# *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**
**October 1, 2008 to December 31, 2008**

**Submitted Via Email on**
**February 5, 2009**

## 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 first quarterly report for waiver year four, covering the period from October 1, 2008 to December 31, 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 Last Day of Qtr 12/31/2008 | Previously Reported Enrollees Last Day of Qtr 9/30/2008 |
|---|---|---|
| Demonstration Population 1: | 41,887 | 41,496 |
| Demonstration Population 2: | 40,838 | 40,487 |
| Demonstration Population 3: | 8,862 | 8,665 |
| Demonstration Population 4: | N/A | N/A |
| Demonstration Population 5: | 1,259 | 1,274 |
| Demonstration Population 6: | 2,856 | 2,574 |
| Demonstration Population 7: | 25,620 | 25,570 |
| Demonstration Population 8: | 7,301 | 7,327 |
| Demonstration Population 9: | 2,553 | 2,563 |
| Demonstration Population 10: | N/A | N/A |
| Demonstration Population 11: | 6,014 | 5,698 |

* 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 first quarter, the Office of Vermont Health Access made a final push to reach the public about the time-sensitive offering under Catamount Health: namely that all pre-existing conditions would be covered without a waiting period for those who apply before November 1, 2008. A linked web button icon used on over 20 websites was used to convey the "amnesty message." The icon reverted to its general message at midnight on October 31, 2008.

During October, OVHA utilized two part-time temporary Ambassadors in Vermont's most populated county to focus outreach on amnesty. Additionally, over the course of three months the Ambassadors staffed job fairs, ski area recruitment days, tabled at fall festivals, distributed materials at a Halloween event and had a weekly presence at a local grocery store. They went door to door in business centers, stocked the shelves at United Way member agencies and local pharmacies. Additionally, they ensured that partnering state agencies had marketing materials prominently displayed at state libraries, the Department of Transportation and the Department of Labor (DOL).

OVHA partnered with the DOL at ten company layoffs to reach over 280 people about their health insurance options under Green Mountain Care.

OVHA partnered with a PayData Payroll Service to send information to 1400 employers, ARIS Payroll

Service to reach 5000 direct care worker, Vermont Federal Credit Union to reach 77 employees, and Champlain College to reach 715 December graduates and alumni.

*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 December, there were 8608 individuals enrolled.

The Department of Banking, Insurance, Securities, and Health Care Administration (BISHCA) has released the results of the 2008 Household Health Insurance Survey, which shows that the rate of uninsured Vermonters has decreased by 2.21 percentage points since the 2005 survey. This is very good news, since in these difficult economic times, one would expect the number of uninsured to increase. There is general agreement that the Catamount Health and ESI premium assistance programs, and the marketing campaign, are responsible for this progress.

Vermont's 2009 legislative session gets underway in January 2009 and discussions have begun on the Catamount Health and ESI premium assistance programs. It is too early at this time to predict whether changes to the programs will be made this year.

**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 December 2008 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 December 31, 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. 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 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.

## 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 | | | |
|---|---|---|---|---|---|
| III. | Induction | $348.97 | + | **BONUS** | = **Final Capitated Rate (depends on the number of patients per level, per provider)** |
| II. | Stabilization/Transfer | $236.32 | | | |
| I. | Maintenance Only | $101. 28 | | | |

| Buprenorphine Program Payment Summary FFY '09 | |
|---|---|
| Oct-08 | $ 34,942.14 |
| Nov-08 | $ 34,723.02 |
| Dec-08 | $ 36,569.72 |
| Total | $ 106,234.88 |

In 2009, OVHA will enroll all patients under the care of providers who are capitated program participants into case management services, which will be provided by OVHA's Chronic Care Initiative. 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.

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. 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 eligible for Medicaid under the Vermont Health Access Program with approval by the Centers for Medicaid and Medicare, and who are not eligible for Medicare. Those specifically 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 provided by the Center for Health Policy and Research (CHPR), a part of 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 opportunity (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 food security, availability of safe and affordable housing, and availability of transportation.

The OVHA began providing face-to-face intensive care coordination in 2006 to very high risk, medically complex beneficiaries, and progressed to a statewide field presence in early 2008. The OVHA staff 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. The OVHA considerably expanded operations to provide a full spectrum of disease management as well as care coordination services beginning in July 2007 when contracted services with APS Healthcare began, and has provided some level of chronic care intervention services to over 25,000 beneficiaries with one or more of the eleven chronic conditions. The focus is to assist beneficiaries in understanding the health risks of their conditions, engage them in changing their own behavior, and facilitate their effective communication with their primary care provider. The intention ultimately is to support the person in taking charge of his or her own health care.

The OVHA CCI has 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 services. Service level needs are determined through both predictive modeling and clinical assessment, in accordance with national evidence-based, disease-specific clinical guidelines. All beneficiaries determined to be at lower risk are provided with printed educational and self-management materials. Beneficiaries at moderate to high risk receive predominantly telephonic health education and coaching services provided through contracted APS Healthcare nurse health coaches, while the OVHA Care Coordination field staff provides intensive face-to-face outreach and support to the highest risk beneficiaries, facilitating a medical home and effective communication among service providers, supporting the primary care provider in achieving the clinical plan of care, and working to increase beneficiaries' success by, for example, addressing issues such as lack of transportation that may interfere 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 nursing and disease management staff, all with access to 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 primary care 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, refocusing resources and changing services for some beneficiaries effective October 1, 2008. Specifically, the CCI has refocused efforts predominantly on the very high and high risk beneficiaries, in particular those who will benefit from face-to-face intensive care coordination services and telephonic health coaching. Medium and low risk individuals may still request information and educational materials and will be contacted twice each year via Interactive Voice Recognition software. If they express interest in speaking directly with a CCI staff member, they will immediately be transferred to an RN Health Coach or Disease Management Coordinator at APS Healthcare**.** A short initial health risk assessment previously administered to all eligible beneficiaries was discontinued, along with quarterly disease management newsletters also previously provided to all eligible beneficiaries. 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 teams 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**

- Emergency room use declined by 7.2% and inpatient admissions declined by 8.3% during SFY'08. Data for October through December 2008 are not yet available due to the claims run out period.
- Since inception of the expanded program in July 2007 through December 2008, 35,200 introductory letters were sent to beneficiaries describing the CCI and providing contact information. 41,000 follow-up letters also were sent. Member brochures with detailed information about the CCI and tips for beneficiaries about working effectively with their PCP were sent to 15,200 members. Quarterly newsletters with healthy living tips and disease specific information were sent to all beneficiaries during SFY'08 (July 2007 through June 2008). A total of 91,600 were sent. As a result of the state budget rescission, quarterly newsletters have been discontinued.
- Over 24,000 SF-8 health assessments were completed with beneficiaries before this function was discontinued effective October 1, 2008, due to the state budget rescission.

- During this quarter, APS disease management health coaches provided services to an average of 1,595 beneficiaries a month and OVHA care coordinators provided intensive face-to-face care coordination to an average of 243 beneficiaries each month. The number of unique beneficiaries who were actively managed by either OVHA or APS staff during this period was 1,438.
- Evidence-based Clinical Guidelines, Touch Levels, and Action Plans were developed and 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 provided to the various medical audiences throughout the State. Beneficiary educational materials and Action Plans also are developed and/or selected in tandem with these partners to ensure standardized approaches to consumer education.

A consumer experience of care survey was administered by WB&A Market Research in the fall of 2008 to evaluate beneficiaries' satisfaction with the program and their perception of its impact on their overall health. Overwhelmingly, consumers rated their satisfaction with the program as very high (90% said they would recommend the program to a friend or relative), and felt they were provided with the help they needed to manage their care (90% said their care coordinator or health coach gave them the help they needed to make changes to manage their current health). Most importantly, consumers who said they needed and received help agreed they have been able to maintain the changes they made while in the program (84% agreed they have been able to maintain the lifestyle changes they made for their health).

## Financial/Budget Neutrality Development/Issues

The IGA for Waiver Year 4 – and associated actuarial certification – was submitted to CMS on December 15, 2008. Effective January 1, 2009, AHS began paying OVHA the PMPM capitation payment prospectively; AHS has trued up its capitation payment obligations to OVHA per the PMPM rates for FFY08 and FFY09 to-date. The PMPM payments will continue to be adjusted per retroactive changes in enrollment with a 12-month runout period. AHS awaits guidance from CMS on how to report the CRT information on the CMS-64 and approval of IGAs for years 2, 3 and 4 before revising the CMS-64 reports for years two, three and four. 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 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.

| Demonstration Population | Month 1<br>10/15/2008 | Month 2<br>11/15/2008 | Month 3<br>12/15/2008 | Total for Quarter Ending 1st Qtr FFY '09 | Total for Quarter Ending 4th Qtr FFY '08 | Total for Quarter Ending 3rd Qtr FFY '08 | Total for Quarter Ending 2nd Qtr FFY '08 | Total for Quarter Ending 1st Qtr FFY '08 |
|---|---|---|---|---|---|---|---|---|
| Demonstration Population 1: | 41,809 | 41,941 | 42,075 | 125,825 | 123,997 | 122,281 | 121,926 | 120,113 |
| Demonstration Population 2: | 40,904 | 40,684 | 40,622 | 122,210 | 121,981 | 123,283 | 122,118 | 120,309 |
| Demonstration Population 3: | 8,910 | 8,847 | 8,798 | 26,555 | 26,452 | 25,723 | 24,676 | 24,821 |
| Demonstration Population 4: | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A |
| Demonstration Population 5: | 1,273 | 1,275 | 1,284 | 3,832 | 3,850 | 3,767 | 3,542 | 3,767 |
| Demonstration Population 6: | 2,791 | 2,842 | 2,575 | 8,208 | 7,428 | 7,357 | 6,208 | 6,084 |
| Demonstration Population 7: | 24,791 | 25,076 | 25,410 | 75,277 | 74,301 | 73,966 | 72,336 | 65,803 |
| Demonstration Population 8: | 7,300 | 7,370 | 7,362 | 22,032 | 21,715 | 23,100 | 22,697 | 22,445 |
| Demonstration Population 9: | 2,561 | 2,558 | 2,530 | 7,649 | 7,626 | 7,838 | 7,919 | 7,929 |
| Demonstration Population 10: | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A |
| Demonstration Population 11: | 6,104 | 6,596 | 6,765 | 19,465 | 16,136 | 12,525 | 7,997 | 1,641 |

