for adults in Medicaid and VHAP was reinstated effective July 1, 2008 per Act 192 of the 2008 Legislative session. As of a July 1, 2008 date of service, allowable and covered services for children and adults will be the same and must be clinically necessary.

### **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. The OVHA was appropriated \$500,000 in one-time funds by the legislature to implement the Buprenorphine initiative in 2006. The current plan for the use of these funds, established in a collaborative manner between ADAP and OVHA, is a capitated program that increases reimbursement in a step-wise manner depending on the number of patients treated by a physician. The Capitated Payment Methodology is depicted below:

Level	Complexity Assessment	Rated Capitation Payment			
III.	Induction	\$348.97	+	<b><u>BONUS</u></b>	= <b>Final Capitated Rate (depends on the number of patients per level, per provider)</b>
II.	Stabilization/Transfer	\$236.32			
I.	Maintenance Only	\$101.28			

CPTOD 2007 - 2008 Payment Summary	
May-07	\$ 680.00
Jun-07	\$ 15,595.40
Jul-07	\$ 15,149.40
Aug-07	\$ 20,505.59
Sep-07	\$ 28,315.04
<b>SURVEY</b>	\$ 10,000.00
Oct-07	\$ 27,968.12
Nov-07	\$ 30,492.75
Dec-07	\$ 38,872.44
Jan-08	\$ 45,163.01
Feb-08	\$ 40,366.07
Mar-08	\$ 41,590.23
Apr-08	\$ 40,309.54
May-08	\$ 37,456.37
June-08	\$ 35,864.01
July-08	\$ 40,542.79
Aug-08	\$ 33,406.08
Sep-08	\$ 36,537.06
Total	\$ 538,813.90

As of September 2008, the Capitated Program for the Treatment of Opiate Dependency (CPTOD) as implemented by the OVHA has 34 enrolled providers and approximately 382 patients undergoing opiate addiction treatment. In the first quarter of SFY '08, the Buprenorphine Program paid \$63,970 in Buprenorphine claims for the 577 patients who received care, and paid a total \$58,507 to 18 enrolled providers. In the 2<sup>nd</sup> quarter of SFY '08, the program paid \$97,333.31 in Buprenorphine claims for 1161 patients. In the 3<sup>rd</sup> quarter of SFY '08, the program paid \$127,119.31 in claims for 1250 patients. In the 4<sup>th</sup> quarter of SFY '08, the program paid \$113,629.92 in claims for 1276 patients. In the 1<sup>st</sup> quarter of SFY'09, the program paid \$110,485.93 in claims for 1229 patients. The program has been successful at increasing patient access to providers who are licensed to prescribe Buprenorphine in Vermont.

Care Coordination Program: The OVHA's Care Coordination Program (CCP) - in conjunction with the Chronic Care Management Program (CCMP) - is a unique undertaking based on the chronic care model to help improve the quality of care and quality of life of Medicaid beneficiaries with chronic conditions. The CCP and CCMP are the vanguard of system redesign efforts to empower beneficiaries and develop the self-confidence required to effectively manage and improve their clinical health outcomes, working with a holistic approach. To achieve our goals, the OVHA is partnering with primary care providers, hospitals, community agencies, and other Agency of Human Services (AHS) departments to address the need for enhanced coordination of services in a climate of increasingly complex health care needs and scarce resources, by utilizing the flexibility granted by the Global Commitment to Health Waiver.

To meet our objectives, the CCP utilizes teams of nurses and social workers in eight districts through out the state, to facilitate the beneficiary-provider relationship. We provide services which assist the primary care provider in tending to the intricate medical and social needs of our beneficiaries, without increasing the administrative burden. In fact, providers are able to bill an enhanced per member per month (pmpm) case management rate for working with the OVHA teams. The CCP supports providers by offering intensive case management services to eliminate barriers and to enable the provider's plan of care (POC) to be successful; and supports the beneficiary in setting and achieving his/her self-management goals. While nurses and medical social workers function as a team, they each maintain an independent case load with an average of 25 beneficiaries with joint case load of 50 beneficiaries based on two member staffing model. While case durations have varied between 2 months and up to 12 months, our goal is to address the immediate needs within a 3 to 4 month timeframe prior to transfer to the CCMP telephonic service for continuity of care to facilitate sustainable change. The CCP anticipates an average monthly case load of 400 high risk beneficiaries based on a full staffing complement of 16 FTE's in 8 district offices; and a total annual case load of roughly 1200 beneficiaries.

Ultimately, the CCP aims to improve health outcomes, decrease inappropriate utilization of services, and increase appropriate utilization of services. Individuals involved in the CCP have at least one chronic condition but generally have multiple conditions which include but are not limited to: Arthritis, Asthma, Chronic Obstructive Pulmonary Disease (COPD), Chronic Renal Failure, Congestive Heart Failure (CHF), Depression, Diabetes, Hyperlipidemia, Hypertension, Coronary Artery Disease, or Low Back Pain.

These conditions and their management are often further complicated by mental health and substance abuse challenges; as well as socio-economic determinants of health including food security, safe and affordable housing, reliable transportation to attend scheduled appointments and the capacity to fill prescriptions for required medications. The CCP team's partner with various internal Agency of Human Services (AHS) partners as well as external partners such as Home Health Agencies, certified diabetic educators, hospital wellness programs (including their community based Healthier Living Workshops) and others to facilitate the care management goals of both beneficiaries and the primary care provider. CCP teams work effectively with multiple community agencies and providers to coordinate required services and address priority health and security needs of our beneficiaries.

**Highlights of CCP efforts for the quarterly reporting period ending September 30<sup>th</sup> include:**

- Case Load: management of an average monthly case load of 255 beneficiaries by a field staff of 12 FTE nurse and social workers. Additional staff positions are under recruitment with a goal of 16 field staff to achieve an average monthly case load of 400.
- Monitoring and Evaluation: A consumer survey was developed, population selected with the vendor mailing of the tool in late September. Results are expected in the first quarter of FY 09. The Center for Health Policy and Research (CHPR) will be completing chart audits for both quarterly and first year outcome data during the first quarter FY 09. CHPR also runs select quarterly metrics based on HEDIS; and will run reports based on the CCP specific intervention

population in FY 09.

- Targeted Clinical efforts: CCP initiated targeted interventions based on evidence based guidelines for CHF and Diabetes in early August and September. This intervention will continue through the next quarter based on staff assessment of beneficiary compliance to evidence based guidelines. The plan is to assure our efforts align with the specific needs of our beneficiaries, including pharmacy usage, and to assess barriers and/or gaps that prevent compliance to the prescribed treatment.
- Staff training: Our medical director has reinforced earlier education with staff on various chronic conditions to support their coaching efforts on CHF and Diabetes guidelines and ‘touch levels’ for intervention.
- Beneficiary Educational Materials: CHF, diabetes and mental health ‘action plans’ were approved for dissemination and use with beneficiaries in order to support ‘self-management’ goals in these key areas.
- Health Care Reform collaboration: CCP has initiated outreach and coordination with providers engaged in the Vermont Blueprint for Health Chronic Care Initiative including the newly deployed Community Care Teams and the Advanced Medical Home project in our St. Johnsbury district office.

*Chronic Care Management Program (CCMP):* The CCMP collaborates with providers, hospitals and community agencies to implement evidence-based practices that support a patient-focused model of care committed to enhanced patient self-management skills and appropriate utilization of healthcare services. In association with the Blueprint for Health and in partnership with the Care Coordination Program (CCP), which addresses the needs of beneficiaries at greatest risk, the CCMP addresses the increasing prevalence of chronic illness among the Medicaid population. The CCMP is based on the Chronic Care Model and is designed to take a holistic approach by evaluating both physical conditions and socioeconomic issues for Medicaid beneficiaries.

The CCMP focuses on beneficiaries identified as having one of the 11 following chronic conditions: Arthritis, Asthma, Chronic Obstructive Pulmonary Disease (COPD), Chronic Renal Failure, Congestive Heart Failure (CHF), Depression, Diabetes, Hyperlipidemia (i.e., high cholesterol, high triglycerides), Hypertension, Ischemic Heart Disease (i.e., coronary artery disease) and Low Back Pain. Beneficiaries who are currently enrolled in Medicaid, VHAP, PCPlus or Dr. Dynasaur and who have one or more of these chronic conditions are eligible for the CCMP. The OVHA estimates there are approximately 25,000 beneficiaries at any given time with at least one of the above-cited diagnoses.

