

*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**  
**April 1, 2008 to June 30, 2008**

**Submitted Via Email on**  
**August 7, 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 third quarterly report for waiver year three, covering the period from April 1, 2008 to June 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
	6/30/2008	3/31/2008
Demonstration Population 1:	40,712	40,716
Demonstration Population 2:	40,818	40,823
Demonstration Population 3:	8,591	8,180
Demonstration Population 4:	N/A	N/A
Demonstration Population 5:	1,280	1,174
Demonstration Population 6:	2,477	2,151
Demonstration Population 7:	25,434	25,399
Demonstration Population 8:	7,877	7,645
Demonstration Population 9:	2,601	2,640
Demonstration Population 10:	N/A	N/A
Demonstration Population 11:	4,496	3,169

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

**Green Mountain Care Outreach / Innovative Activities**

During the third quarter, the successful Green Mountain Care marketing campaign to reach graduates concluded. Public and private colleges showed unprecedented support by allowing outside marketing efforts to occur directly to their seniors and faculty including direct emails to 6,250 college seniors and 3,600 faculty and staff. Colleges also posted the message on their electronic bulletin boards, wrote it into their COBRA letters, put flyers where seniors picked up their caps and gowns, put flyers on chairs during graduation rehearsal, and stocked their Career Planning and Placement offices for the summer.

Additionally, 6,240 state employees received an email encouraging them to check out health insurance options for their dependents before their sons and daughters graduated. State legislators received the same information and were asked to join the effort by including information about Green Mountain Care in their electronic or hard copy legislative updates or other articles they provide for local newsletters and newspapers.

The Lake Champlain Chamber of Commerce contacted 300 of its members from the restaurant and hotel industry, and the City of Burlington joined this effort by emailing 600 employees with the same message.

Specific to this effort a concert was held in partnership with the radio station, 99.9 The Buzz on May 25. Four weeks of concert promotions highlighted Green Mountain Care on The Buzz, in Seven Days, The Burlington Free Press and B-Scene, a new publication targeting a younger market, which is produced by the Free Press. There was an on-line link from the concert promotional on The Buzz website to the Green Mountain Care website. Each week during May, the disc jockey congratulated seniors at the college that was holding graduation and encouraged them to check out Green Mountain Care. A minimum of 120 promotional announcements ran in May. Through special arrangements with the record company this show was offered at a ticket price of 99 cents. There was a sold out crowd of over 750 people in the target market who each received information highlighting Green Mountain Care.

These efforts dovetailed with a campaign that Blue Cross Blue Shied of Vermont ran simultaneously.

Collaboration also occurred with the Vermont Bar Association on a publication titled “On Your Own: Your Legal Rights at 18.” Information pertaining to Green Mountain Care is part of this publication and has been distributed to 5200 high-school seniors statewide.

Act 203 provides amnesty for those preexisting conditions which were previously subject to a 12-month waiting period. Efforts are currently underway to highlight that amnesty ends November 1, 2008. This message is being integrated in all outreach efforts by the state and its public and private partners.

*Enrollment and legislative action:* Enrollment in the new premium assistance program components (Catamount Health and Employer-Sponsored Insurance) has continued to grow over the quarter. As of the end of June, there were 5827 individuals enrolled. The administration is working with the legislature’s Joint Fiscal Office to revise enrollment and expenditure projections for the 2010 fiscal year.

The legislature passed a few minor changes to Catamount Health and the premium assistance programs during this past session. Individuals who are enrolled in an insurance plan with a deductible of at least \$10,000 will be allowed to enroll in Catamount Health without waiting 12 months; however, the individuals will have to pay the full Catamount premium for 12 months before they become eligible for premium assistance. In addition, individuals who lost insurance coverage due to domestic violence will also be exempt from the 12-month waiting period (pending approval of a global commitment waiver amendment, which has not yet been submitted. The legislature also raised the premium levels for Catamount Health and ESI premium assistance programs.

Act 70 from last year’s legislative session requires a proactive outreach system that uses web-based tools and an inquiry tracking system establishing a case file for potential applicants at the first point of contact. The OVHA took the lead in creating a work group to implement a tracking tool; the work group includes representatives from the OVHA, DCF/ESD, and Bi-State Primary Care Association. The tracking tool, and the links to outreach specialists who can provide assistance to Vermonters applying for health care programs, has been developed by OVHA’s IT staff. OVHA and Bi-State now have a grant agreement in place, and Bi-State has hired a person to fill the new position that will promote the enrollment and tracking tool with health care providers and coordinate and train the cadre of outreach assistors in communities across the state.

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

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

The OVHA, in conjunction with the Vermont Department of Health (VDH), has implemented the 12 targeted initiatives to provide a comprehensive, balanced approach to improve oral health and oral health access for all Vermonters. Updates as of June 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 broader educational campaign for the fall of 2008.

**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.

**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.

**Initiative #4:** Place Dental Hygienists in Each of the 12 District Health Offices - Successful pilot project will result in three 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.

**Initiative #7:** Codes for Missed Appointments/Late Cancellations - Vermont introduced a code to report 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.

**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.

**Initiative #10:** Scholarships - Scholarships, administered through the Vermont Student Assistance Corporation, are awarded to encourage new dentists to practice in Vermont.

**Initiative #11:** Access Grants - 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.

Initiative #12: Supplemental Payment Program - The OVHA distributed \$292,836 to recognize and reward dentists serving high volumes of Medicaid beneficiaries; 30 dentists qualified for semi-annual payouts.

The Dental Dozen is a multi-pronged effort that impacts providers, beneficiaries and future providers for Vermont; the initiatives require a number of years to achieve desired results and measurable improvement. 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 is reinstated effective July 1, 2008 per Act 65 of the 2007 Legislative session. Coverage is consistent with Title 8, §4088a, and within the scope of chiropractic practice as defined in Chapter 10 of Title 26 of the Vermont Statutes. Beginning with a July 1, 2008 date of service, allowable and covered services for children and adults will be the same and must be clinically necessary. Coverage is limited to the description of services below.

According to the statute, services of a chiropractor include:

- Diagnosis of conditions related to subluxations, joint dysfunctions, neuromuscular and skeletal disorders to detect, correct or refer in order to restore and maintain health, without providing drugs or performing surgery;
- Use of physical and clinical examinations, conventional radiological procedures and interpretation (X-rays), as well as the use of diagnostic imaging (such as MRI or CT scans) read and interpreted by a person so licensed, and laboratory tests to determine if the chiropractic care is appropriate; and
- Adjunctive therapies approved by the state board of chiropractic, by rule, to be used in conjunction with chiropractic treatment, and limited to physiotherapy modalities (these include ultrasound, diathermy- heat treatment using electricity, laser therapy for pain, heat, cold, electricity, and traction) and rehabilitative exercises; and
- Treatment by adjustment or manipulation of the spine or other joints and connected neuromusculoskeletal tissues and bodily articulations.