## Consumer Issues

The AHS and OVHA have several mechanisms whereby consumer issue are tracked and summarized. The first is through the MCO, Health Access Member Services. This is a contracted function for providing information on health care programs, assisting with the eligibility process, and helping beneficiaries to understand the benefits and responsibilities of their particular programs. The complaints received by Member Services are based on anecdotal weekly reports that the contractor provides to OVHA (see Attachment 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), EQRO completed their Performance Improvement Project (PIP) Validation Report. In its PIP evaluation and validation, Health Services Advisory Group (HSAG) used the Centers for Medicare & Medicaid Services (CMS) publication, *Validating Performance Improvement Projects: A Protocol for Use in Conducting Medicaid External Quality Review Activities*, final protocol, Version 1.0, May 1, 2002 (CMS PIP Protocol). For the 2007 – 2008

validation cycle, HSAG validated activities I through IV of the protocol. This was the first year for the Office of Vermont Health Access's (OVHA) PIP; therefore, only the first four activities (i.e., study design) were completed and validated. The PIP received a score of 100 percent for all evaluation elements *Met*, a score of 100 percent for critical evaluation elements *Met*, and an overall validation status of *Met*. Based on the validation of the PIP, HSAG's assessment determined high confidence in the results. During this quarter, HSAG also completed their Validation of Performance Measures (PM) Report. HSAG conducted the validation activities as outlined in the CMS publication, *Validating Performance Measures: A Protocol for Use in Conducting External Quality Review Activities*, final protocol, Version 1.0, May 1, 2002 (CMS PM Validation Protocol). Through the validation process, HSAG found all six performance measures to be fully compliant with State specifications. Finally during this quarter, HSAG completed their External Quality Review of Compliance with Standards Report. In its compliance review, HSAG used the CMS publication, *Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs): A Protocol for Determining Compliance with Medicaid Managed Care Proposed Regulations at 42 CFR Parts 400, 430, et al*, final protocol, Version 1.0, February 11, 2003. During this review, the first year of a three-year cycle of external quality reviews, HSAG evaluated the degree to which OVHA complied with Federal Medicaid managed care structure and operations standards outlined in CFR 438.214-438.230. Overall, OVHA complied with 84 percent of the requirements associated with the structure and operations standards. OVHA will develop Corrective Action Plans (CAPs) for those requirements receiving a score of *Partially Met* or *Not Met*. The CAPs will be submitted to AHS during the next quarter for approval.

*Quality Assurance Performance Improvement Committee(QAPI)*: During this quarter, the Committee reviewed the Agency of Human Services (AHS)/OVHA Internal Governmental Agreement (IGA) as well as the IGAs that OVHA has with other State Departments. The group discussed the relationship between the Medicaid MCO QAPI standards contained in 42 CFR 438 Sub-Part D, the content of the agreements, and the MCO Quality Plan. The group also spent time during this quarter discussing the organization of the MCO Quality Plan. It was agreed that OVHA will have a "master" plan and that the IGA Partners will have separate, yet related plans. The group continues to cross walk the policies and procedures contained in plans. The group also discussed the current set of performance measures that OVHA calculates and reports to AHS. The group agreed that there might be some utility in modifying the current list of measures. During the next quarter, the AHS Quality Improvement Manager will meet with OVHA staff to discuss the suitability of the current measures. The group also discussed the timing of the Consumer Assessment of Healthcare Providers and Systems (CAHPS). It was recommended that planning for the survey should begin next quarter. The group also discussed the results of the recent EQRO activities. Specifically, the group reviewed the findings and CAPs associated with the compliance with Medicaid MCO standards review. All parties agree to work together to address requirements determined to be partially or not met during the review. The group discussed the role that the AHS/EQRO would play re: CAP follow-up activities. The group recommended that the AHS should take the lead in following up on the CAPs identified during the review. Finally, the group spent time this quarter discussing their relationship to other MCO groups that address QAPI related issues (e.g., utilization management, program integrity, etc). It was recommended that representative from the aforementioned groups be invited to future QAPI committee meetings to help clarify any areas of overlap.

*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 Quality Improvement Manager 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 geographic mapping schedule has been updated is as follows:

January 2009 - Primary Care Providers (Family Medicine, Pediatrics, and Internal Medicine, Naturopaths, Nurse Practitioners)
February 2009 – Dental Providers; Psychiatric Providers
March 2009 – Primary Care Providers
April 2009 - Pharmacy and Durable Medical Equipment Providers
May 2009 – Physical Therapists, Occupational Therapists, Speech Therapists
June 2009 – Nursing Home Facilities

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 AHS Quality Improvement Manager worked with AHS staff to review the Global Commitment to Health Waiver Evaluation Plan develop by Pacific Health Policy Group (PHPG). Their plan is a revision of the original document sent to CMS during waiver implementation. The revised plan was developed in accordance with CMS guidelines contained in *Evaluating Demonstrations: A Technical Assistance Guide for States* (September 2008) and contains the following items: background information on the demonstration and its principles, goals, and objectives, detailed evaluation design, and information on the evaluation report to be provided to CMS during the lifetime of the demonstration and at its conclusion. It is anticipated that PHPG will incorporate AHS staff feedback into the plan and have it ready for submission to CMS during the next quarter.

**Reported Purposes for Capitated Revenue Expenditures**

Provided that OVHA's contractual obligation to the populations covered under the Demonstration is met, any revenue from capitation payments related to the beneficiaries covered under this demonstration may only be used for the following purposes:

- Reduce the rate of uninsured and/or underinsured in Vermont;
- Increase the access of quality health care to uninsured, underinsured, and Medicaid beneficiaries;
- Provide public health approaches to improve the health outcomes and the quality of life for Medicaid-eligible individuals in Vermont; and
- Encourage the formation and maintenance of public-private partnerships in health care.

Please see Attachment 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 | |
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| | Waterbury, VT 05671-0201 | jim.giffin@ahs.state.vt.us |
| Policy/Program: | Suzanne Santarcangelo, Director | |
| | AHS Health Care Operations, Compliance, and Improvement | |
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| | Waterbury, VT 05671-0203 | suzanne.santarcangel@ahs.state.vt.us |
| MCO: | Susan W. Besio, PhD, Director | |
| | VT Office of Health Access | 802-879-5901 (P) |
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**Date Submitted to CMS**: February 5, 2009

# ATTACHMENTS

**Office of Vermont Health Access**
SFY '09 Catamount Health Actual Revenue and Expense Tracking
Thursday, January 15, 2009