The CCMP is administered by two contracts: (1) the Center for Health Policy and Research (CHPR) at the University of Massachusetts Medical School provides population selection and program monitoring services, and (2) APS Healthcare Services, Inc.(APS), provided Health Risk Assessments (HRA) and Intervention Services (IVS) to eligible beneficiaries.

CHPR uses a predictive modeling methodology to identify candidates for both CCMP and CCP; those selected for CCP case management services have the highest medical risks and most complex needs. APS has completed HRAs on beneficiaries eligible for either CCP or CCMP; based on findings during the assessment process, those eligible for CCMP are then enrolled in one of four levels of disease management services. All interventions are tracked using APS CareConnection®, a proprietary case tracking and management system also used by CCP care coordinators.

CHPR updates the target population quarterly, provides ongoing program monitoring, and produces quarterly monitoring reports that track administrative health outcome measures and intervention service effectiveness.

Disease management services have included quarterly newsletters, educational tools and self-management



strategies, telephonic access to disease management specialists, and, for those beneficiaries assessed as relatively higher risk, one-on-one support provided by an APS nurse health coach or social worker. Health coaches provide predominantly telephonic consultation and support and assist beneficiaries and their health care providers in developing a Plan of Care with individualized health goals. As goals are reached and outcomes achieved, beneficiaries move to a less intense level of services.

Achievements as of September 30, 2008, include the following:

- **24,190** CCMP and CCP beneficiaries completed HRAs.
- **2,658** CCMP participants have completed at least one detailed assessment to generate a Plan of Care for Intervention Services; a total of **4,595 assessments** were completed.

The OVHA is currently negotiating a contract amendment with APS. The primary purpose of the amendment will be to reduce the annual cost of this contract by \$872,720 to meet OVHA contract budget targets for state fiscal year 2009 and beyond. These targets were established on August 21 as the result of a joint rescission process undertaken by the executive and legislative branch. At that time, the Office entered into negotiations with APS to determine what service changes needed to occur in order to meet the APS contract budget target. OVHA and APS have agreed that at a minimum it will be necessary to discontinue quarterly newsletters and administering Health Risk Assessments.

### **Financial/Budget Neutrality Development/Issues**

AHS has submitted Intergovernmental Agreements (IGAs) between the AHS and OVHA to CMS for Global Commitment waiver years one, two and three. The IGAs included per-member-per-month capitation rates within the actuarially certified ranges. CMS has approved year one IGA and the State has completed final waiver year one reporting on the CMS-64. AHS awaits guidance from CMS on how to report the CRT information on the CMS-64 and approval of the IGA's for years two and three before revising the CMS-64 reports for years two and three.

The State has received the actuarially certified rate ranges for FFY09 from Aon Consulting; FFY09 PMPM capitated rates are in development at this time.

Please see Attachment 2 for current budget neutrality workbook.

### **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 15<sup>th</sup> of the preceding month. Upon implementation of prospective capitation rate payment, AHS will use the enrollment data as of the 15<sup>th</sup> of the month to pay OVHA's per member, per month capitation payment on the 1<sup>st</sup> of the following 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.

Demonstration Population	Month 1 7/15/2008	Month 2 8/15/2008	Month 3 9/15/2008	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:	41,200	41,377	41,420	123,997	122,281	121,926	120,113
Demonstration Population 2:	40,663	40,729	40,589	121,981	123,283	122,118	120,309
Demonstration Population 3:	8,861	8,848	8,743	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
Demonstration Population 5:	1,285	1,296	1,269	3,850	3,767	3,542	3,767
Demonstration Population 6:	2,481	2,468	2,479	7,428	7,357	6,208	6,084
Demonstration Population 7:	24,608	24,876	24,817	74,301	73,966	72,336	65,803
Demonstration Population 8:	7,145	7,249	7,321	21,715	23,100	22,697	22,445
Demonstration Population 9:	2,512	2,549	2,565	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
Demonstration Population 11:	4,962	5,385	5,789	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 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 External Quality Review Organization (EQRO), Health Services Advisory Group (HSAG), conducted three of its mandatory activities: validation of Performance Improvement Projects (PIP), validation of Performance Measures (PM), and a review of the MCO's ability to comply with the Quality Assessment and Performance Improvement

(QAPI) standards found in the Code of Federal Regulations (CFR) and the Agency of Human Services (AHS)/Office of Vermont Health Access (OVHA) Intergovernmental Agreement (IGA). The validation of the PIP was conducted via desk review, while the validation of Performance Measures and compliance review was conducted via a desk and an on-site review. Also during this quarter, monthly update calls with Health Services Advisory Group, Inc. (HSAG) continued. During this quarter, HSAG provided feedback on the PIP information submitted via the PIP Summary Form. Feedback focused on the specific research questions and the indicators associated with them. An update summary form was submitted to HSAG. It is anticipated that the resubmission will be reviewed by HSAG and a final report will be delivered during the next quarter. Also during this quarter, the AHS Quality Improvement Manager participated in HSAG's onsite review of MCO Performance Measures. During a three day site visit, HSAG validated 7 HEDIS measures that the MCO is required to report to the AHS on an annual basis. A draft report of findings was prepared by HSAG with a final report due next quarter. Finally, the AHS QI Manager participated in HSAG's onsite review to determine the MCO's ability to comply with MCO QAPI standards. During this three day review, HSAG interviewed key OVHA staff and reviewed documents to determine the MCO's ability to comply with the Medicaid MCO Structure and Operations standards. An exit conference was conducted and a draft report was produced with a final report due next quarter.

*Quality Assurance Performance Improvement Committee:* During this quarter, the Committee recommended 21 agency-wide MCO performance measures for year three of the waiver. The measures include 17 HEDIS measures and 4 experience of care measures (i.e., getting needed care, getting care quickly, customer service, and overall rating of health plan) that should be reported by the MCO on a regular basis. For the sake of trending, these measures are the same measures that the MCO reported during the first two years of the waiver. Results of the measures will be reviewed by the committee. During this quarter, the Quality Assurance Performance Improvement Committee (QAPI) also made a recommendation to have the MCO continue the Fostering Healthy Families Performance Improvement Project. Year three project activities should focus around the following activities: reviewing sampling methods, reviewing data collection procedures, assessing improvement strategies, reviewing data analysis and interpreting study results, assessing the likelihood that reported improvement is "real" improvement, and assessing whether improvements are sustained. The committee recommended that the EQRO review the Measurement and Improvement standards found in the CFR and AHS OVHA IGA during year three. These standards include the following: use of practice guidelines, Quality Assurance Performance Improvement Program, Health Information System, and Utilization Management activities. The Quality Assurance Performance Improvement Committee continued to discuss the MCO Quality Plan. This document will mirror the quality framework established in the Quality Strategy and identify how OVHA and its IGA partners will assess and improve the quality of care for Medicaid enrollees/beneficiaries. Finally, during this quarter, the QAPI committee continued its discussion regarding its oversight/monitoring role. As the MCO Quality Plan is developed, it is anticipated that the committee's oversight/monitoring role will become more established and thus the types of reports needed should be come clearer.

*Quality Strategy:* The Quality Framework contained in the Quality Strategy continues to be used by the Quality Assurance Performance Improvement Committee to guide the development of the MCO Quality Plan (discussed above).