The following benefit limits apply to chiropractic services:

- Coverage for all beneficiaries is limited to ten visits per patient per calendar year. For more visits, the chiropractor must submit a prior authorization request, accompanied by sufficient documentation to support the medical necessity of continued care. This may include full clinical data, x-rays, progress notes, or other documentation required by the Office of Vermont Health Access (OVHA) for review.
- Chiropractic services will not be subject to a referral from a primary care provider, however, chiropractors will send primary care providers their case notes from the initial visit within 10 days of that visit.
- Chiropractic services for children under the age of 12 will continue to require prior authorization and related documentation.

Naturopathic Physicians: The Office of Vermont Health Access (OVHA) began accepting applications for enrollment of licensed naturopathic physicians as Vermont Medicaid Providers in accordance with Act

59 of the 2007 legislative session. As part of enrollment, naturopathic physicians would provide additional required information to be a primary care provider (PCP) in the Primary Care Plus Program. Thirteen naturopathic physicians have enrolled; two as primary care providers.

**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:

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

<b>CPTOD 2007 - 2008 Payment Summary</b>	
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
<b>Total</b>	<b>\$ 428,327.97</b>

As of June 2008, the Capitated Program for the Treatment of Opiate Dependency (CPTOD) as implemented by the OVHA has 34 enrolled providers and approximately 418 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. 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 throughout 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 pmpm case management rate for working with the OVHA teams. The CCP supports providers by offering intensive case management services to the beneficiary to eliminate barriers and to enable the plan of care (POC) to be most 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 and case durations which range from 2 to 12 months, depending on the diagnoses and complexity of socio-economic challenges. When fully staffed, the CCP anticipates maintaining an average monthly case load of 400 high risk beneficiaries 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 including, but 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 joint management by the primary care provider and the individual beneficiary are further complicated by the often co-occurring conditions of mental health and substance abuse; as well as socio-economic determinants of health including procurement of nourishing food, availability of safe and affordable housing and lack of reliable transportation. 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 effectively coordinate required services and address priority health and security needs of our beneficiaries.

Highlights of CCP efforts for the quarterly reporting period ending June 30<sup>th</sup> include management of an average monthly case load of over 340 beneficiaries by a field staff of 13 FTE nurse and social workers; and 2 regional supervisors. Additional positions are under recruitment with a goal of 16 field staff within the next reporting period; and a case load increase to 400.

CCP is in the early stages of utilizing quarterly evaluation data provided by the Center for Health Policy and Research (CHPR) to facilitate our targeted interventions based on clinical best practice and HEDIS measures. This will help focus efforts to the specific needs of our beneficiaries, such as pharmaceutical usage, and assess reasons for not getting prescriptions filled (i.e. not ordered by MD; no transportation to pharmacy; no funds for co-payment required, etc...). Chart audit by CHPR are planned for this summer to secure both baseline and 1 year program data. Results are expected by late fall.

Clinical guidelines for 11 chronic conditions under CCP management have been approved by our Medical Director. Staff is being trained on best practice standards. In June staff received training on Diabetes and CHF best practices and 'touch points' for intervention. Staff are able to utilize motivational interviewing techniques to effectively educate, coach and support beneficiaries in their self management goals in tandem with the primary care provider. In furtherance of this goal, the OVHA CCP is working to finalize and disseminate additional educational materials to support self-management, working in partnership with APS Healthcare and the Vermont Department of Health, to assure consistent messaging and appropriate literacy levels for our chronic disease materials. Draft documents were developed by APS Healthcare and have been preliminarily approved by the OVHA Medical Director and the Vermont Department of Health with minor edits. Final approval within OVHA is required with materials anticipated to be available to our beneficiaries within the next 45-60 days.

*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., provides 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 completes 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 assessments and interventions are tracked using APS CareConnection®, a proprietary case tracking and management system also used by CCP care coordinators.

Disease management services include 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. During the upcoming quarter, APS plans to conduct a satisfaction survey of beneficiaries who have received health coaching services.

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

- **17,244** CCMP and CCP beneficiaries have completed HRAs.
- **1,950** CCMP participants have completed at least one detailed assessment to generate a Plan of Care for Intervention Services; a total of **3,188 assessments** were completed.

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. During the upcoming quarter, CHPR will complete its first review of selected beneficiary medical records to incorporate this information in evaluating the program's first year.

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

AHS has submitted its IGAs with the OVHA to CMS for Global Commitment waiver years one, two and three. The IGAs included per-member-per-month capitation rates that are within the actuarially certified ranges. On April 30, 2008, AHS received approval from CMS on the waiver year one IGA. On July 30, 2008, AHS updated the CMS MBES reports to reflect the actual PMPM costs incurred during waiver year one. Upon receipt of final approval from CMS for the waiver years two and three IGAs and upon agreement with CMS reporting staff, AHS will then amend the CMS-64 submissions for waiver years two and three to reflect the appropriate costs as allocated to each Medicaid eligibility group.

On April 1, 2008, the State entered into a new contractual arrangement with Aon Consulting for actuarial consulting services for waiver years four and five. This is a two-year agreement, in which Aon will develop actuarially certified rate ranges for FFY09 and FFY10. AHS is currently working with Aon to provide information for development of the rate ranges, with the final report deliverable from Aon due in August.

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 individual 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	Month 2	Month 3	Total for Quarter Edning	Total for Quarter Edning	Total for Quarter Edning
	4/15/2008	5/15/2008	6/15/2008	3rd Qtr FFY '08	2nd Qtr FFY '08	1st Qtr FFY '08
Demonstration Population 1:	40,761	40,837	40,683	122,281	121,926	120,113
Demonstration Population 2:	41,194	41,202	40,887	123,283	122,118	120,309
Demonstration Population 3:	8,533	8,568	8,622	25,723	24,676	24,821
Demonstration Population 4:	N/A	N/A	N/A	N/A	N/A	N/A
Demonstration Population 5:	1,238	1,256	1,273	3,767	3,542	3,767
Demonstration Population 6:	2,537	2,436	2,384	7,357	6,208	6,084
Demonstration Population 7:	24,619	24,677	24,670	73,966	72,336	65,803
Demonstration Population 8:	7,606	7,658	7,836	23,100	22,697	22,445
Demonstration Population 9:	2,619	2,616	2,603	7,838	7,919	7,929
Demonstration Population 10:	N/A	N/A	N/A	N/A	N/A	N/A
Demonstration Population 11:	3,715	4,231	4,579	12,525	7,997	1,641

**Consumer Issues** *A summary of the types of complaints or problems consumers identified about the program in the current quarter. Include any trends discovered, the resolution of complaints, and any actions taken or to be taken to prevent other occurrences. Also discuss feedback received from the other consumer groups.*

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.

In addition to these activities the MCO and its IGA partners routinely assess consumer satisfaction with various aspects of care. Future reports will contain results as available of these targeted surveys and feedback forums.