| | SFY '09 Revised Appropriated | | | Consensus Estimates for SFY to Date | | | Actuals thru 12/31/08 | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | *<=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 | 9,129,487 | 3,890,434 | 13,019,921 | 9,041,402 | 4,485,657 | 13,527,060 | 103.90% |
| Catamount Eligible Employer-Sponsored Insurance | 803,144 | 406,981 | 1,210,125 | 341,278 | 172,937 | 514,215 | 314,428 | 163,417 | 477,845 | 92.93% |
| **Subtotal New Program Spending** | 21,620,395 | 9,318,399 | 30,938,794 | 9,470,765 | 4,063,371 | 13,534,136 | 9,355,830 | 4,649,075 | 14,004,905 | 103.48% |
| Catamount and ESI Administrative Costs | 1,658,945 | 1,297,834 | 2,956,780 | 829,473 | 648,917 | 1,478,390 | 829,473 | 648,917 | 1,478,390 | 100.00% |
| **TOTAL GROSS PROGRAM SPENDING** | 23,279,340 | 10,616,233 | 33,895,573 | 10,300,238 | 4,712,288 | 15,012,526 | 10,185,303 | 5,297,992 | 15,483,295 | 103.14% |
| **TOTAL STATE PROGRAM SPENDING** | **9,463,052** | **10,616,233** | **20,079,285** | **4,187,047** | **4,712,288** | **8,899,335** | **4,140,326** | **5,297,992** | **9,438,317** | **106.06%** |
| **TOTAL OTHER EXPENDITURES** | | | | | | | | | | |
| Immunizations Program | - | 2,500,000 | 2,500,000 | - | 1,250,000 | 1,250,000 | - | 1,250,000 | 1,250,000 | 100.00% |
| VT Dept. of Labor Admin Costs Assoc. With Employer Assess. | - | 394,072 | 394,072 | - | 197,036 | 197,036 | - | 197,036 | 197,036 | 100.00% |
| Marketing and Outreach | 500,000 | - | 500,000 | 250,000 | - | 250,000 | 250,000 | - | 250,000 | 100.00% |
| Blueprint | - | 1,846,713 | 1,846,713 | - | 923,357 | 923,357 | - | 923,357 | 923,357 | 100.00% |
| **TOTAL OTHER SPENDING** | 500,000 | 4,740,785 | 5,240,785 | 250,000 | 2,370,393 | 2,620,393 | 250,000 | 2,370,393 | 2,620,393 | 100.00% |
| **TOTAL STATE OTHER SPENDING** | **203,250** | **4,740,785** | **4,944,035** | **101,625** | **2,370,393** | **2,472,018** | **101,625** | **2,370,393** | **2,472,018** | **100.00%** |
| **TOTAL ALL STATE SPENDING** | **9,666,302** | **15,357,018** | **25,023,320** | **4,288,672** | **7,082,681** | **11,371,352** | **4,241,951** | **7,668,384** | **11,910,335** | **104.74%** |
| **TOTAL REVENUES** | | | | | | | | | | |
| Catamount Health Premiums | 3,299,886 | 2,972,223 | 6,272,109 | 1,447,203 | 1,295,358 | 2,742,560 | 1,319,705 | 1,039,412 | 2,359,117 | 86.02% |
| Catamount Eligible Employer-Sponsored Insurance Premiums | 246,580 | 269,856 | 516,436 | 104,779 | 114,669 | 219,448 | 97,743 | 81,860 | 179,603 | 81.84% |
| **Subtotal Premiums** | 3,546,466 | 3,242,079 | 6,788,545 | 1,551,981 | 1,410,027 | 2,962,008 | 1,417,448 | 1,121,272 | 2,538,720 | 85.71% |
| Federal Share of Premiums | (2,104,828) | - | (2,104,828) | (921,101) | - | (921,101) | (841,255) | - | (841,255) | 91.33% |
| **TOTAL STATE PREMIUM SHARE** | 1,441,638 | 3,242,079 | 4,683,718 | 630,880 | 1,410,027 | 2,040,907 | 576,193 | 1,121,272 | 1,697,464 | 83.17% |
| Cigarette Tax Increase ($.60 / $.80) | | | 9,207,000 | | | 4,603,500 | | | 5,104,206 | 110.88% |
| Floor Stock | | | 500,000 | | | 250,000 | | | 347,348 | 138.94% |
| Employer Assessment | | | 5,480,159 | | | 2,740,080 | | | 3,169,000 | 115.65% |
| Interest | | | - | | | - | | | 76,320 | 0.00% |
| **TOTAL OTHER REVENUE** | | | 15,187,159 | | | 7,593,580 | | | 8,696,875 | 114.53% |
| **TOTAL STATE REVENUE** | **1,441,638** | **3,242,079** | **19,870,877** | **630,880** | **1,410,027** | **9,634,487** | **576,193** | **1,121,272** | **10,394,339** | **107.89%** |
| State-Only Balance | | | (5,152,443) | | | (1,736,866) | | | (1,515,996) | |
| Carryforward | | | 9,820,186 | | | 9,820,186 | | | 9,820,186 | |
| **(DEFICIT)/SURPLUS** | | | **4,667,743** | | | **8,083,320** | | | **8,304,190** | |
| Reserve Account Funding | | | - | | | - | | | - | |
| **REVISED (DEFICIT)/SURPLUS WITH RESERVE FUNDING** | | | **4,667,743** | | | **8,083,320** | | | **8,304,190** | |

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

# Green Mountain Care Enrollment Report
## December 2008
### TOTAL ENROLLMENT BY MONTH

| | Oct-07 | Nov-07 | Dec-07 | Jan-08 | Feb-08 | Mar-08 | Apr-08 | May-08 | Jun-08 | Jul-08 | Aug-08 | Sep-08 | Oct-08 | Nov-09 | Dec-08 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Adults:** | | | | | | | | | | | | | | | |
| **VHAP-ESIA** | - | 35 | 131 | 287 | 411 | 542 | 589 | 607 | 632 | 672 | 691 | 733 | 747 | 759 | 809 |
| **ESIA** | - | 21 | 69 | 127 | 169 | 242 | 273 | 304 | 324 | 336 | 358 | 413 | 447 | 499 | 569 |
| **CHAP** | - | 320 | 1,186 | 1,834 | 2,419 | 3,033 | 3,507 | 3,918 | 4,265 | 4,608 | 5,003 | 5,384 | 5,684 | 6,120 | 6,239 |
| **Catamount Health** | - | 120 | 165 | 268 | 345 | 361 | 344 | 470 | 606 | 697 | 701 | 785 | 853 | 932 | 991 |
| **Total** | **-** | **376** | **1,551** | **2,516** | **3,344** | **4,178** | **4,713** | **5,299** | **5,827** | **6,313** | **6,753** | **7,315** | **7,731** | **8,310** | **8,608** |

| | Oct-07 | Nov-07 | Dec-07 | Jan-08 | Feb-08 | Mar-08 | Apr-08 | May-08 | Jun-08 | Jul-08 | Aug-08 | Sep-08 | Oct-08 | Nov-09 | Dec-08 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Adults:** | | | | | | | | | | | | | | | |
| **VHAP** | 24,245 | 24,849 | 25,295 | 25,899 | 26,150 | 26,301 | 26,670 | 26,516 | 26,650 | 26,441 | 26,721 | 26,622 | 26,900 | 26,860 | 27,198 |
| **Other Medicaid** | 70,134 | 69,969 | 69,805 | 70,466 | 70,858 | 70,851 | 70,789 | 70,766 | 70,754 | 70,947 | 70,846 | 71,638 | 71,403 | 35,601 | 35,610 |
| **Children:** | | | | | | | | | | | | | | | |
| **Dr Dynasaur** | 19,629 | 19,733 | 19,781 | 19,822 | 19,977 | 20,210 | 20,227 | 20,297 | 20,410 | 19,960 | 20,061 | 20,251 | 20,481 | 20,511 | 20,468 |
| **SCHIP** | 3,355 | 3,428 | 3,481 | 3,479 | 3,170 | 3,166 | 3,200 | 3,231 | 3,215 | 3,396 | 3,363 | 3,415 | 3,504 | 3,527 | 3,482 |
| **Other Medicaid*** | Included | Included | Included | Included | Included | Included | Included | Included | Included | Included | Included | Included | Included | 34,015 | 33,759 |
| **Total** | **117,363** | **117,979** | **118,362** | **119,666** | **120,155** | **120,528** | **120,886** | **120,810** | **121,029** | **120,744** | **120,991** | **121,926** | **122,288** | **120,514** | **120,517** |
| | | | | | | | | | | | | | | | |
| **TOTAL ALL** | **117,363** | **118,355** | **119,913** | **122,182** | **123,499** | **124,706** | **125,599** | **126,109** | **126,856** | **127,057** | **127,744** | **129,241** | **130,019** | **128,824** | **129,125** |

**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

## December 2008 Demographics

| Income | VHAP-ESIA* | ESIA* | CHAP* | TOTAL |
|---|---|---|---|---|
| 0-50% | 17 | 8 | 494 | |
| 50-75% | 41 | 1 | 71 | |
| 75-100% | 78 | 3 | 93 | |
| 100-150% | 423 | 11 | 296 | |
| 150-185% | 243 | 162 | 2,084 | |
| 185-200% | 6 | 186 | 1,372 | |
| 200-225% | - | 89 | 875 | |
| 225-250% | 1 | 66 | 563 | |
| 250-275% | - | 25 | 279 | |
| 275-300% | - | 18 | 112 | |
| **Total** | **809** | **569** | **6,239** | **7,617** |

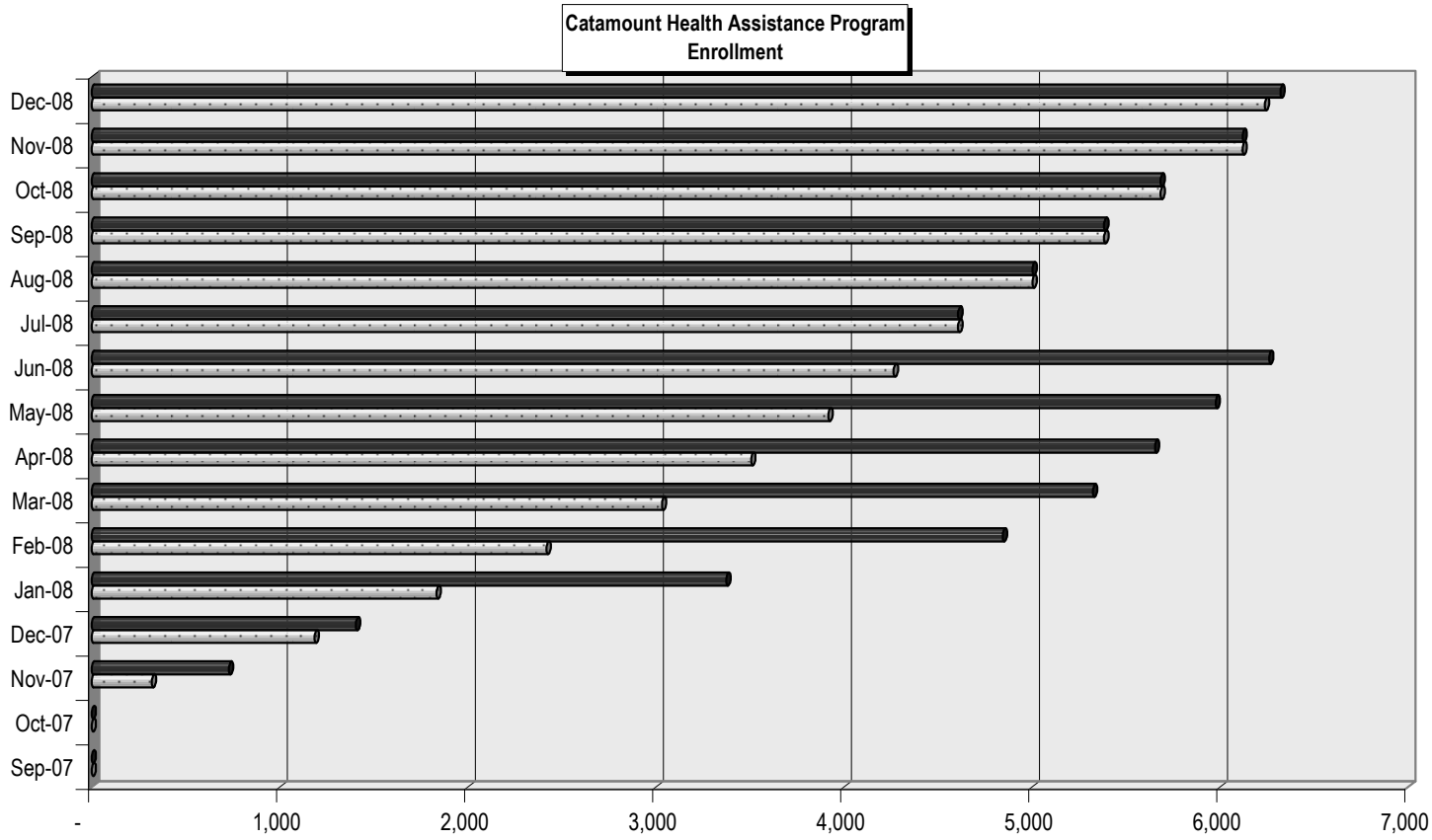
| Age | VHAP-ESIA | ESIA | CHAP | TOTAL |
|---|---|---|---|---|
| 18-24 | 63 | 71 | 1,191 | |
| 25-35 | 224 | 138 | 1,045 | |
| 36-45 | 298 | 175 | 1,076 | |
| 46-55 | 169 | 141 | 1,494 | |
| 56-64 | 55 | 44 | 1,427 | |
| 65+ | - | - | 6 | |
| **Total** | **809** | **569** | **6,239** | **7,617** |