## **Mapping and Network Analysis**

The Office of Vermont Health Access (OVHA) has initiated systematic analysis and monitoring of the provider network. The first step is geographic mapping of all health care providers to evaluate and monitor access, target licensed but not enrolled providers, and evaluate providers in comparison to beneficiaries to ensure access. 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 outreach. The geographic mapping schedule has been updated is as follows:

November 2008 - Dental Providers

December 2008 - Psychiatric Providers (Psychiatrist, Psychologist, and Clinical Social Workers)

January 2009 - Primary Care Providers (Family Medicine, Pediatrics, and Internal Medicine, Naturopaths, Nurse Practitioners)

February 2009 – Nursing Homes

March 2009 – Pharmacy and Durable Medical Equipment Providers

April 2009 - Pharmacy and DME Suppliers

May 2009 - Physical Therapists, Occupational Therapists, Speech Therapists

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

## **Demonstration Evaluation**

A contract was finalized with Pacific Health Policy Group (PHPG) to evaluate the impact of the Global to Health Medicaid Waiver. During this quarter, the contract was signed and the evaluation of the waiver initiated. David Murphey, AHS senior policy analysts, will act as the contract manager. It is anticipated that David will work with PHPG to modify the draft Evaluation Plan and submit a final plan to CMS during 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 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)**

Fiscal:	Jim Giffin, CFO VT Agency of Human Services 103 South Main Street Waterbury, VT 05671-0201	802-241-2949 (P) 802-241-1200 (F) <a href="mailto:jim.giffin@ahs.state.vt.us">jim.giffin@ahs.state.vt.us</a>
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) <a href="mailto:suzanne.santarcangel@ahs.state.vt.us">suzanne.santarcangel@ahs.state.vt.us</a>
MCO:	Joshua Slen, Director VT Office of Health Access 312 Hurricane Lane, Suite 201 Williston, VT 05495	802-879-5901 (P) 802-879-5952 (F) <a href="mailto:joshua.slen@ahs.state.vt.us">joshua.slen@ahs.state.vt.us</a>

**Date Submitted to CMS:** November 4, 2008

# **ATTACHMENTS**

**Office of Vermont Health Access**  
SFY '09 Catamount Health Actual Revenue and Expense Tracking  
Monday, October 20, 2008

	SFY '09 Revised Appropriated			Consensus Estimates for SFY to Date			Actuals thru 9/30/08			
	<=200%	>200%	Total	<=200%	>200%	Total	<=200%	>200%	Total	% of SFY to-Date
<b>TOTAL PROGRAM EXPENDITURES</b>										
Catamount Health	19,041,555	8,724,313	27,765,868	3,880,148	1,777,776	5,657,924	4,126,152	2,045,520	6,171,672	109.08%
Catamount Eligible Employer-Sponsored Insurance	828,835	419,999	1,248,834	151,702	76,873	228,575	140,719	62,323	203,042	88.83%
<b>Subtotal New Program Spending</b>	<b>19,870,390</b>	<b>9,144,312</b>	<b>29,014,702</b>	<b>4,031,850</b>	<b>1,854,649</b>	<b>5,886,499</b>	<b>4,266,871</b>	<b>2,107,843</b>	<b>6,374,714</b>	<b>108.29%</b>
Catamount and ESI Administrative Costs	1,643,868	1,312,912	2,956,780	410,967	328,228	739,195	410,967	328,228	739,195	100.00%
<b>TOTAL GROSS PROGRAM SPENDING</b>	<b>21,514,258</b>	<b>10,457,224</b>	<b>31,971,482</b>	<b>4,442,817</b>	<b>2,182,877</b>	<b>6,625,694</b>	<b>4,677,838</b>	<b>2,436,071</b>	<b>7,113,909</b>	<b>107.37%</b>
<b>TOTAL STATE PROGRAM SPENDING</b>	<b>8,745,546</b>	<b>10,457,224</b>	<b>19,202,770</b>	<b>1,806,005</b>	<b>2,182,877</b>	<b>3,988,882</b>	<b>1,901,541</b>	<b>2,436,071</b>	<b>4,337,612</b>	<b>108.74%</b>
<b>TOTAL OTHER EXPENDITURES</b>										
Immunizations Program	-	3,250,000	3,250,000	-	812,500	812,500	-	812,500	812,500	100.00%
VT Dept. of Labor Admin Costs Assoc. With Employer Assess.	-	394,072	394,072	-	98,518	98,518	-	98,518	98,518	100.00%
Marketing and Outreach	500,000	-	500,000	125,000	-	125,000	125,000	-	125,000	100.00%
Blueprint	-	1,846,713	1,846,713	-	461,678	461,678	-	461,678	461,678	100.00%
<b>TOTAL OTHER SPENDING</b>	<b>500,000</b>	<b>5,490,785</b>	<b>5,990,785</b>	<b>125,000</b>	<b>1,372,696</b>	<b>1,497,696</b>	<b>125,000</b>	<b>1,372,696</b>	<b>1,497,696</b>	<b>100.00%</b>
<b>TOTAL STATE OTHER SPENDING</b>	<b>203,250</b>	<b>5,490,785</b>	<b>5,694,035</b>	<b>50,813</b>	<b>1,372,696</b>	<b>1,423,509</b>	<b>50,813</b>	<b>1,372,696</b>	<b>1,423,509</b>	<b>100.00%</b>
<b>TOTAL ALL STATE SPENDING</b>	<b>8,948,796</b>	<b>15,948,009</b>	<b>24,896,805</b>	<b>1,856,818</b>	<b>3,555,573</b>	<b>5,412,391</b>	<b>1,952,354</b>	<b>3,808,767</b>	<b>5,761,121</b>	<b>106.44%</b>
<b>TOTAL REVENUES</b>										
Catamount Health Premiums	3,012,187	2,456,605	5,468,792	613,801	594,703	1,208,504	599,162	451,059	1,050,221	86.90%
Catamount Eligible Employer-Sponsored Insurance Premiums	265,278	290,319	555,597	46,575	50,972	97,547	44,465	28,080	72,545	74.37%
<b>Subtotal Premiums</b>	<b>3,277,465</b>	<b>2,746,925</b>	<b>6,024,389</b>	<b>660,377</b>	<b>645,675</b>	<b>1,306,051</b>	<b>643,627</b>	<b>479,139</b>	<b>1,122,766</b>	<b>85.97%</b>
Federal Share of Premiums	(1,945,175)	-	(1,945,175)	(391,934)	-	(391,934)	(381,993)	-	(381,993)	97.46%
<b>TOTAL STATE PREMIUM SHARE</b>	<b>1,332,289</b>	<b>2,746,925</b>	<b>4,079,214</b>	<b>268,443</b>	<b>645,675</b>	<b>914,118</b>	<b>261,634</b>	<b>479,139</b>	<b>740,773</b>	<b>81.04%</b>
Cigarette Tax Increase (\$.60 / \$.80)			9,207,000			2,301,750			2,732,304	118.71%
Floor Stock			500,000			125,000			374,956	299.96%
Employer Assessment			6,210,000			1,552,500			1,353,000	87.15%
Interest			-			-			17,564	0.00%
<b>TOTAL OTHER REVENUE</b>			<b>15,917,000</b>			<b>3,979,250</b>			<b>4,477,824</b>	<b>112.53%</b>
<b>TOTAL STATE REVENUE</b>	<b>1,332,289</b>	<b>2,746,925</b>	<b>19,996,214</b>	<b>268,443</b>	<b>645,675</b>	<b>4,893,368</b>	<b>261,634</b>	<b>479,139</b>	<b>5,218,597</b>	<b>106.65%</b>
State-Only Balance			(4,900,591)			(519,023)			(542,523)	
Carryforward			9,820,186			9,820,186			9,820,186	
<b>(DEFICIT)/SURPLUS</b>			<b>4,919,595</b>			<b>9,301,163</b>			<b>9,277,662</b>	
Reserve Account Funding			1,800,000			1,800,000			1,800,000	
<b>REVISED (DEFICIT)/SURPLUS WITH RESERVE FUNDING</b>			<b>6,719,595</b>			<b>11,101,163</b>			<b>11,077,662</b>	

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

## Green Mountain Care Enrollment Report September 2008

### TOTAL ENROLLMENT BY MONTH

	Jul-07	Aug-07	Sep-07	Oct-07	Nov-07	Dec-07	Jan-08	Feb-08	Mar-08	Apr-08	May-08	Jun-08	Jul-08	Aug-08	Sep-08
<b>VHAP-ESIA</b>	-	-	-	-	35	131	287	411	542	589	607	632	672	691	733
<b>ESIA</b>	-	-	-	-	21	69	127	169	242	273	304	324	336	358	413
<b>CHAP</b>	-	-	-	-	320	1,186	1,834	2,419	3,033	3,507	3,918	4,265	4,608	5,003	5,384
<b>Catamount Health</b>	-	-	-	-	120	165	268	345	361	344	470	606	697	701	785
<b>Total</b>	-	-	-	-	376	1,551	2,516	3,344	4,178	4,713	5,299	5,827	6,313	6,753	7,315