### **Quality Assurance/Monitoring Activity**

*External Quality Review Organization:* During this quarter, the AHS worked with OVHA and Vermont Program for Quality Health Care, to calculate/review 16 performance measures for baseline and year one of the Global Commitment to Health Waiver. A final report was delivered to AHS and OVHA. The new EQRO, Health Services Advisory Group, Inc. (HSAG) will validate 6-8 of these measures during an on-site review during the next quarter. During this quarter, the AHS Quality Improvement Manager and HSAG developed a Review of Compliance with Standards Documentation Request and Evaluation Form for the MCO and monthly update calls continue. This work has centered on identifying requirements for each of the Structure and Operation Standards found in 42 CFR 438 and the AHS/OVHA IGA. Dates for the submission of documents and the on-site visit were established. Also during this quarter, the AHS Quality Improvement Manager worked collaboratively with OVHA to submit the Performance Improvement Project (PIP) Summary Form. This tool will be used by HSAG to review the MCO's current PIP, Fostering Healthy Families. Feedback from HSAG re: information contained in the Summary Form is anticipated next quarter. Finally, the AHS Quality Improvement Manager worked with OVHA and HSAG to better understand and prepare for the Performance Measure Validation Process. Topics of discussion included the following: overview of service data processing, membership/eligibility data, provider data, data integration, and primary source verification. During the next quarter, mutual expectations for Performance Measure Validation will be established and desk/on-site review procedures will be finalized.

*Quality Assurance /Performance Improvement (QAPI) Committee:* During this quarter, the Committee finalized their review of the Review of Compliance with Standards Documentation Request and Evaluation Form created by HSAG. The committee continued to prioritize agency-wide performance measures and Performance Improvement Projects. Specifically, the committee reviewed historical Consumer Assessment of Healthcare Providers and Systems (CAHPS) data from OVHA and recommended 4 specific measures that should be reported by the MCO on a regular basis (i.e., getting needed care, getting care quickly, customer service, and overall rating of health plan). In addition to these 4 CAHPS measures, the group recommended that the MCO continue to collect and report the 16 HEDIS measures discussed above. While there was much discussion re: additional Performance Improvement Projects for next year, no recommendations were made during this quarter. However, the committee did recommend that the MCO continue with the current project, Fostering Healthy Families. During next quarter, the committee will recommend a prioritized list of Performance Improvement Projects to the Medicaid Operations Team. Additionally, the QAPI Committee began 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 re: its oversight/monitoring role. Recommendations for additional reports were discussed. 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 become clearer.

*Quality Strategy:* During this quarter, the Global Commitment Quality Strategy received final approval from CMS. A copy of the letter is attached to this report. The Quality Framework contained in this document will be used by the QAPI Committee to guide the development of the MCO Quality Plan (discussed above). The AHS Quality Improvement Manager will review the Quality Strategy on a regular basis and discuss any necessary modifications with the QAPI committee as needed.

## **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 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, Rural Health Centers (RHC) and Federally Qualified Health Centers (FQHC)

February 2009 - Surgical Providers (Surgical Specialty and OB-GYN)

March 2009 – Nursing (Nursing Homes, Home Health, PACE, Home and Community Based Services, Hospice, and Other Related Services)

April 2009 - Pharmacy and DME Suppliers

May 2009 - Personal Care Services (PCS), Physical Therapists, Occupational Therapists, Speech Therapists

June 2009 – Other (Chiropractors, Podiatrists, Opticians, Ophthalmologists)

The OVHA will begin the sequencing/process again with comparisons from year to year after initially mapping all provider types since the analysis and monitoring is a continuous process.

## **Demonstration Evaluation**

*GC Evaluation Plan:* During this quarter, the AHS Quality Improvement Manager participated in the review of responses to the Global Commitment Evaluation RFP. The purpose of the review was to select the most appropriate applicant to conduct the evaluation. After reviewing and discussing the proposals, the committee asked the AHS Quality Improvement Manager to follow-up with the two finalists. This involved a discussion with the proposed project director and interviews with professional references. Based on the information contained in the proposals and the additional information gathered, the committee recommended that Pacific Health Policy Group be awarded the contract. This recommendation was accepted and the AHS Quality Improvement Manager worked with AHS Central Office staff to draft the contract. It is anticipated that the contract will be signed and the evaluation initiated 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 draft 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 Legislative and Choices For Care Grievance and Appeal Reports

Attachment 5: Office of VT Health Access Quarterly Report

Attachment 6: OVHA MCO Investment Summary

Attachment 7: Global Commitment Quality Strategy Approval Letter

## **State Contact(s)**

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Policy/Program:	Suzanne Santarcangelo, Director AHS Health Care Operations, Compliance, and Improvement VT Agency of Human Services 103 South Main Street Waterbury, VT 05671-0203	802-241-3155 (P) 802-241-4461 (F) <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:** August 7, 2008

# **ATTACHMENTS**

Office of Vermont Health Access  
SFY '08 Catamount Health Actual Revenue and Expense Tracking  
Tuesday, July 15, 2008