## Green Mountain Care Enrollment Report (continued)

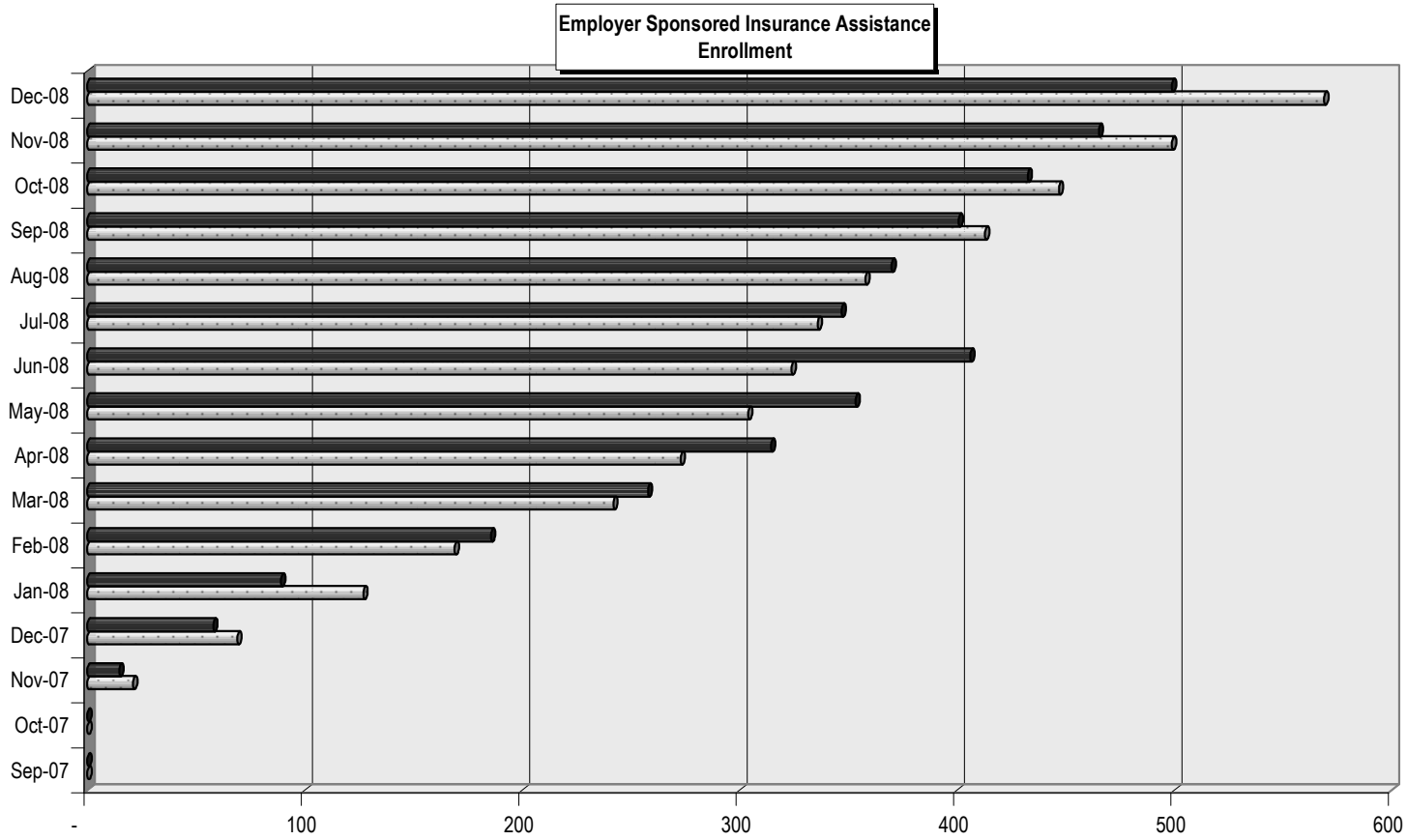
### December 2008 Demographics

| Gender | VHAP-ESIA | ESIA | CHAP | TOTAL |
|---|---|---|---|---|
| Male | 284 | 205 | 2,705 | |
| Female | 525 | 364 | 3,534 | |
| **Total** | **809** | **569** | **6,239** | **7,617** |

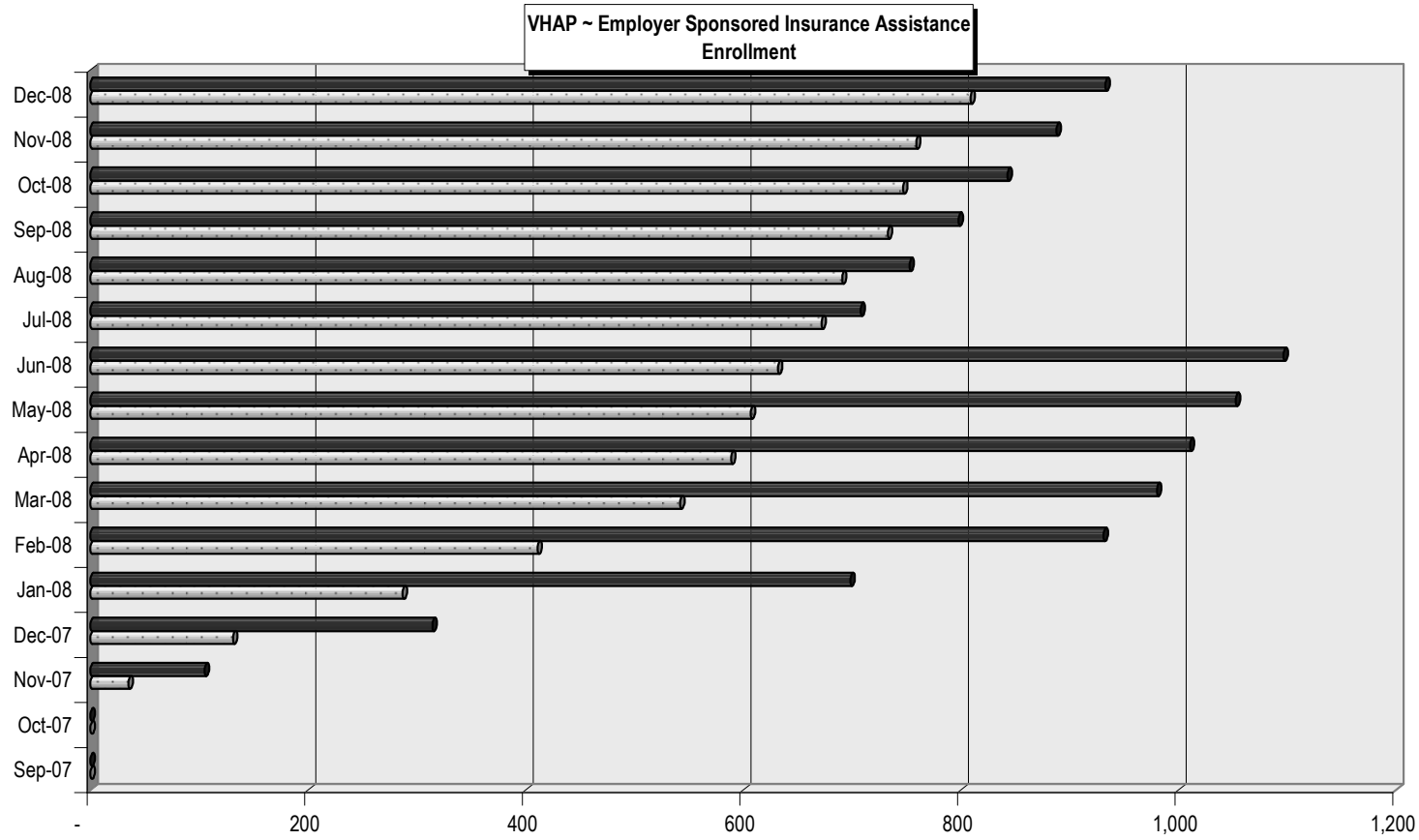
| County | VHAP-ESIA | ESIA | CHAP | TOTAL |
|---|---|---|---|---|
| Addison | 47 | 32 | 391 | |
| Bennington | 85 | 45 | 346 | |
| Caledonia | 31 | 28 | 385 | |
| Chittenden | 137 | 116 | 1,112 | |
| Essex | 9 | 3 | 74 | |
| Franklin | 90 | 49 | 411 | |
| Grand Isle | 6 | 11 | 68 | |
| Lamoille | 46 | 35 | 320 | |
| Orange | 29 | 27 | 332 | |
| Orleans | 67 | 37 | 394 | |
| Other | - | - | 3 | |
| Rutland | 87 | 76 | 677 | |
| Washington | 77 | 32 | 602 | |
| Windham | 49 | 39 | 526 | |
| Windsor | 49 | 39 | 598 | |
| **Total** | **809** | **569** | **6,239** | **7,617** |