	Jul-07	Aug-07	Sep-07	Oct-07	Nov-07	Dec-07	Jan-08	Feb-08	Mar-08	Apr-08	May-08	Jun-08	Jul-08	Aug-08	Sep-08
<b>Other Medicaid</b>	69,764	70,016	70,278	70,134	69,969	69,805	70,466	70,858	70,851	70,789	70,766	70,754	70,947	70,846	70,996
<b>Dr Dynasaur</b>	19,738	19,664	19,475	19,629	19,733	19,781	19,822	19,977	20,210	20,227	20,297	20,410	19,960	20,061	20,251
<b>SCHIP</b>	3,097	3,137	3,173	3,355	3,428	3,481	3,479	3,170	3,166	3,200	3,231	3,215	3,396	3,363	3,415
<b>VHAP</b>	23,725	23,767	23,870	24,245	24,849	25,295	25,899	26,150	26,301	26,670	26,516	26,650	26,441	26,721	26,622
<b>Total</b>	116,324	116,584	116,796	117,363	117,979	118,362	119,666	120,155	120,528	120,886	120,810	121,029	120,744	120,991	121,284

<b>TOTAL ALL</b>	116,324	116,584	116,796	117,363	118,355	119,913	122,182	123,499	124,706	125,599	126,109	126,856	127,057	127,744	128,599
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**KEY:**

VHAP-ESIA = Eligible for VHAP AOD enrolled in ESI with premium assistAOce

ESIA = Between 150% AOD 300% AOD enrolled in ESI with premium assistAOce

CHAP = Between 150% AOD 300% AOD enrolled in Catamount Health with premium assistAOce

Catamount Health = Over 300% AOD enrolled in Catamount Health with no premium assistAOce

VHAP = Enrolled in VHAP with no ESI that is cost-effective AOD/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



## Green Mountain Care Enrollment Report

### September 2008 Demographics

Income	VHAP-ESIA*	ESIA*	CHAP*	TOTAL
0-50%	16	7	242	
50-75%	34	1	73	
75-100%	81	1	109	
100-150%	368	12	314	
150-185%	207	137	1,919	
185-200%	15	131	1,200	
200-225%	6	53	727	
225-250%	2	45	485	
250-275%	1	23	210	
275-300%	3	3	105	
<b>Total</b>	<b>733</b>	<b>413</b>	<b>5,384</b>	<b>6,530</b>

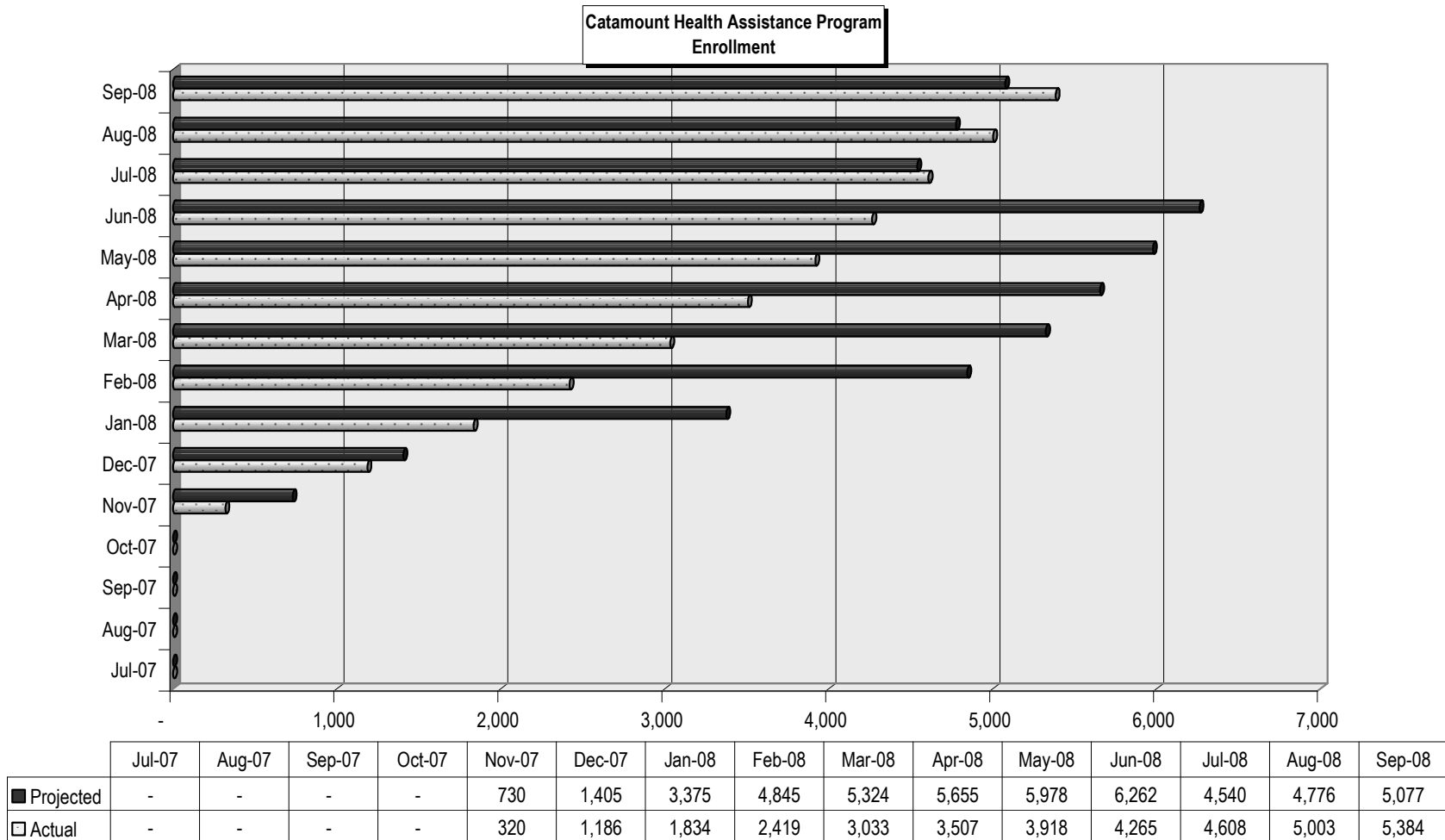
Age	VHAP-ESIA	ESIA	CHAP	TOTAL
18-24	37	50	969	
25-35	197	110	873	
36-45	282	115	979	
46-55	165	97	1,291	
56-64	52	41	1,261	
65+	-	-	11	
<b>Total</b>	<b>733</b>	<b>413</b>	<b>5,384</b>	<b>6,530</b>