	SFY '08 Revised Appropriated			Consensus Estimates for SFY to Date			Actuals thru 6/30/08			
	<=200%	>200%	Total	<=200%	>200%	Total	<=200%	>200%	Total	% of SFY to-Date
<b>TOTAL PROGRAM EXPENDITURES</b>										
Catamount Health	6,317,850	6,881,030	13,198,880	6,317,850	6,881,030	13,198,880	2,903,808	3,534,524	6,438,332	48.78%
Catamount Eligible Employer-Sponsored Insurance	88,278	96,147	184,424	88,278	96,147	184,424	99,604	159,131	258,734	140.29%
<b>Subtotal New Program Spending</b>	<b>6,406,128</b>	<b>6,977,177</b>	<b>13,383,304</b>	<b>6,406,128</b>	<b>6,977,177</b>	<b>13,383,304</b>	<b>3,003,411</b>	<b>3,693,655</b>	<b>6,697,066</b>	<b>50.04%</b>
Catamount and ESI Administrative Costs	1,688,833	1,839,378	3,528,211	1,688,833	1,839,378	3,528,211	1,688,833	1,270,308	2,959,141	83.87%
<b>TOTAL GROSS PROGRAM SPENDING</b>	<b>8,094,961</b>	<b>8,816,554</b>	<b>16,911,515</b>	<b>8,094,961</b>	<b>8,816,554</b>	<b>16,911,515</b>	<b>4,692,244</b>	<b>4,963,963</b>	<b>9,656,207</b>	<b>57.10%</b>
<b>TOTAL STATE PROGRAM SPENDING</b>	<b>3,318,125</b>	<b>8,816,554</b>	<b>12,134,679</b>	<b>3,318,125</b>	<b>8,816,554</b>	<b>12,134,679</b>	<b>1,923,351</b>	<b>4,963,963</b>	<b>6,887,314</b>	<b>56.76%</b>
<b>TOTAL OTHER EXPENDITURES</b>										
Immunizations Program	-	4,000,000	4,000,000	-	4,000,000	4,000,000	-	3,832,030	3,832,030	95.80%
VT Dept. of Labor Admin Costs Assoc. With Employer Assess.	-	394,072	394,072	-	394,072	394,072	-	258,466	258,466	65.59%
Marketing and Outreach	1,316,167	-	1,316,167	1,316,167	-	1,316,167	1,316,167	-	1,316,167	100.00%
Blueprint	-	1,846,713	1,846,713	-	1,846,713	1,846,713	-	1,846,713	1,846,713	100.00%
<b>TOTAL OTHER SPENDING</b>	<b>1,316,167</b>	<b>6,240,785</b>	<b>7,556,952</b>	<b>1,316,167</b>	<b>6,240,785</b>	<b>7,556,952</b>	<b>1,316,167</b>	<b>5,937,209</b>	<b>7,253,376</b>	<b>95.98%</b>
<b>TOTAL STATE OTHER SPENDING</b>	<b>539,497</b>	<b>6,240,785</b>	<b>6,780,282</b>	<b>539,497</b>	<b>6,240,785</b>	<b>6,780,282</b>	<b>539,497</b>	<b>5,937,209</b>	<b>6,476,706</b>	<b>95.52%</b>
<b>TOTAL ALL STATE SPENDING</b>	<b>3,857,621</b>	<b>15,057,339</b>	<b>18,914,960</b>	<b>3,857,621</b>	<b>15,057,339</b>	<b>18,914,960</b>	<b>2,462,848</b>	<b>10,901,172</b>	<b>13,364,020</b>	<b>70.65%</b>
<b>TOTAL REVENUES</b>										
Catamount Health Premiums	964,287	2,012,969	2,977,257	964,287	2,012,969	2,977,257	399,085	953,319	1,352,404	45.42%
Catamount Eligible Employer-Sponsored Insurance Premiums	48,371	100,976	149,347	48,371	100,976	149,347	30,864	67,134	97,998	65.62%
<b>Subtotal Premiums</b>	<b>1,012,659</b>	<b>2,113,945</b>	<b>3,126,604</b>	<b>1,012,659</b>	<b>2,113,945</b>	<b>3,126,604</b>	<b>429,949</b>	<b>1,020,453</b>	<b>1,450,402</b>	<b>46.39%</b>
Federal Share of Premiums	(597,570)	-	(597,570)	(597,570)	-	(597,570)	(253,713)	-	(253,713)	42.46%
<b>TOTAL STATE PREMIUM SHARE</b>	<b>415,089</b>	<b>2,113,945</b>	<b>2,529,034</b>	<b>415,089</b>	<b>2,113,945</b>	<b>2,529,034</b>	<b>176,236</b>	<b>1,020,453</b>	<b>1,196,689</b>	<b>47.32%</b>
Cigarette Tax Increase (\$.60 / \$.80)			9,052,000			9,052,000			8,686,425	95.96%
Floor Stock			-			-			29,329	0.00%
Employer Assessment			7,500,000			7,500,000			5,421,491	72.29%
Interest			161,625			161,625			311,966	193.02%
<b>TOTAL OTHER REVENUE</b>			<b>16,713,625</b>			<b>16,713,625</b>			<b>14,449,211</b>	<b>86.45%</b>
<b>TOTAL STATE REVENUE</b>	<b>415,089</b>	<b>2,113,945</b>	<b>19,242,659</b>	<b>415,089</b>	<b>2,113,945</b>	<b>19,242,659</b>	<b>176,236</b>	<b>1,020,453</b>	<b>15,645,900</b>	<b>81.31%</b>
State-Only Balance			327,699			327,699			2,281,881	
Carryforward			4,617,848			4,617,848			4,617,848	
<b>(DEFICIT)/SURPLUS</b>			<b>4,945,547</b>			<b>4,945,547</b>			<b>6,899,729</b>	
Reserve Account Funding			3,500,000			3,500,000			3,500,000	
<b>REVISED (DEFICIT)/SURPLUS WITH RESERVE FUNDING</b>			<b>8,445,547</b>			<b>8,445,547</b>			<b>10,399,729</b>	

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

## ESI and CATAMOUNT HEALTH PREMIUM ASSISTANCE PROGRAM REPORT June 2008

### TOTAL ENROLLMENT BY MONTH

	<u>Jul-07</u>	<u>Aug-07</u>	<u>Sep-07</u>	<u>Oct-07</u>	<u>Nov-07</u>	<u>Dec-07</u>	<u>Jan-08</u>	<u>Feb-08</u>	<u>Mar-08</u>	<u>Apr-08</u>	<u>May-08</u>	<u>Jun-08</u>
<b>VHAP-ESIA</b>	-	-	-	-	35	131	287	411	542	589	607	632
<b>ESIA</b>	-	-	-	-	21	69	127	169	242	273	304	324
<b>CHAP</b>	-	-	-	-	320	1,186	1,834	2,419	3,033	3,507	3,918	4,265
<b>Catamount Health</b>	-	-	-	-	120	165	268	345	361	344	470	606
<b>Total</b>	-	-	-	-	<b>376</b>	<b>1,551</b>	<b>2,516</b>	<b>3,344</b>	<b>4,178</b>	<b>4,713</b>	<b>5,299</b>	<b>5,827</b>
	<u>Jul-07</u>	<u>Aug-07</u>	<u>Sep-07</u>	<u>Oct-07</u>	<u>Nov-07</u>	<u>Dec-07</u>	<u>Jan-08</u>	<u>Feb-08</u>	<u>Mar-08</u>	<u>Apr-08</u>	<u>May-08</u>	<u>Jun-08</u>
<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
<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
<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
<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
<b>Total</b>	<b>116,324</b>	<b>116,584</b>	<b>116,796</b>	<b>117,363</b>	<b>117,979</b>	<b>118,362</b>	<b>119,666</b>	<b>120,155</b>	<b>120,528</b>	<b>120,886</b>	<b>120,810</b>	<b>121,029</b>
<b>TOTAL ALL</b>	<b>116,324</b>	<b>116,584</b>	<b>116,796</b>	<b>117,363</b>	<b>118,355</b>	<b>119,913</b>	<b>122,182</b>	<b>123,499</b>	<b>124,706</b>	<b>125,599</b>	<b>126,109</b>	<b>126,856</b>