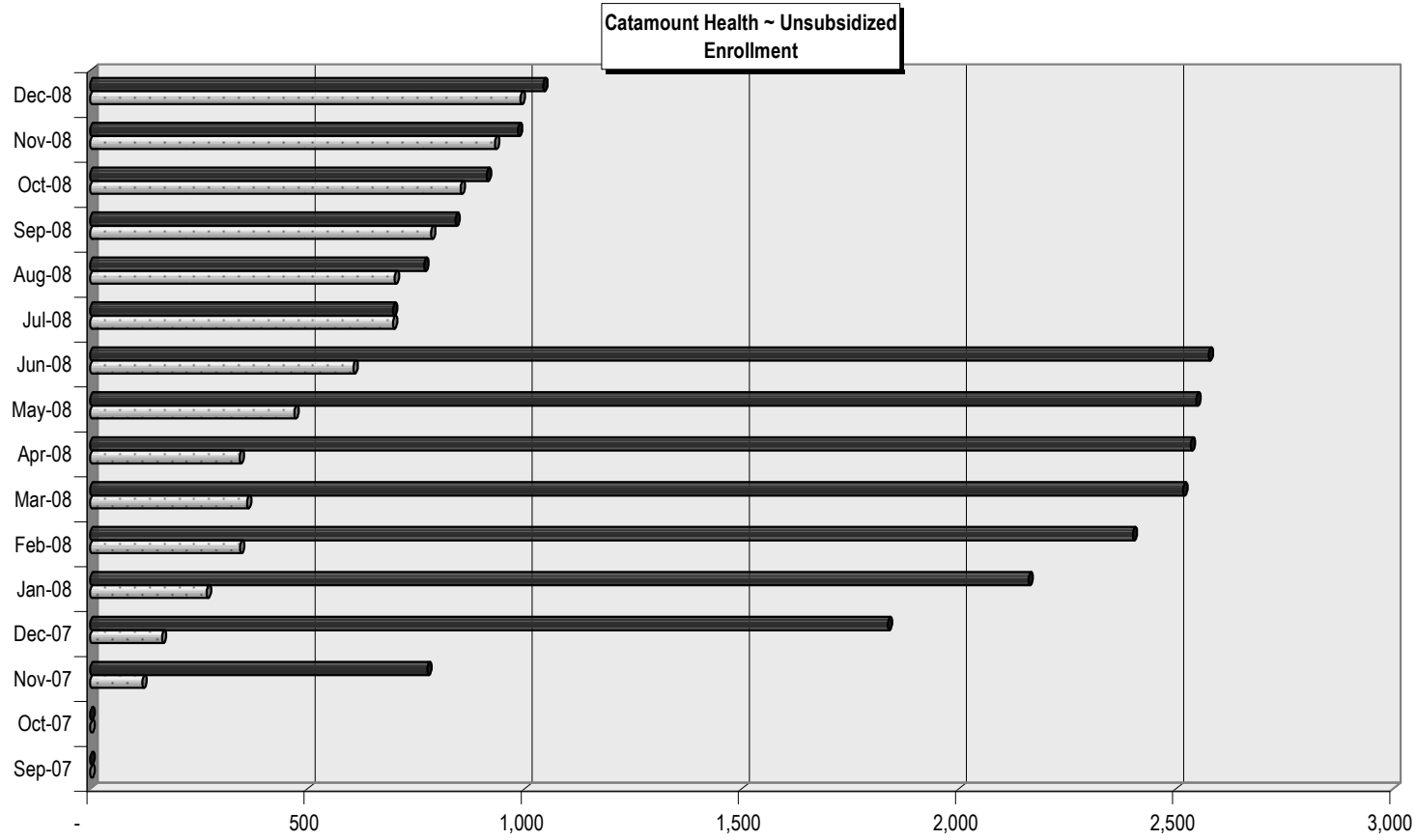

| | Sep-07 | Oct-07 | Nov-07 | Dec-07 | Jan-08 | Feb-08 | Mar-08 | Apr-08 | May-08 | Jun-08 | Jul-08 | Aug-08 | Sep-08 | Oct-08 | Nov-08 | Dec-08 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Projected | - | - | 730 | 1,405 | 3,375 | 4,845 | 5,324 | 5,655 | 5,978 | 6,262 | 4,608 | 5,003 | 5,384 | 5,684 | 6,120 | 6,321 |
| Actual | - | - | 320 | 1,186 | 1,834 | 2,419 | 3,033 | 3,507 | 3,918 | 4,265 | 4,608 | 5,003 | 5,384 | 5,684 | 6,120 | 6,239 |




| | 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 | Oct-08 | Nov-08 | Dec-08 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Projected | - | - | 15 | 58 | 89 | 186 | 258 | 315 | 353 | 406 | 347 | 370 | 401 | 433 | 465 | 499 |
| Actual | - | - | 21 | 69 | 127 | 169 | 242 | 273 | 304 | 324 | 336 | 358 | 413 | 447 | 499 | 569 |




| | 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 | Oct-08 | Nov-08 | Dec-08 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Projected | - | - | 105 | 314 | 699 | 931 | 980 | 1,011 | 1,053 | 1,097 | 708 | 753 | 798 | 843 | 888 | 933 |
| Actual | - | - | 35 | 131 | 287 | 411 | 542 | 589 | 607 | 632 | 672 | 691 | 733 | 747 | 759 | 809 |




| | 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 | Oct-08 | Nov-08 | Dec-08 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Projected | - | - | 776 | 1,837 | 2,161 | 2,401 | 2,517 | 2,535 | 2,547 | 2,576 | 697 | 769 | 841 | 913 | 985 | 1,043 |
| Actual | - | - | 120 | 165 | 268 | 345 | 361 | 344 | 470 | 606 | 697 | 701 | 785 | 853 | 932 | 991 |

Attachment 2

**Global Commitment Expenditure Tracking**

| QE | 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) |
|---|---|---|---|---|---|---|---|---|---|---|
| 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** | **$ 6,457,896** | $ 848,587,455 | | |
| 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 | | |
| Cumulative | | | | | | | | **$ 2,691,835,141** | **$ 3,779,000,000** | **$ 1,087,164,859** |
| 1209 | | | | | | | | | | |
| 0310 | | | | | | | | | | |
| 0610 | | | | | | | | | | |
| 0910 | | | | | | | | | | |
| WY5 SUM | $ - | $ - | $ - | | $ - | $ - | $ - | $ - | | |
| 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 | LTC Admin | LTC Admin | LTC Admin | LTC Admin | LTC Admin | LTC Admin | |
|---|---|---|---|---|---|---|---|---|
| QE | LTC Admin Quarterly Expenditures | PQA: WY1 | PQA: WY2 | PQA: WY3 | PQA: WY4 | PQA: WY5 | Net Admin PQA | Net LTC Admin Expenditures as reported on 64 |
| 1205 | $ 572,438 | | | | | | $ - | |
| 0306 | $ 618,636 | | | | | | $ - | |
| 0606 | $ 718,078 | | | | | | $ - | |
| 0906 | $ 529,913 | | | | | | $ - | |
| WY1 SUM | | | | | | | | $ 2,272,141 |
| 1206 | $ 346,732 | | | | | | | |
| 0307 | $ 972,273 | | | | | | | |
| 0607 | $ 947,875 | $ (166,924) | | | | | | |
| 0907 | $ 328,298 | | | | | | | |
| WY2 SUM | | | | | | | | $ 2,594,618 |
| 1207 | $ 301,255 | | | | | | | |
| 0308 | $ 344,759 | | $ (560) | | | | | |
| 0608 | $ 420,377 | | | | | | | |
| 0908 | $ 351,308 | | | | | | | |
| WY3 SUM | | | | | | | | $ 1,417,699 |
| 1208 | $ 360,286 | | | | | | | |
| 0309 | | | | | | | | |
| 0609 | | | | | | | | |
| 0909 | | | | | | | | |
| WY4 SUM | | | | | | | | $ 360,286 |
| 1209 | | | | | | | | |
| 0310 | | | | | | | | |
| 0610 | | | | | | | | |
| 0910 | | | | | | | | |
| WY5 SUM | | | | | | | | $ - |
| | | $ (166,924) | $ (560) | $ - | $ - | $ - | | |