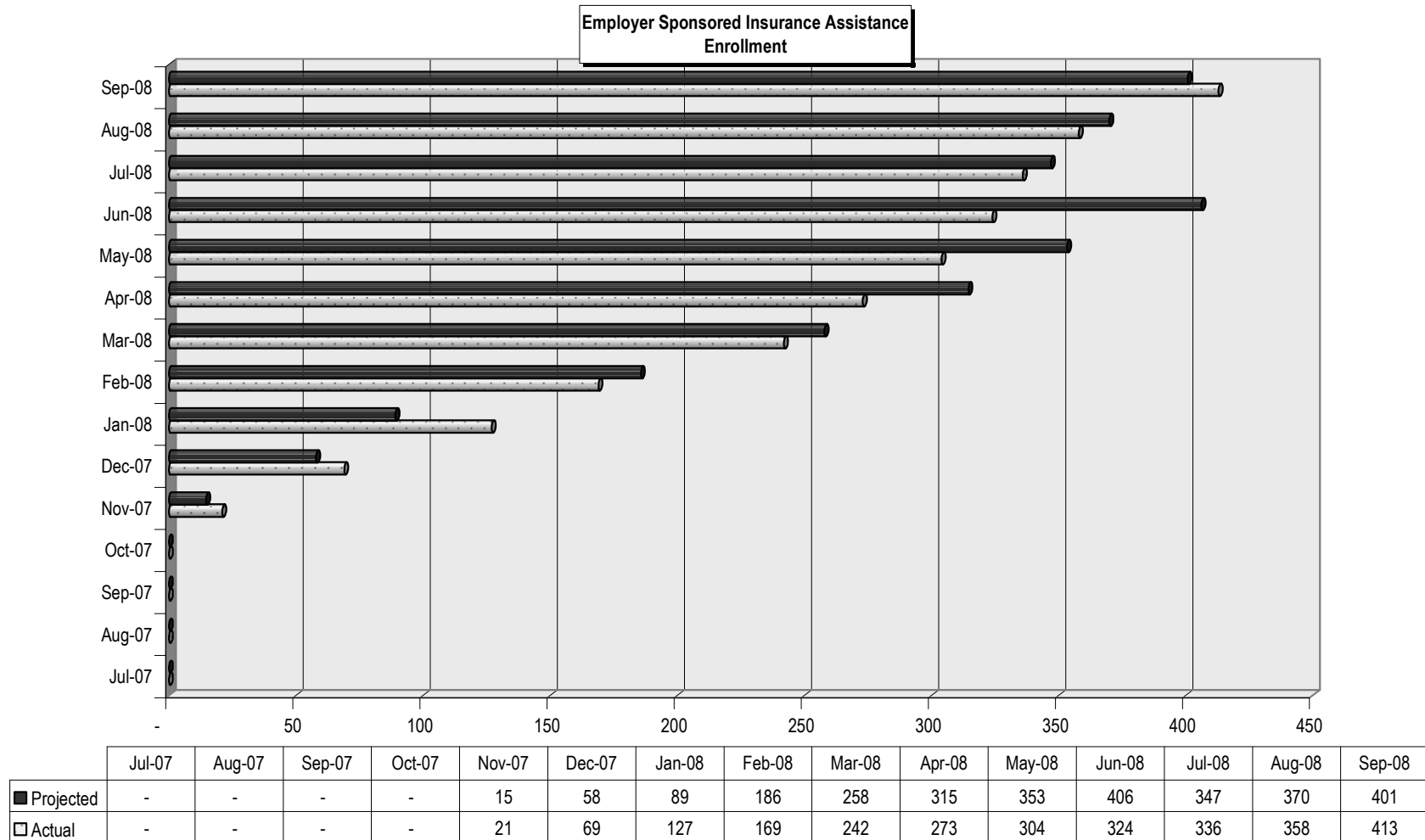
## Green Mountain Care Enrollment Report (continued)

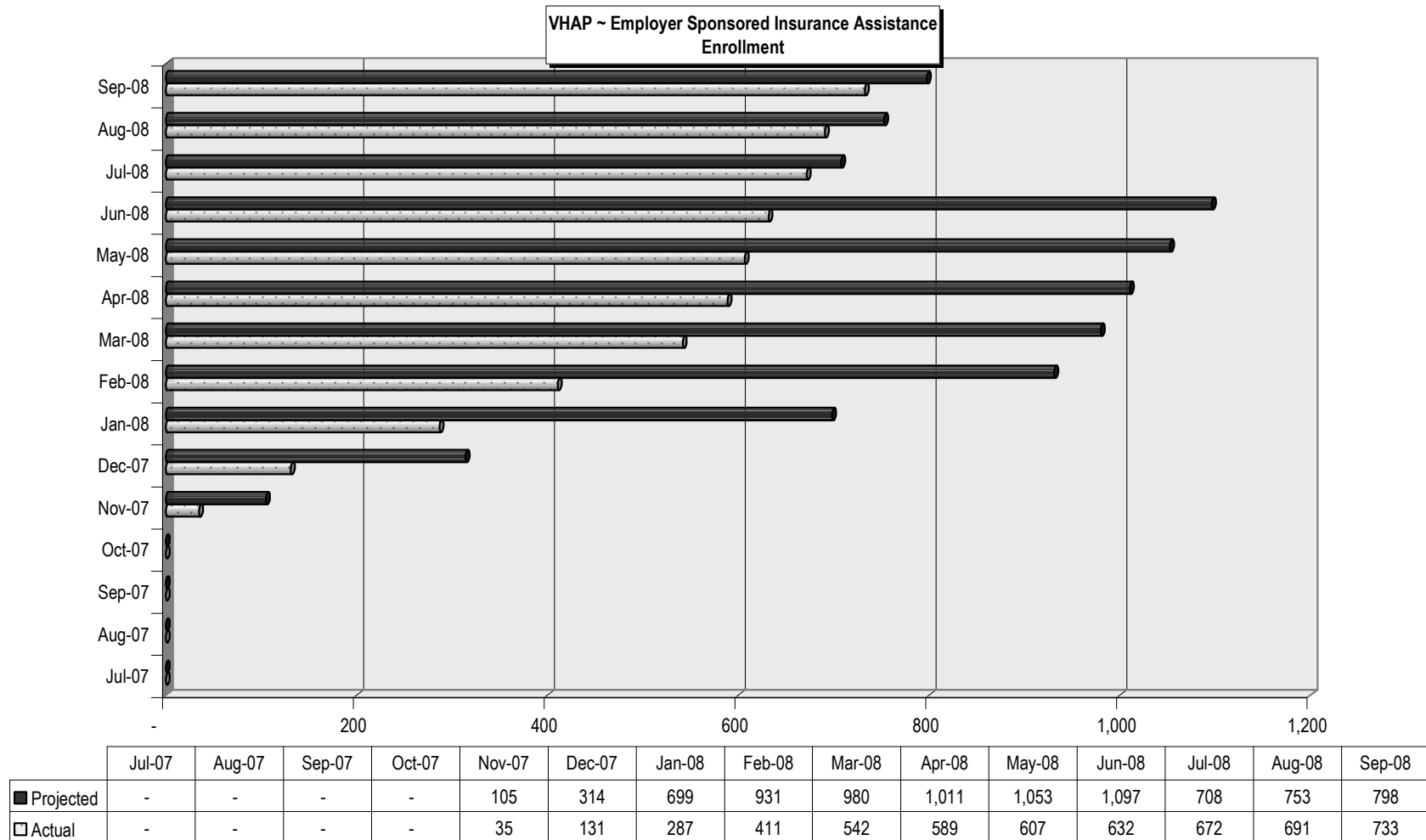
### September 2008 Demographics

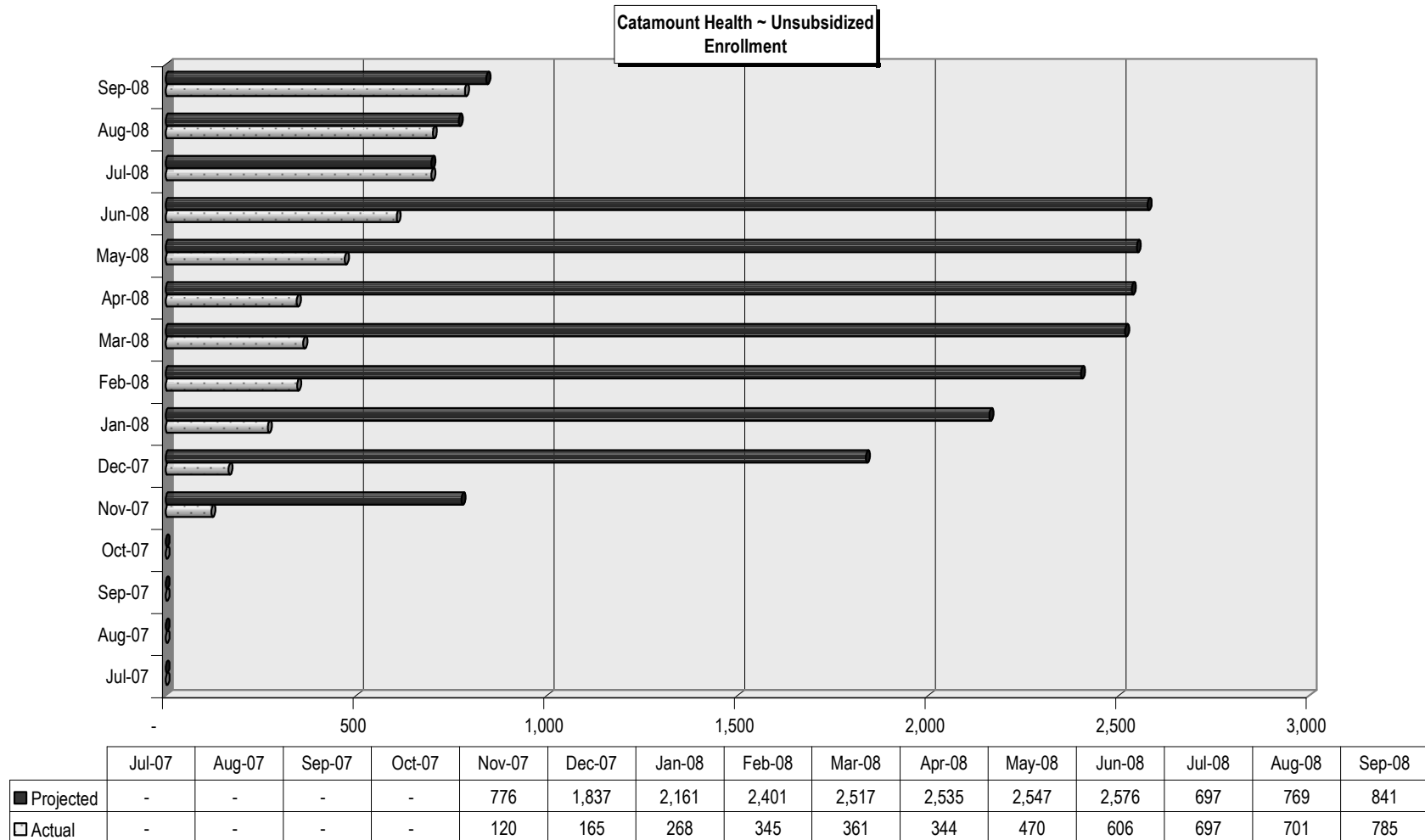
Gender	VHAP-ESIA	ESIA	CHAP	TOTAL
Male	256	155	2,352	
Female	477	258	3,032	
<b>Total</b>	<b>733</b>	<b>413</b>	<b>5,384</b>	<b>6,530</b>