**KEY:**

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

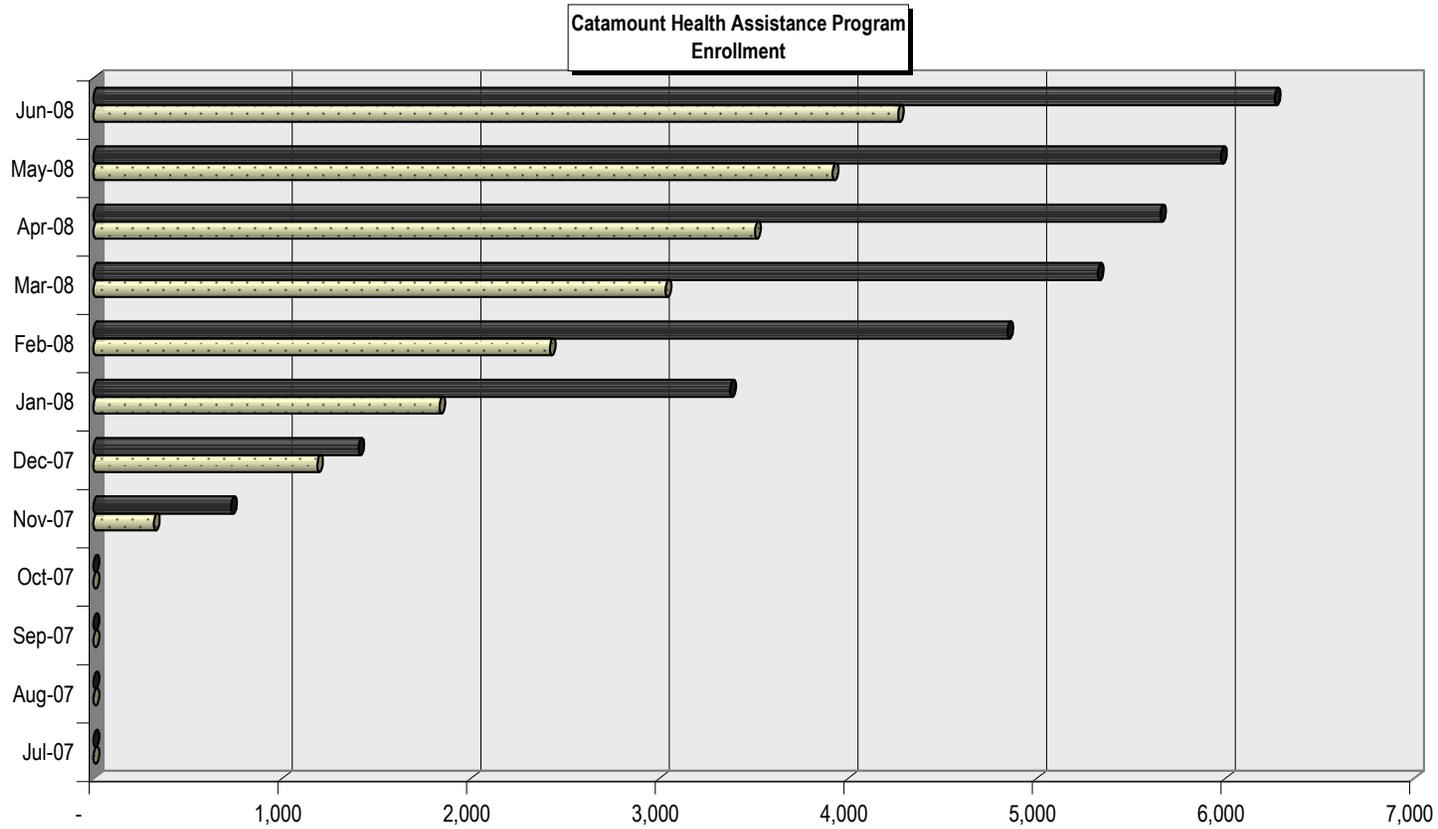
**ESI and CATAMOUNT HEALTH PREMIUM ASSISTANCE PROGRAM REPORT (continued)**
**June 2008 Demographics**

<b>Income</b>	<b>VHAP-ESIA*</b>	<b>ESIA*</b>	<b>CHAP*</b>	<b>TOTAL</b>
0-50%	30	-	146	
50-75%	30	-	45	
75-100%	76	2	59	
100-150%	322	5	204	
150-185%	171	72	1,099	
185-200%	2	69	562	
200-225%	1	62	832	
225-250%	-	49	581	
250-275%	-	35	425	
275-300%	-	30	314	
<b>Total</b>	<b>632</b>	<b>324</b>	<b>4,265</b>	<b>5,221</b>

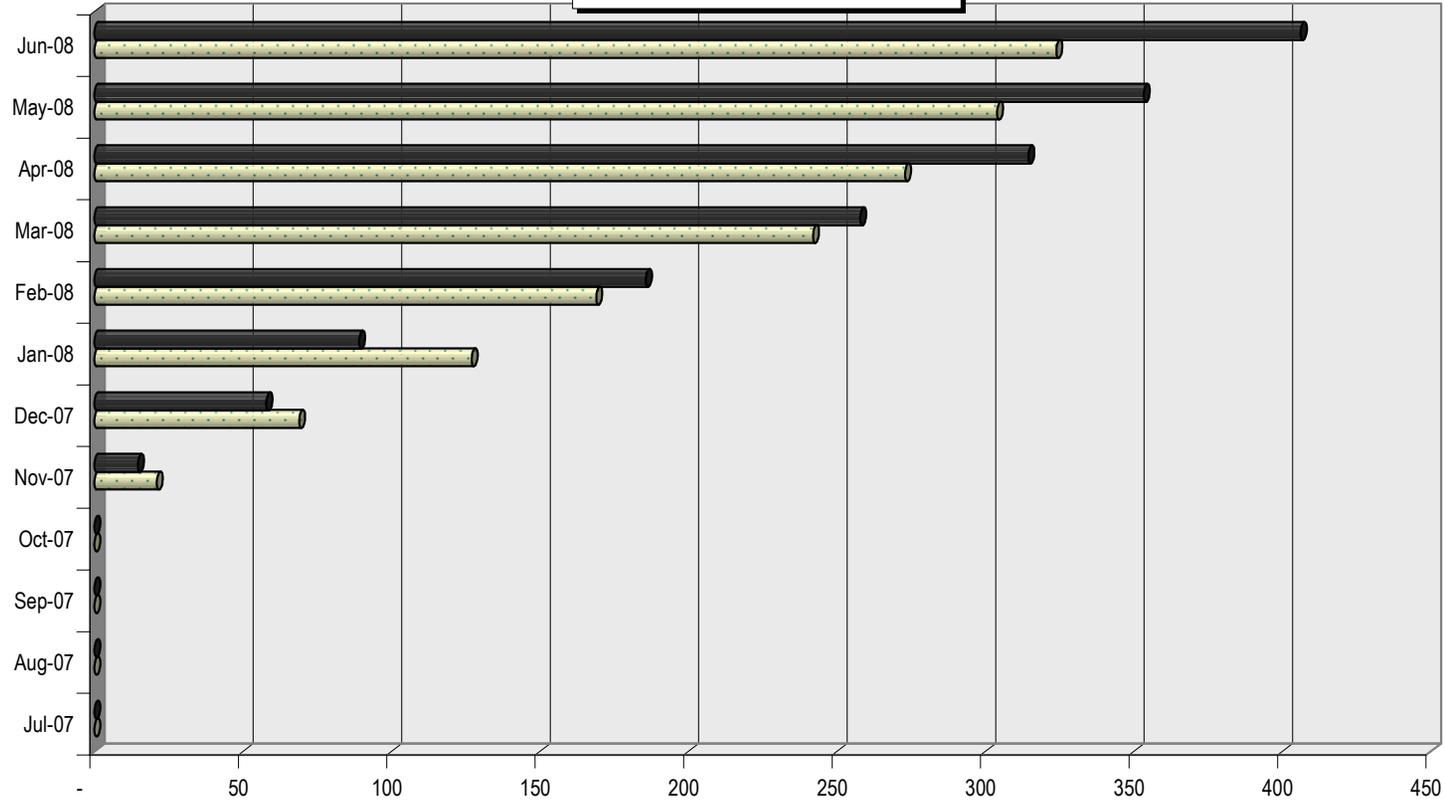
  

<b>Age</b>	<b>VHAP-ESIA</b>	<b>ESIA</b>	<b>CHAP</b>	<b>TOTAL</b>
18-24	33	33	729	
25-35	183	110	732	
36-45	246	74	844	
46-55	134	74	1,028	
56-64	36	27	922	
65+	-	6	10	
<b>Total</b>	<b>632</b>	<b>324</b>	<b>4,265</b>	<b>5,221</b>