PQA = Prior Quarter Adjustments

| from CMS-64 line: | MMIS 90% Admin | MMIS 90% Admin | MMIS 90% Admin | MMIS 90% Admin | MMIS 90% Admin | MMIS 90% Admin | MMIS 90% Admin | |
|---|---|---|---|---|---|---|---|---|
| | MMIS 90% Admin Quarterly Expenditures | PQA: WY1 | PQA: WY2 | PQA: WY3 | PQA: WY4 | PQA: WY5 | Net Admin PQA | Net MMIS 90% Admin Expenditures as reported on 64 |
| 1205 | | | | | | | $ - | |
| 0306 | $ 668,742 | | | | | | $ - | |
| 0606 | | | | | | | $ - | |
| 0906 | | | | | | | $ - | |
| WY1 SUM | | | | | | | | $ 668,742 |
| 1206 | $ 376,007 | | | | | | | |
| 0307 | | | | | | | | |
| 0607 | $ 1,300,509 | | | | | | | |
| 0907 | $ 453,894 | | | | | | | |
| WY2 SUM | | | | | | | | $ 2,130,410 |
| 1207 | $ 171,297 | | | | | | | |
| 0308 | $ - | | | | | | | |
| 0608 | | | | | | | | |
| 0908 | | | | | | | | |
| WY3 SUM | | | | | | | | $ 171,297 |
| 1208 | $ - | | | | | | | |
| 0309 | | | | | | | | |
| 0609 | | | | | | | | |
| 0909 | | | | | | | | |
| WY4 SUM | | | | | | | | $ - |
| 1209 | | | | | | | | |
| 0310 | | | | | | | | |
| 0610 | | | | | | | | |
| 0910 | | | | | | | | |
| WY5 SUM | | | | | | | | $ - |
| | | $ - | $ - | $ - | $ - | $ - | | |

PQA = Prior Quarter Adjustments

| from CMS-64 line: | AHSCO Admin | AHSCO Admin | AHSCO Admin | AHSCO Admin | AHSCO Admin | AHSCO Admin | AHSCO Admin | |
|---|---|---|---|---|---|---|---|---|
| | AHSCO Admin Quarterly Expenditures: includes 50% & 75% | PQA: WY1 | PQA: WY2 | PQA: WY3 | PQA: WY4 | PQA: WY5 | Net Admin PQA | Net AHSCO Admin Expenditures as reported on 64 |
| 1205 | $ 14,580,556 | | | | | | $ - | |
| 0306 | $ - | $ (14,306,555) | | | | | $ (14,306,555) | |
| 0606 | $ 833,644 | | | | | | $ - | |
| 0906 | $ 616,842 | | | | | | $ - | |
| WY1 SUM | | | | | | | | $ 1,967,428 |
| 1206 | $ 713,940 | | | | | | | |
| 0307 | $ 1,159,770 | | | | | | | |
| 0607 | $ 591,699 | | | | | | | |
| 0907 | $ 870,212 | | | | | | | |
| WY2 SUM | | | | | | | | $ 3,869,820 |
| 1207 | $ 932,757 | | | | | | | |
| 0308 | $ 1,343,619 | $ 242,941 | $ 534,199 | $ 171,279 | | | | |
| 0608 | $ 1,223,320 | | | $ 15,823 | | | | |
| 0908 | $ 1,334,391 | | | | | | | |
| WY3 SUM | | | | | | | | $ 5,040,197 |
| 1208 | $ 1,386,183 | | | $ 19,008 | | | | |
| 0309 | | | | | | | | |
| 0609 | | | | | | | | |
| 0909 | | | | | | | | |
| WY4 SUM | | | | | | | | $ 1,386,183 |
| 1209 | | | | | | | | |
| 0310 | | | | | | | | |
| 0610 | | | | | | | | |
| 0910 | | | | | | | | |
| WY5 SUM | | | | | | | | $ - |
| | | $ (14,063,614) | $ 534,199 | $ 206,109 | $ - | $ - | | |

PQA = Prior Quarter Adjustments

VERMONT

**Office of Vermont Health Access**
312 Hurricane Lane Suite 201
Williston, VT 05495-2086
**www.ovha.state.vt.us**
[phone] 802-879-5900

*Agency of Human Services*

## Complaints Received by Health Access Member Services
## October 1, 2008 – December 31, 2008

| | |
|---|---|
| Eligibility forms, notices, or process | 12 |
| Catamount Health Assistance Program premiums, process, ads, plans | 10 |
| Use of social security numbers as identifiers | 9 |
| General premium complaints | 5 |
| Green Mountain Care website | 4 |
| Provider issues (perceived rudeness, refusal to provide service, prices) (variety of provider types) | 4 |
| Member services | 2 |
| Eligibility rules | 2 |
| Eligibility local office | 1 |
| Prescription drug plan issues | 1 |
| PBM complaint | 1 |
| Coverage rules | 0 |
| Copays/service limit | 0 |
| Provider enrollment issues | 0 |
| OVHA forms | 0 |
| Shortage of enrolled dentists | 0 |
| Reimbursement for services from non-enrolled provider | 0 |
| Dental initiative confusion | 0 |
| **Total** | **54** |

# Grievance and Appeal Quarterly Report
# Medicaid MCO All Departments Combined Data
# October 1, 2008 – December 31, 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 on January 22, 2009, from the centralized database for grievances and appeals that were filed from October 1, 2008 through December 31, 2008.

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 six grievances filed with the MCO. Five of them were addressed during the quarter, none were withdrawn and one was 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 twenty-five days. Acknowledgement letters of the receipt of a grievance must be sent within five days, and as the MCO, we averaged only one day, and in this quarter, none of those letters were sent late. Of the grievances filed, 100% were filed by beneficiaries and none were filed by a representative of the beneficiary or anyone else on the beneficiary's behalf. Of the six grievances filed, OVHA had 17% and DMH had 83%. There were no grievances filed for the Department of Disabilities, Aging and Independent Living; the Department of Health; or the Department for Children and Families during this quarter of the grievance process.

At the end of the last quarter there were three cases pending. All three were addressed this quarter, and all within the required 90-day time frame.

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 27 appeals filed with the MCO, of which four requested an expedited decision, and none met the criteria. Of these 27 appeals, eighteen were resolved (67% of filed appeals), three were withdrawn (11%), and six appeals were still pending (61%). In fifteen cases (83% of those resolved), the

original decision was upheld by the person hearing the appeal, none were reversed, none were modified, and three were approved by the department/DA/SSA before the appeal meeting (17%).

Seventeen of the eighteen appeals that were resolved this quarter were resolved within the statutory time frame of 45 days. Although two cases were extended (one by the MCO and one by the beneficiary), only one was resolved within the extended time frame of 59 days, the other was resolved within the original timeframes. In addition, thirteen appeals were resolved within 30 days. The average number of days it took to resolve the non-extended appeal cases was 21 days. The extended cases were resolved in 57 days. Acknowledgement letters of the receipt of an appeal must be sent within five days, and as the MCO, we averaged only one day, although two of those letters were sent late.

Of the appeals filed, nine were filed by beneficiaries (33%), sixteen were filed by a representative of the beneficiary (59%), one was filed by a provider (4%), and one was filed by someone else as requested by the beneficiary (4%). Of the 27 appeals filed, OVHA had 48%, DAIL had 48%, and DMH had 4%. 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 (78%), five were for a reduction/suspension/termination of a previously authorized covered service or service plan (19%), and one was left blank (3%).

There were eighteen cases filed between July 1, 2008 and September 30, 2008 that were still pending at the beginning of this quarter. In addition, there were two DAIL cases that were still pending from before July 1, 2008. Of those twenty cases, fifteen were resolved this quarter. 60% of these cases were upheld (six for DAIL & three for OVHA), 27% were reversed (four for OVHA); none were modified, none were withdrawn, and 13% were approved before the appeal hearing (two for DAIL). Not including the withdrawn case, 47% of the cases were resolved within thirty days, 80% in forty-five days, and 93% within fifty-nine days. The DAIL cases were not recorded as being extended, they were just decided late. The other case was a DAIL case that took 91 days to be resolved. On December 31, 2008 there were five DAIL cases still pending; one for 111 days, one for 118 days, one for 176, one for 188, and the last for 274 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 five fair hearings filed this quarter. One was filed concurrently with the appeal, while the other four were filed subsequent to the appeal decision. One case was withdrawn and the other four are still pending. There were four fair hearings that were pending from previous quarters. There are now eight fair hearings pending, three for DAIL and five 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.