County	VHAP-ESIA	ESIA	CHAP	TOTAL
Addison	38	23	347	
Bennington	75	31	316	
Caledonia	29	20	355	
Chittenden	133	95	940	
Essex	8	4	82	
Franklin	67	32	348	
Grand Isle	9	9	49	
Lamoille	41	26	282	
Orange	29	17	279	
Orleans	68	23	343	
Other	1	1	5	
Rutland	87	56	583	
Washington	59	22	516	
Windham	37	29	438	
Windsor	52	25	501	
<b>Total</b>	<b>733</b>	<b>413</b>	<b>5,384</b>	<b>6,530</b>









## Global Commitment Expenditure Tracking

										Total columns J:K	
	Quarterly Expenditures	PQA: WY1	PQA: WY2	PQA: WY3	Net Program PQA	Net Program Expenditures as reported on 64	non-MCO Admin Expenses	for Budget Neutrality calculation	Cumulative Waiver Cap	Variance to Cap under/(over)	
QE											
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			
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	\$ 6,438,888	\$ 848,568,447			
Cumulative								\$ 2,461,300,880	\$ 2,848,000,000	\$ 386,699,120	
1208											
0309											
0609											
0909											
WY4 SUM	\$ -	\$ -	\$ -		\$ -	\$ -	\$ -	\$ -			
Cumulative								\$ 2,461,300,880	\$ 3,779,000,000	\$ 1,317,699,120	
1209											
0310											
0610											
0910											
WY5 SUM	\$ -	\$ -	\$ -		\$ -	\$ -	\$ -	\$ -			
Cumulative								\$ 2,461,300,880	\$ 4,700,000,000	\$ 2,238,699,120	
	\$ 2,392,773,284	\$ 10,166,327	\$ 941,940	\$ 40,276,433			\$ 17,142,895				

PQA = Prior Quarter Adjustments

**Complaints Received by Health Access Member Services  
July 1, 2008 – September 30, 2008**

Eligibility forms, notices, or process	10
General premium complaints	4
Catamount Health Assistance Program premiums, process, ads, plans	16
Use of social security numbers as identifiers	9
Coverage rules	3
Member services	2
Eligibility rules	2
Eligibility local office	3
Prescription drug plan complaint	1
Copays/service limit	0
PBM complaint	5
Provider issues (perceived rudeness, refusal to provide service, prices) (variety of provider types)	4
Provider enrollment issues	5
OVHA forms	1
Shortage of enrolled dentists	1
Reimbursement for services from non-enrolled provider	1
Dental initiative confusion	2
<b>Total</b>	<b>69</b>



**Medicaid MCO Grievance and Appeal Report: July 1, 2008 – September 30, 2008**

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 from the centralized database.

**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 the this quarter, there were ten grievances filed with the MCO. The grievance and appeal coordinator analyzes the content of each grievance and categorizes each grievance into one or more topic areas. During this quarter 50% of the cases were filed with the OVHA, 10% were filed with the DAIL, and 40% were filed with the DMH. Of these ten grievances, four were addressed, two were withdrawn and four are still pending, which is to be expected given the 90-day timeframe to address a grievance.

**Appeals:** Medicaid rule M180.1 defines actions that an MCO entity makes that are subject to an appeal as:

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 31 appeals filed with the MCO, of which eight requested an expedited decision, and none met the criteria. Of these 31 appeals, twelve were resolved (39% of filed appeals), none were withdrawn, and nineteen appeals were still pending (61%). In seven cases (58% of those resolved), the original decision was upheld by the person hearing the appeal, four were reversed (33%), and one was approved by the department/DA/SSA before the appeal meeting (9%).

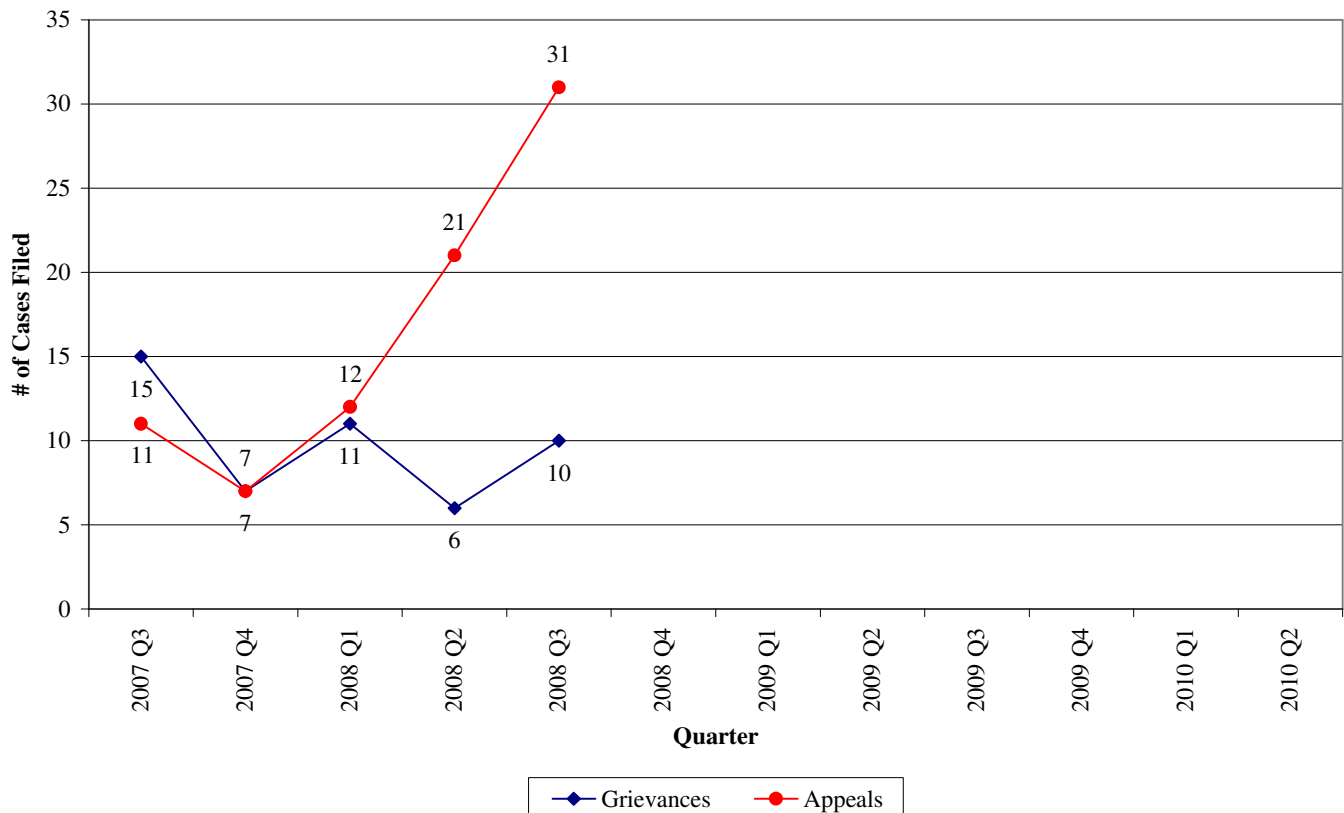
Eleven of the twelve appeals that were resolved this quarter were resolved within the statutory time frame of 45 days. One case was extended by the MCO, and was resolved within the extended time frame of 59 days. In addition, nine appeals were resolved within 30 days. The average number of days it took to resolve the eleven non-extended appeal cases was 21 days. The extended case was resolved in 51 days.