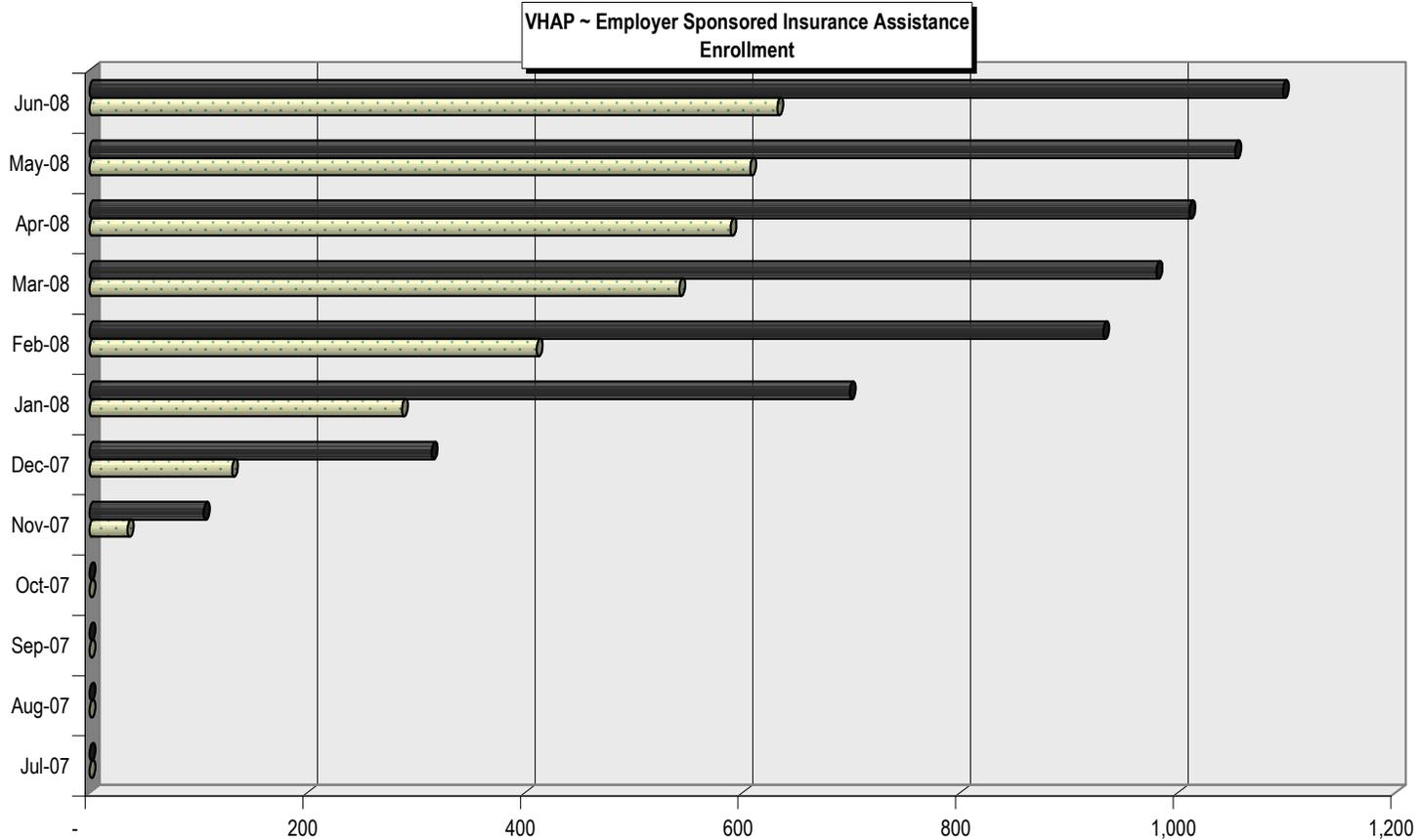
<b>ESI and CATAMOUNT HEALTH PREMIUM ASSISTANCE PROGRAM REPORT (continued)</b>				
<b>June 2008 Demographics</b>				
<b>Gender</b>	<b>VHAP-ESIA</b>	<b>ESIA</b>	<b>CHAP</b>	<b>TOTAL</b>
Male	217	118	1,847	
Female	415	206	2,418	
<b>Total</b>	<b>632</b>	<b>324</b>	<b>4,265</b>	<b>5,221</b>
<b>County</b>	<b>VHAP-ESIA</b>	<b>ESIA</b>	<b>CHAP</b>	<b>TOTAL</b>
Addison	36	13	283	
Bennington	63	27	235	
Caledonia	30	11	280	
Chittenden	106	88	751	
Essex	7	5	61	
Franklin	62	24	282	
Grand Isle	8	10	40	
Lamoille	34	15	239	
Orange	25	11	232	
Orleans	57	11	260	
Other	3	-	6	
Rutland	83	39	481	
Washington	49	20	402	
Windham	28	30	316	
Windsor	41	20	397	
<b>Total</b>	<b>632</b>	<b>324</b>	<b>4,265</b>	<b>5,221</b>