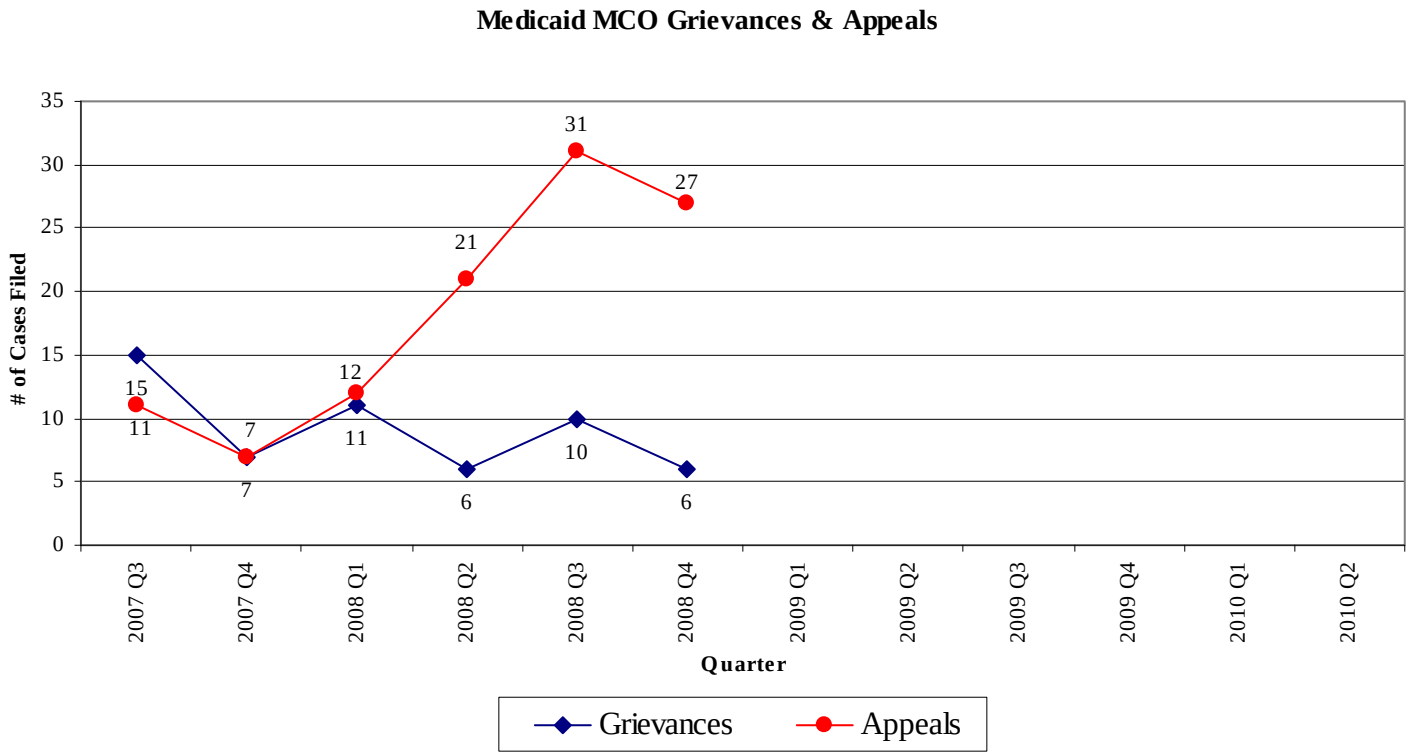
DCF was supposed to identify and have trained, program specific individuals, and that has not happened yet. In addition, to date, there are no known Grievance & Appeal procedures being used by the DCF. The MCO Grievance and Appeal Coordinator previously met with Theo Kennedy and discussed what needs to be done to get DCF up and running in the G&A process. Mr. Kennedy will pursue getting the process initiated and the MCO G&A Coordinator will 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.

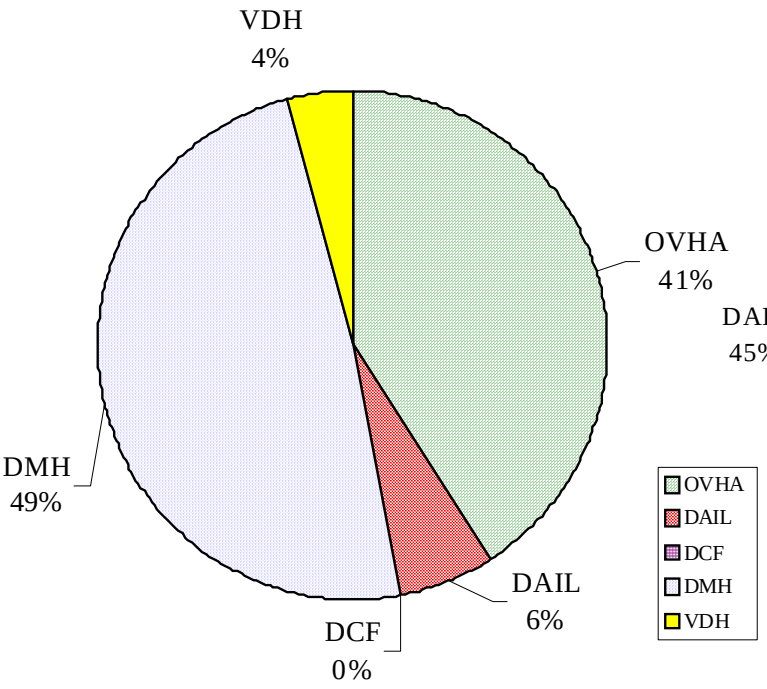
For this reporting quarter, QI reports were sent out on December 23rd and were due back on January 15th. The following agencies/DAs/SSAs did not respond:

DAIL - Choices for Care/TBI
DAIL - Outpatient/Emergency
Sterling Area Services

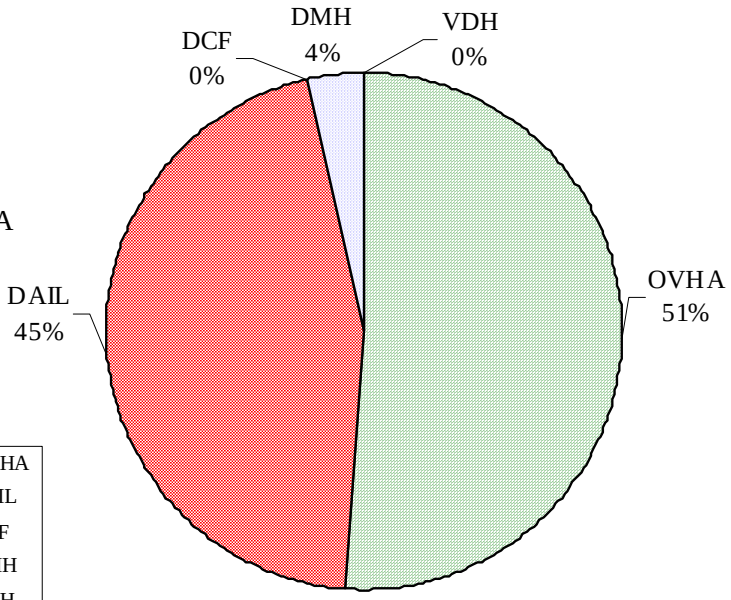
For the third quarter of 2009, we received a response back from the following agencies/DAs/SSAs after the original G&A report was sent out:
United Counseling Service of Bennington



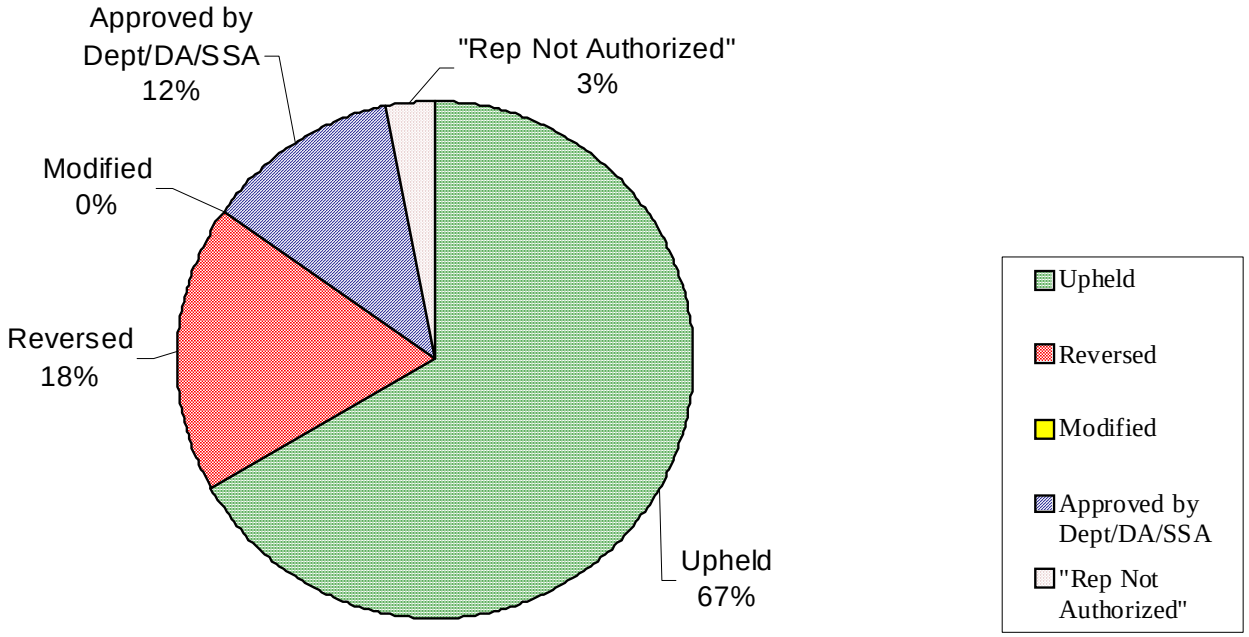
**Total Grievances By Department**




**Total Appeals by Department**




**MCO Appeal Resolutions**
**from July 1, 2007 through December 31, 2008**



Grievance and Appeal Quarterly Report
Medicaid MCO All Departments Combined Data
for the period: October 1, 2008 – December 31, 2008

## Grievances

### Total Number of Grievances Filed: 6

Number Pending: 1 *[OVHA]*

Number Withdrawn: 0

Number Addressed: 5 *[DMH]*

Number of Grievances filed too late: 2 *[DMH: CMC & HCRS]*

Average number of days from "pertinent issue" to filing grievance: 1

Average number of days from filing to entering into database: 1

Average number of days from filing to being addressed: 25

Average number of days to send acknowledgement letter: 1

Number of late acknowledgement letters: 0

Number of Grievance Reviews Requested: 0

Source of Grievance Request:

| | | |
|---|---|---|
| Beneficiary: | 6 | 100% |
| Beneficiary Representative: | 0 | 0% |
| Other: | 0 | 0% |

Number Related To:

| | | |
|---|---|---|
| OVHA: | 1 | 17% |
| DAIL: | 0 | 0% |
| DCF: | 0 | 0% |
| DMH: | 5 | 83% |
| VDH: | 0 | 0% |

Top Services Grieved:

1. Mental Health Services (4)
2. Psychiatric Services (1)
3. Transportation (1)

Number by Category: [Check ALL that apply]

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

* * * * * *

Number Pending from all previous quarters: 3
*[DMH-1; OVHA-2 (last qtr said 4, but one was a DMH late data entry.]*