Of the appeals filed, eleven were filed by beneficiaries (35%), eleven were filed by a representative of the beneficiary (35%), none were filed by a provider, and nine were filed by someone else as requested by the beneficiary (30%). Of the 31 appeals filed, OVHA had 58%, and the DAIL had 42%. 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 27 appeals for a denial or limitation of authorization of a requested service or eligibility for service (87%) and four were for a reduction/suspension/termination of a previously authorized covered service or service plan (13%).

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 no fair hearings filed this quarter. There were four fair hearings that were pending from previous quarters. Two cases (50%) were resolved this quarter; one was upheld and one was reversed. The average number of days for these resolutions was 97 days. There are now two fair hearings pending from any/all quarters.

### Medicaid MCO Grievances & Appeals



Medicaid MCO Grievance and Appeal Report  
Data Summary  
July 1, 2008 – September 30, 2008

Number of Grievances filed: 10

Number by Category:

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

*Since more than one category can be chosen for each grievance or appeal, total number by category may exceed total number filed.*

Number of Appeals Filed: 31

Regular Appeals:	31
Expedited (met criteria) Appeals:	0

*The number of resolved appeals may not add up to the number filed, since an appeal may span two report periods.*

Number Resolved: 12

Number Upheld:	7
Number Reversed:	4
Number Modified:	0
Number Withdrawn:	0
Number Approved by Dept/DA/SSA:	1

*"Approved by Dept/DA/SSA" is when additional information received allowed the department/DA/SSA that made the original decision to reverse itself without a decision from the person hearing the internal appeal.*

Number by "Action" Category:

Denial or limitation of authorization of a requested service or eligibility for service:	27
Reduction/suspension/termination of a previously authorized covered service or service plan:	4
Denial, in whole or in part, of payment for a covered service:	0
Failure to provide clinically indicated covered service when the MCO provider is a DA/SSA:	0
Denial of a beneficiary request to obtain covered services outside the network:	0
Failure to act in a timely manner when required by state rule:	0

Number of Fair Hearings Filed with an Appeal: 0

(these are fair hearings filed during this reporting period that have also had an appeal filed for the same action)

Number of Pending Fair Hearings with an Appeal: 4

Number of Resolved Fair Hearings with an Appeal: 2

Number Upheld:	1
Number Reversed:	1
Number Modified:	0
Number Withdrawn:	0

*The number of pending and resolved fair hearings may not add up to the number filed, since a fair hearing may span two report periods.*

# OFFICE OF HEALTH CARE OMBUDSMAN

264 NORTH WINOOSKI AVE.  
P.O. Box 1367  
BURLINGTON, VT 05402  
(802) 863-2316, (800) 917-7787 (VOICE)  
(802) 863-2473, (888) 884-1955 (TTY)  
(802) 863-7152 (FAX)

## QUARTERLY REPORT

July 1, 2008 - September 30, 2008

### 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 for the quarter July 1, 2008 through September 30, 2008. During this quarter we were forced to reduce the hours we took calls on our hotline in order to get better control of our caseload. The reasons for this were outlined in last quarter's report. This reduction in hours allowed us to finish up some long-standing cases and further train our new staff. Hours were reduced from mid-July through the end of September. Starting in October 2008, we are back to regular intake hours.

We received 218 OVHA-related calls this quarter, down from 316 last quarter. This was a significant drop, most likely attributable to our reduced intake hours. The total number of all calls for this quarter was 503, down from 687 last quarter, and 770 the previous quarter. Still, because we had such a high volume during the first half of 2008, we are still on track for a yearly total of about 2400 calls. Our five year average for total number of calls per year is 2,467.

This quarter OVHA-related calls were 43% of the total call volume, which is basically the same as last quarter.

We only had 15 OVHA-related prescription drug and Medicare Part D calls this quarter, although we had 28 total Medicare Modernization Act-related calls, so not every Part D call was from someone coded as being on an OVHA program. OVHA's total call volume related to prescription drugs was 28, compared to 60 total calls related to medications.

We also started tracking pain management cases as a new and separate category this quarter for the first time because we have seen an increase in the number of this type of calls. Many pain management cases involve access to prescription drugs, but most involve access to primary care doctors. We had 8 OVHA pain management cases, out of 16 total calls under this new issue code. Thus, 50% of the pain management cases involved state programs. One particular problem that's come up a few times is Medicaid transportation problems resulting in patients missing doctor appointments for drug tests, and subsequently losing access to that doctor.

The number of calls we received related to the new Catamount and premium assistance programs fell to 55, from 89 last quarter. We are still hearing about individuals having problems with the

application process and the transition between programs as a result of income changes.

## II. Disposition of cases

We closed 231 OVHA cases this quarter, compared to 286 last quarter.

- 14% (32 calls) of the OVHA calls were resolved in the initial call;
- 42% (98 calls) were resolved by advising or referring the client after analyzing the problem;
- 40% (93 calls) required direct intervention on the caller's behalf, including advocacy with OVHA and providers, writing letters, gathering medical information, and representation at fair hearings.

## III. Issues

We opened 218 OVHA cases, compared to 316 last quarter:

- 31% (67 calls) involved access to care, compared to 26% (81 calls) last quarter;
- 28% (62) involved eligibility issues, compared to 25% (78) last quarter;
- 20% (43) involved billing or coverage problems, down from 21% (66 calls) last quarter;
- 18% (39) involved other issues, compared to 26% (81) last quarter;
- 3% (6) were coded as OVHA consumer education, compared to 3% (9 calls) last quarter.

### A. Access to Care

We received 67 OVHA-related access to care calls, down from 81 last quarter.

- 11 calls involved access to specialty care, compared to 12 calls last quarter;
- 9 calls involved access to dental care, up from 8 last quarter;
- 8 calls involved pain management (this is a new category);
- the categories of access to primary care doctors and transportation tied with 4 calls each;
- 3 calls in this category involved access to prescription drugs, not including Part D calls, significantly down from the 21 calls last quarter;
- behavioral health, orthodontics, transition/continuity of care and wheelchairs all also had 3 calls.

### B. Billing/Coverage

We received 43 calls in this category, down from 66 last quarter.

- 14 calls involved Medicaid/VHAP managed care billing, compared to 25 last quarter;
- 11 calls involved hospital billing, down from 18 calls last quarter.

### C. Eligibility

We received 62 calls in this category, down from 78 last quarter.

- 18 calls involved Medicaid eligibility, compared to 40 last quarter;
- 16 calls involved VHAP, up from 15 last quarter;
- 13 involved Catamount Health and Premium Assistance. However, these cases are sometimes difficult to code and 43 of this issue category showed up in our "all cases/all coverages" statistics, i.e. individuals calling with questions about

Catamount are sometimes not coded as OVHA cases because they may have other insurance at the time of the call.

D. Medicare Part D/Prescription Drug Problems

- 15 calls involved Medicare Part D, a Prescription Drug Plan, or VPharm, in the OVHA statistics, compared to 39 last quarter.
- 28 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/pharmacy, compared to 60 last quarter.

IV. Uninsured Callers

In addition to the 218 OVHA callers, the HCO received an additional 25 calls from uninsured individuals, down from the 47 calls last quarter. We discussed Catamount Health and Premium Assistance with many of these callers as well when we talked about their insurance options, but they weren't coded as OVHA callers.