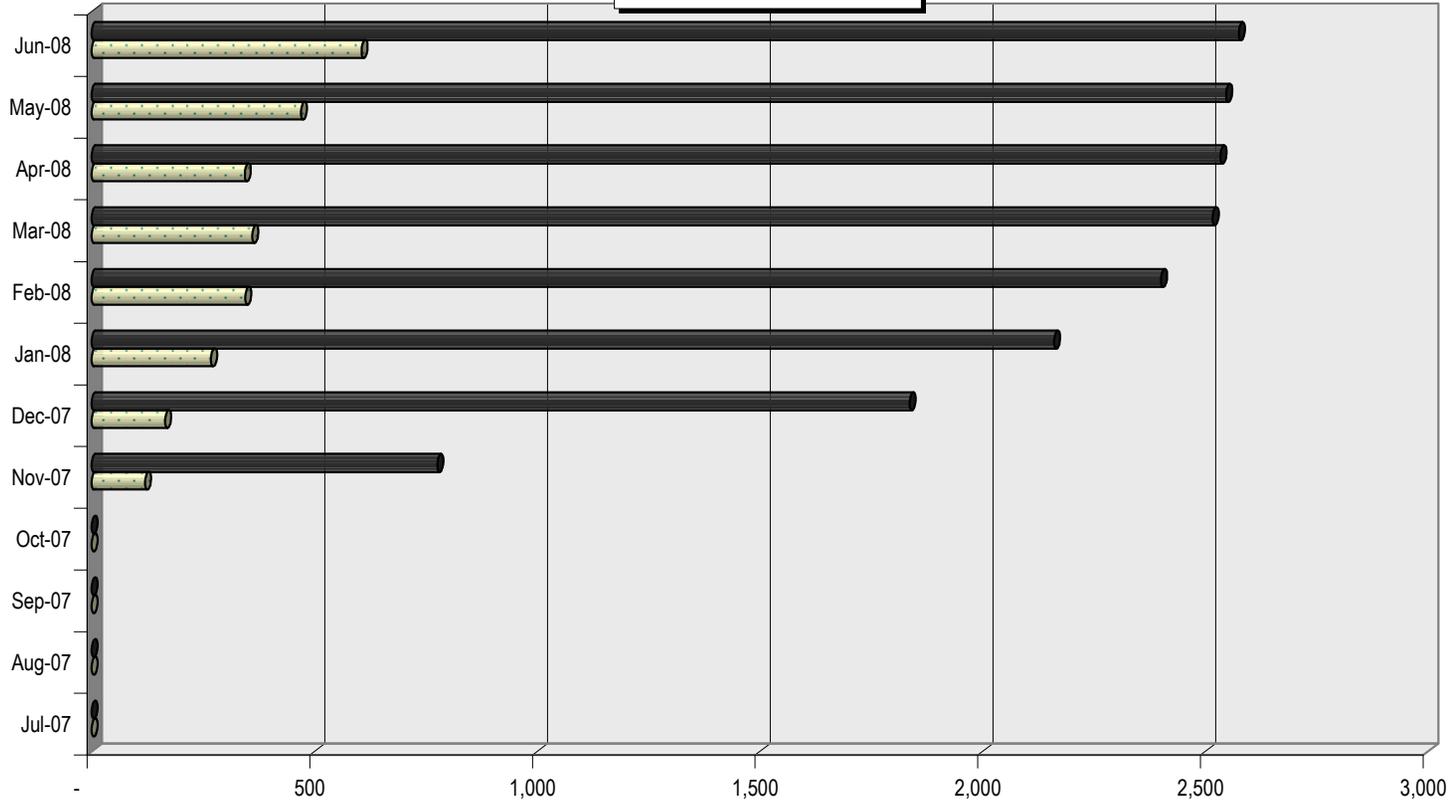
	Jul-07	Aug-07	Sep-07	Oct-07	Nov-07	Dec-07	Jan-08	Feb-08	Mar-08	Apr-08	May-08	Jun-08
■ Projected	-	-	-	-	730	1,405	3,375	4,845	5,324	5,655	5,978	6,262
▨ Actual	-	-	-	-	320	1,186	1,834	2,419	3,033	3,507	3,918	4,265

**Employer Sponsored Insurance Assistance Enrollment**


	Jul-07	Aug-07	Sep-07	Oct-07	Nov-07	Dec-07	Jan-08	Feb-08	Mar-08	Apr-08	May-08	Jun-08
■ Projected	-	-	-	-	15	58	89	186	258	315	353	406
▨ Actual	-	-	-	-	21	69	127	169	242	273	304	324



	Jul-07	Aug-07	Sep-07	Oct-07	Nov-07	Dec-07	Jan-08	Feb-08	Mar-08	Apr-08	May-08	Jun-08
■ Projected	-	-	-	-	105	314	699	931	980	1,011	1,053	1,097
▨ Actual	-	-	-	-	35	131	287	411	542	589	607	632

**Catamount Health ~ Unsubsidized Enrollment**


	Jul-07	Aug-07	Sep-07	Oct-07	Nov-07	Dec-07	Jan-08	Feb-08	Mar-08	Apr-08	May-08	Jun-08
■ Projected	-	-	-	-	776	1,837	2,161	2,401	2,517	2,535	2,547	2,576
□ Actual	-	-	-	-	120	165	268	345	361	344	470	606

# 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	\$ 1,936,000,000	\$ 323,267,567
Cumulative								\$ 1,612,732,433	\$ 1,936,000,000	\$ 323,267,567
1207	\$ 213,871,059	\$ -	\$ 1,010,348		\$ 1,010,348	\$ 214,881,406				
0308	\$ 162,921,830	\$ -	\$ -	\$ -	\$ -	\$ 162,921,830				
0608	\$ 196,466,768	\$ 14,717		\$ 40,276,433	\$ 40,291,150	\$ 236,757,918				
0908										
WY3 SUM	\$ 573,259,657	\$ 14,717	\$ 1,010,348	\$ 40,276,433	\$ 41,301,498	\$ 613,536,090	\$ 4,753,189	\$ 618,289,279	\$ 2,848,000,000	\$ 616,978,289
Cumulative								\$ 2,231,021,711	\$ 2,848,000,000	\$ 616,978,289
1208										
0309										
0609										
0909										
WY4 SUM	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Cumulative								\$ 2,231,021,711	\$ 3,779,000,000	\$ 1,547,978,289
1209										
0310										
0610										
0910										
WY5 SUM	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Cumulative								\$ 2,231,021,711	\$ 4,700,000,000	\$ 2,468,978,289
	\$ 2,164,179,815	\$ 10,166,327	\$ 941,940	\$ 40,276,433			\$ 15,457,197			

PQA = Prior Quarter Adjustments

**Complaints Received by Health Access Member Services  
April 1, 2008 – June 30, 2008**

Eligibility forms, notices, or process	14
General premium complaints	8
Catamount Health Assistance Program premiums, process, ads	5
Use of social security numbers as identifiers	5
Coverage rules	4
Member services	2
Eligibility rules	1
Eligibility local office	1
Prescription drug plan complaint	1
Copays/service limit	0
PBM complaint	0
Provider issues (perceived rudeness, refusal to provide service, prices) (variety of provider types)	0
<b>Total</b>	<b>41</b>

Memo to: House Committee on Human Services  
House Committee on Health Care  
Senate Committee on Health and Welfare

From: Joshua Slen, Director, Office of Vermont Health Access  
Joan Senecal, Commissioner, Department of Disabilities, Aging and Independent Living

Re: Medicaid MCO Legislative Grievance and Appeal Report: January 1, 2008 – June 30, 2008  
Choices for Care Appeal Report: January 1, 2008 – June 30, 2008

Date: July 30, 2008

The Office of Vermont Health Access became the first state-wide publically run Managed Care Organization (MCO) under the Global Commitment to Health waiver. The Grievance and Appeal process is a federal requirement under MCO regulations [42 C.F.R. 438.408]. In addition, the Choices for Care (CFC) program, operated within DAIL, utilizes the MCO Grievance and Appeals database to track appeals, bringing all public health care programs into alignment with one standard process. Following the direction of Act 65 of the 2007 legislative session, AHS is pleased to present to you our second semi-annual report on the implementation of the Grievance and Appeal process.

Act 65, Sec. 111a. Global Commitment; Grievance And Appeal Rules: Beginning January 1, 2008 and every six months thereafter, the secretary of the agency of human services or designee shall report on the implementation of the grievance and appeal rules for Global Commitment for health and for Choices for Care, including the number and types of grievances, internal appeals, and appeals to the human services board, and the number of internal appeals that were reversed by the independent decision-maker.

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 as of July 16, 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 the second report period (January 1, 2008 – June 30, 2008), there were 17 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. Again, approximately half of these grievances related to quality of service. The breakdown of topic areas is in the attached data summary.

The DAIL Choices for Care program does not have a grievance component.