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

Number that were pending in previous quarters and addressed this quarter: 3

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

Number of Grievance Reviews pending from all previous quarters: 0

Number of pending Grievance Reviews addressed this quarter: 0

# Appeals

## Number of Appeals Filed: 27

Number Pending: 6 *[DAIL-4; DMH-1; OVHA-1]*

Number Withdrawn: 3 *[OVHA]*

Number Resolved: 18
- Number Upheld: 15 83% *[DAIL-7; OVHA-8]*
- Number Reversed: 0 0%
- Number Modified: 0 0%
- Number Approved by Dept/DA/SSA: 3 17% *[DAIL-2; OVHA-1]*

Number of Cases Extended: 2
- By Beneficiary: 1
- By MCO: 1

Resolved Time Frames
- Within 30 days: 72%
- Within 45 days: 94%
- Within 59 days: 100%
  - Extended (100%) vs. Late (0)
- Over 59 days: 0%

Number of Appeals filed too late: 0

Average number of days from Notice of Action to filing appeal: 16

Average number of days from filing to entering data into database: 1

Average number of days from filing to resolution: 21

Average number of days from filing to resolution when extended: 57

Average number of days to send acknowledgement letter: 1

Number of late acknowledgement letters: 2 *[DAIL]*

Average number of days from filing to withdrawing: 5

Average number of days to send withdrawal letter: 0 *[SAME DAY]*

Number of late withdrawal letters: 0

Source of Appeal Request:

| | | |
|---|---|---|
| Beneficiary: | 9 | 33% |
| Beneficiary Representative: | 16 | 59% |
| Provider: | 1 | 4% |
| Other: | 1 | 4% |

Number Related To:

| | | |
|---|---|---|
| OVHA: | 13 | 48% |
| DAIL: | 13 | 48% |
| DCF: | 0 | 0% |
| DMH: | 1 | 4% |
| VDH: | 0 | 0% |

Top Services Appealed:
1. Personal Care Services (8)
2. Prescriptions (6)
3. Orthodontics (5)

Number of Beneficiaries that requested that their services be continued: 5 19%

Of those that requested their services be continued:

| | | |
|---|---|---|
| Number that met criteria: | 3 | 60% |
| Number that did not meet criteria: | 2 | 40% |

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: | 5 |
| 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 |
| Left Blank | 1 |

## Expedited Appeals

Number of Expedited Appeals Filed: 4 *[OVHA]*

Number of Expedited Appeals that:
Met Criteria: 0
Did Not Meet Criteria: 4

### *NOT meeting criteria:*

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

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

Number late letters: 0

* * * * * *

Number pending from last quarter: 18 *[DAIL-11; OVHA-7 (Last report said there were 19 pending, but one was resolved before 09/30/08, but the information was not entered until after 10/9/08)]*

Number pending from previous quarters: 2 *[DAIL-2 (Last report said there were 3 pending, but one was resolved before 07/1/08, but the information was not entered until after 10/9/08)*

Total pending from ALL quarters: 20 *[DAIL-13; OVHA-7]*

Number of total pending that were resolved this quarter: 15

| | | | |
|---|---|---|---|
| Number Upheld: | 9 | 60% | *[DAIL-6; OVHA-3]* |
| Number Reversed: | 4 | 27% | *[OVHA-4]* |
| Number Modified: | 0 | 0% | |
| Number Approved by Dept/DA/SSA: | 2 | 13% | *[DAIL-2]* |
| Number Withdrawn: | 0 | 0% | |

Resolution Time Frames for resolving above cases (except withdrawn cases):

| | | |
|---|---|---|
| Within 30 days: | 47% | *[OVHA-7 (100%)]* |
| Within 45 days: | 80% | *[DAIL-5 (63%); OVHA-7 (100%)]* |
| Within 59 days: | 93% | *[DAIL-7 (88%); OVHA-7 (100%)]* |
| Extended *(0)* vs. Late *(2)* | | |
| Over 59 days: | 7% | *[DAIL-1]* |

Number of appeals still pending from all previous quarters: 5 *[DAIL-5]*

## Fair Hearings

### Total number of Fair Hearings filed: 5

Number of Fair Hearings filed with a concurrent Appeal: 1 *[OVHA]*

Number of Fair Hearings filed after appeal resolution: 4 *[DAIL-1; OVHA-3]*

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

Number Resolved: 1

- Number Upheld: 0
- Number Reversed: 0
- Number Modified: 0
- Number Dismissed: 0
- Number Withdrawn: 1 *[OVHA]*

* * * * *

Number of pending Fair Hearings from previous quarters: 4 *[DAIL-2; OVHA-2]*

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

Number of pending Fair Hearings from all quarters pending at the end of this quarter: 8 *[DAIL-3; OVHA-5]*

# OFFICE OF HEALTH CARE OMBUDSMAN

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## QUARTERLY REPORT
## October 1, 2008 - December 31, 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 (OVHA) for the quarter October 1, 2008 through December 31, 2008. The total number of all cases/all coverages that we opened this quarter was 643. This compares to 503 last quarter and 687 the previous quarter. This quarter's total call volume is similar to earlier quarterly totals. Our year end total was 2,603. This is the highest call volume for a calendar year, ever. Previous year end totals were: 2,563 (in 2007); 2,584 (2006); and 2,200 (2005).

We received 248 OVHA-related calls[1] this quarter, up from 218 last quarter. This was 39% of the total call volume. In the previous quarter, July through September, OVHA calls made up 43% of our total calls.

The slump in call volume in the previous quarter was due to our reduced intake hours in August and September. We curtailed our intake hours during those months because we were experiencing a very high call volume, had only four rather than five advocates working our hotline, and had a backlog of cases. Although we still have only four advocates, we were able to catch up and change our priorities so that in October we went back to regular intake hours. Under our new priorities, we do less direct intervention on behalf of people with billing problems. We still give advice on billing issues, but generally now we are directing our limited resources to assist people having problems accessing health care. Thus, Access and Eligibility cases, which tend to be our largest issue categories, receive a larger percentage of our time.

Access to prescription drugs tends to be the largest category within our Access to Care code. The total number of prescription drug related calls this quarter, including access to medications generally, as well as issues with Medicare Part D, VPharm and VScript, went up to 74 from 44 last quarter. Viewed together, the issue categories involving prescription drugs represented 12 % of all calls received. Last quarter they made up 9% of all calls. There were 39 Medicare Part D related calls this quarter, compared to 31 last quarter.

[1] "OVHA-related" calls are designated that way because the caller is insured by an OVHA program at the time of the call.

We had 38 OVHA calls regarding prescription drugs and Medicare Part D this quarter, which is 51% of the total of all prescription-related calls (74 calls). This compares to 28 OVHA prescription calls in the previous quarter. Of the 38 OVHA calls, 22 involved Medicare Part D. So, 58 % of these calls involved Part D.

The number of calls we received related to Catamount and premium assistance programs rose to 64, from 55 last quarter. This is 10 % of the total calls this quarter, which is similar to last quarter. Catamount and Premium Assistance calls are usually related to eligibility for those programs.

Last quarter we began tracking pain management cases as a new and separate category. Many pain management cases involve access to prescription drugs, but most involve access to primary care doctors or other issues. We had 9 OVHA pain management cases, out of 21 total calls under this new issue code, compared to 8 out of 16 last quarter. Thus, 43 % of our pain calls involved state programs, compared to 50% last quarter. Only three of the pain management callers had commercial insurance. This statistic is of growing concern to us.

II. Disposition of cases

We closed 266 OVHA cases this quarter, compared to 231 last quarter:

- 9% (23 calls) of the OVHA calls were resolved in the initial call;
- 53% (141 calls) were resolved by advice or referral, after an analysis of the problem. Last quarter 42% (98 calls) were resolved in this manner;
- 28% (75 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 40% (93 calls) were resolved in this manner.

III. Issues

We opened 248 OVHA cases, compared to 218 last quarter:

- 37% (91 calls) involved access to care, compared to 31% (67 calls) last quarter;
- 23% (58 calls) involved eligibility issues, compared to 28% (62) last quarter;
- 21% (53 calls)involved other issues, compared to 26% (66). "Other" includes Medicare Part D calls;
- 15% (36 calls) involved billing or coverage problems, compared to 20% (43); and
- 4% (9 calls) were coded as OVHA consumer education, compared to 3% (6).

A. Access to Care

We received 91 OVHA access to care calls, up from 67 last quarter. Of the 17 subcategories in this issue code, the top call volume ones were:

- 16 calls on access to prescription drugs, not including Medicare Part D, up from 3 calls last quarter;
- 12 involved specialty care, compared to 11 last quarter;
- 12 involved dental care or orthodontia, up from 9;
- 11 involved transportation, up from 4;
- 9 involved behavioral health, up from 3;
- 9 involved pain management, up from 8.

B. Billing/Coverage

We received 36 calls in this category, down from 43 last quarter.

- 11 involved Medicaid/VHAP managed care billing, compared to 14 last quarter;
- 7 involved hospital billing, compared to 11 last quarter.

C. Eligibility

We received 58 calls in this category, down from 62 last quarter:

- 26 involved Medicaid eligibility, compared to 18 last quarter;
- 16 involved VHAP, the same as last quarter;
- 7 involved Catamount Health and Premium Assistance, down from 13. However, we had 53 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

- 22 calls involved Medicare Part D or VPharm in the OVHA statistics, compared to 15 last quarter;
- 38 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 28 last quarter, and 60 the previous quarter;
- 51% of all calls related to prescriptions involved OVHA beneficiaries.

IV. Uninsured Callers

The HCO received 66 calls from uninsured Vermonters this quarter, compared to 25 last quarter. We discussed Catamount Health and Premium Assistance, as well as the other state programs with these callers, who were not coded as OVHA-related.

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 |