# OFFICE OF HEALTH CARE OMBUDSMAN

## TOTAL CASES - Office of Vermont Health Access

### Total Number of Cases by Issue Category

Calendar Years 2007 and 2008

Issue Category	Calendar Year 2007							Calendar Year 2008						
	Jan 1-Mar 31	Apr 1-June 30	July 1-Sept 30	Oct 1-Dec 31	2007 Total			Jan 1-Mar 31	Apr 1-June 30	July 1-Sept 30	Oct 1-Dec 31	2008 Total		
Access to Care	106	92	61	80	339			85	81	67				
Billing /Coverage	77	72	66	58	273			74	66	43				
Buying Insurance	1	0	2	1	4			0	1	1				
Consumer Education	8	7	7	6	28			13	9	6				
Eligibility	33	52	89	64	238			67	78	62				
Other	111	115	79	68	373			83	81	39				
<b>Grand Total</b>	<b>336</b>	<b>338</b>	<b>304</b>	<b>277</b>	<b>1255</b>			<b>322</b>	<b>316</b>	<b>218</b>				

### Percentage of Cases by Issue Category

Issue Category	Calendar Year 2007							Calendar Year 2008						
	Jan 1-Mar 31	Apr 1-June 30	July 1-Sept 30	Oct 1-Dec 31	2007 Total			Jan 1-Mar 31	Apr 1-June 30	July 1-Sept 30	Oct 1-Dec 31	2008 Total		
Access to Care	31.55%	27.22%	20.07%	28.88%	27.01%			26.40%	25.62%	30.73%				
Billing /Coverage	22.92%	21.30%	21.71%	20.94%	21.75%			22.98%	20.88%	19.73%				
Buying Insurance	0.30%	0.00%	0.66%	0.36%	0.32%			0.00%	0.30%	0.45%				
Consumer Education	2.38%	2.07%	2.30%	2.17%	2.23%			4.04%	2.94%	2.75%				
Eligibility	10.25%	15.38%	29.28%	23.10%	18.96%			20.81%	24.66%	28.45%				
Other	33.04%	34.02%	25.99%	24.55%	29.73%			25.78%	25.60%	17.89%				
<b>Grand Total</b>	<b>100.43%</b>	<b>100.00%</b>	<b>100.00%</b>	<b>100.00%</b>	<b>100.00%</b>			<b>100.00%</b>	<b>100.00%</b>	<b>100.00%</b>				

**Caseload Report**  
**7/1/2008 TO 9/30/2008**  
**OVHA only Coverage Types**

	Carried Cases	Opened Cases	Closed Cases	Open at End Cases
1. Jul	67	89	95	61
2. Aug	61	65	85	41
3. Sep	41	64	51	54
<b>Grand Totals:</b>		218	231	



# OVHA Quarterly Report

## Quarter Ending 09/30/2008

### Types of Callers

Applicant	5
Insured	146
Provider	2
Advocate	21
Other	42
Unknown	2
Totals	<hr/> 218

8:46:11 AM, 10/2/2008

## OVHA Quarterly Report Quarter Ending 09/30/2008

How did the Caller Hear about HCO?

Provider	4
Called Before	86
State Agency	14
HCO Materials	1
Other	29
DSW	1
Maximus	24
Consumer Group	1
Outreach	1
Unknown	50
Legislator	7
Totals	<hr/> 218

# OVHA Quarterly Report

Quarter Ending 09/30/2008

## Distribution by County

Addison	12
Bennington	9
Caledonia	6
Chittenden	71
Franklin	6
Grand Isle	4
Lamoille	5
Orange	2
Orleans	12
Rutland	18
Unknown	24
Washington	17
Windham	12
Windsor	20

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218

8:46:16 AM, 10/2/2008

# OVHA Quarterly Report

## Quarter Ending 09/30/2008

### Plan Type

Choices For Care	3
Dual eligible	51
PCCM	140
VHAP Limited	4
VPharm	20
	<hr/>
	218

8:46:08 AM, 10/2/2008

# OVHA Quarterly Report

## Quarter Ending 09/30/2008

### Coverage Summary

Dual Eligible	51
Medicaid Managed Care	84
VHAP	63
VPHARM	20
	<hr/>
Totals	218

# OVHA Quarterly Report

## Quarter Ending 09/30/2008

### Who Is the Problem With?

Hospital	17
Insurance Company/Plan	7
Not Specified	2
OVHA	99
Other	20
Other Agency	16
PBM	1
PDP	9
Provider	45
Unknown	2
	<hr/>
	218

# OVHA Quarterly Report

## Quarter Ending 09/30/2008

### Disposition Summary

Inquiry Answered During Initial Call	32
Brief Analysis and/or Referral	41
Brief Analysis and/or Advice	57
Direct Intervention	72
Complex Intervention	21
Client Withdrew	4
Other	4
Totals	<hr/> 231

# OVHA Quarterly Report

## Quarter Ending 09/30/2008

### ISSUE Summary

#### Access to Care

Affordability	1
Behavioral Health	3
DME, Supplies	7
Delay In Appointments	1
Delay In Obtaining Care	1
Dental	9
Emergency Care	1
Eye Care	2
Orthodontics	3
Other	2
Pain Management	8
Prescription Drugs/Pharmacy	3
Routine Care/PCP	4
Speciality Care	11
Transition/Continuity Of Care	3
Transportation	4
Urgent Care	1
Wheelchairs	3

Access to Care

67

#### Billing/Coverage

Behavioral Health	1
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# OVHA Quarterly Report

## Quarter Ending 09/30/2008

### ISSUE Summary

#### Billing/Coverage

Catamount	1
Claim Delays	1
Copayments	2
Dr. Dynasaur Premiums	1
General Billing Questions	2
Hosp Financial Assistance	1
Hospital billing	11
Indemnity Billing-Usual and Customary	1
Insurance Coverage/Contract Questions	1
ME Rx	2
Medicaid Fee-For-Service Billing	2
Medicaid/VHAP Managed Care Billing	14
OVHA premiums	2
Other	1

Billing/Coverage	43
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#### Buying Insurance

Insurance In Another State	1
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Buying Insurance	1
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#### Consumer Education

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

# OVHA Quarterly Report

## Quarter Ending 09/30/2008

### ISSUE Summary

#### Consumer Education

Other Insurance Laws and Regulations	2
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Consumer Education	6
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#### Eligibility

Buy In Programs	4
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Catamount Health	5
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Medicaid	18
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Medicare	3
----------	---

Other OVHA Programs	5
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PDP	1
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Premium Assistance	8
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VHAP	16
------	----

VPharm	2
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Eligibility	62
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#### Other

Access To Medical Records	1
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Communication Problems: DSW/HAEU	3
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Communication/Complaint: Provider	6
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Disenrollment	1
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Enrollment	1
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MMA	12
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Medicare Part C	1
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OVHA Policy Issues	1
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# OVHA Quarterly Report

## Quarter Ending 09/30/2008

### ISSUE Summary

#### Other

Other	11
Termination	1
Worker's Compensation	1

Other

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39

Totals

218

**Office of Health Care Ombudsman**  
**Quarter Ending 09/30/2008**  
**Report of Outcomes and Disposition**  
**OVHA**

<b>Outcome</b>	<b>Complex Intervention</b>	<b>Direct Intervention</b>			
Client Responsible For Bill		4			
Other Access/Eligibility Outcome	3	19			
Other Billing Assistance		4			
Patient Assistance Provided		4			
Prevented Termination or Reduction in Coverage	1	7			
Reimbursement Obtained		1			

# Office of Health Care Ombudsman

## Quarter Ending 09/30/2008

### OVHA Coverages

## Report of Outcomes and Issues

Outcome	Access to Care	Billing/Coverage	Eligibility
Client Responsible For Bill	1	3	
Other Access/Eligibility Outcome	13	2	7
Other Billing Assistance	2	2	
Patient Assistance Provided	1		3
Prevented Termination or Reduction in Coverage			8
Reimbursement Obtained			1

# Office of Health Care Ombudsman

Quarter Ending 09/30/2008

## Report of Outcomes and Issues Prescription Drugs OVHA Only

Outcome	Access to Care
Other Billing Assistance	1

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
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
2	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	DSH Payment
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