- 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 the second report period (January 1, 2008 – June 30, 2008), there were 34 appeals filed with the MCO, with only one of them receiving an expedited appeal. Of the 34 appeals, 24 were resolved within this reporting period (71%). In twelve cases (50% of those resolved), the original decision was upheld by the hearing officer. There was one case reversed (4%), no cases were modified from the original decision, seven were withdrawn (29%), three were approved as a result of the information received prior to or at the appeal meeting (13%), and one case was closed because the person filing the appeal was not authorized by the beneficiary (4%).

As each appeal was received the grievance and appeal coordinator assigned it to an action category that related to the content of the appeal. There were 25 appeals for a denial or limitation of authorization of a requested service or eligibility for service (74%), seven were for a reduction/suspension/termination of a previously authorized covered service or service plan (20%), and two cases have not had their category entered yet (6%).

During the first report period (July 1, 2007 – December 31, 2007), there were five appeals left pending that were resolved within this reporting period. In four cases (80%), the original decision was upheld by the hearing officer. There were no cases reversed or modified from the original decision, and one was withdrawn (20%).

During the second report period (January 1, 2008 – June 30, 2008), there were 24 appeals filed in the Choices for Care program. There were no requests for an expedited appeal. Of those 24 appeals, none have been resolved within this reporting period. The Choices for Care program also assigns one of the MCO action categories to each appeal, bringing all public health care programs into alignment with one standard process. Of the 24 appeals, 13 were for a denial or limitation of authorization of a requested service or eligibility for service (54%), and 11 were for a reduction/suspension/termination of a previously authorized covered service or service plan (46%).

During the first report period (July 1, 2007 – December 31, 2007), there were six appeals left pending for CFC that were resolved within this reporting period. In four cases (66%), the original decision was upheld by the hearing officer. There was one case reversed (17%), none were modified from the original decision, and one was withdrawn (17%).

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.

During the second report period (January 1, 2008 – June 30, 2008), there were four fair hearings filed for MCO appeal decisions. None of them were resolved this period. There were two fair hearings pending from the last period and both of them were withdrawn. There are still four fair hearings pending at the end of this quarter.

During the second report period (January 1, 2008 – June 30, 2008), there were ten fair hearings filed for the Choices for Care program. One was withdrawn, leaving nine pending. There was one fair hearing pending from the last period that has not been resolved yet. There are still ten total fair hearings pending at the end of this quarter.

Medicaid MCO Legislative Grievance and Appeal Report  
 Data Summary  
 January 1, 2008 – June 30, 2008

 Number of Grievances filed:   17  

## Number by Category:

Staff/Contractor:	<u>  9  </u>
Program Concern:	<u>  2  </u>
Management:	<u>  3  </u>
Policy or Rule Issue:	<u>  4  </u>
Quality of Service:	<u>  5  </u>
Service Accessibility:	<u>  4  </u>
Timeliness of Service Response:	<u>  2  </u>
Service Not Offered/Available:	<u>  5  </u>
Other:	<u>  2  </u>

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

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

 Number of Appeals Filed:   34  

Regular Appeals:	<u>  34  </u>
Expedited (met criteria) Appeals:	<u>  0  </u>

 Number Resolved:   24  

Number Upheld:	<u>  12  </u>
Number Reversed:	<u>  1  </u>
Number Modified:	<u>  0  </u>
Number Withdrawn:	<u>  7  </u>
Number Approved by Dept/DA/SSA:	<u>  3  </u>
"Representative not authorized"	<u>  1  </u>

## From Last Period:

Number Pending: <u>  5  </u>	
Number Upheld:	<u>  4  </u>
Number Reversed:	<u>  0  </u>
Number Modified:	<u>  0  </u>
Number Withdrawn:	<u>  1  </u>
Number Approved by Dept/DA/SSA:	<u>  0  </u>

## Number by "Action" Category:

Denial or limitation of authorization of a requested service or eligibility for service:	<u>  25  </u>
Reduction/suspension/termination of a previously authorized covered service or service plan:	<u>  7  </u>
Denial, in whole or in part, of payment for a covered service:	<u>  0  </u>
Failure to provide clinically indicated covered service when the MCO provider is a DA/SSA:	<u>  0  </u>
Denial of a beneficiary request to obtain covered services outside the network:	<u>  0  </u>
Failure to act in a timely manner when required by state rule:	<u>  0  </u>
Did not answer:	<u>  2  </u>

 Number of Fair Hearings Filed with an Appeal this period:   4  

 From last period:   2  

 Number of Resolved Fair Hearings with an Appeal:   0  

 From Last Period:   2  

Number Upheld:	<u>  0  </u>	Number Upheld:	<u>  0  </u>
Number Reversed:	<u>  0  </u>	Number Reversed:	<u>  0  </u>
Number Modified:	<u>  0  </u>	Number Modified:	<u>  0  </u>
Number Withdrawn:	<u>  0  </u>	Number Withdrawn:	<u>  2  </u>

Total Number of Pending Fair Hearings (all report periods):   4

Choices for Care Legislative Appeal Report  
Data Summary  
January 1, 2008 – June 30, 2008

Number of Appeals Filed: 24

Regular Appeals: 24

Expedited (met criteria) Appeals: 0

Number Resolved: 0

Number Upheld: 0

Number Reversed: 0

Number Modified: 0

Number Withdrawn: 0

Number Approved by Dept/DA/SSA: 0

From Last Period:

Number Pending: 6

Number Upheld: 4

Number Reversed: 1

Number Modified: 0

Number Withdrawn: 1

Number Approved by Dept/DA/SSA: 0

Number by "Action" Category:

Denial or limitation of authorization of a requested service or eligibility for service: 13

Reduction/suspension/termination of a previously authorized covered service or service plan: 11

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 this period: 10

From last period: 1

Number of Resolved Fair Hearings with an Appeal: 1

From Last Period: 0

Number Upheld: 0

Number Upheld: 0

Number Reversed: 0

Number Reversed: 0

Number Modified: 0

Number Modified: 0

Number Withdrawn: 1

Number Withdrawn: 0

Total Number of Pending Fair Hearings (all report periods): 10

**ATTACHMENT 5**  
**QUARTERLY REPORT: April 1, 2008 - June 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 April 1, 2008 through June 30, 2008. This has been a difficult quarter for the HCO for a combination of reasons: continued high call volume, staffing issues, and the rising complexity of the problems we try to address.

We received 316 OVHA-related calls this quarter, down just slightly from 322 last quarter. The number of OVHA calls was similar to past quarters, but once again the total number of all calls was high. Total number of cases, all coverages, was 687 this quarter. This compares to 770 last quarter which was the all time high. Still, 687 is higher than any quarter in 2007. April was the busiest April ever at 235 total calls, May was about average, and June was the third busiest ever at 245.

The first six months of 2008 have been our busiest since the HCO began, at 1457. Previous six month totals were: 1315 (in 2007), 1377 (in 2006, the year Medicare Part D started), 1090 (2005), 1286 (2004), and 1252 (2003). The effect on the Office is cumulative: as we try to work on cases that take longer to resolve, we are constantly dealing with a high volume of new incoming calls. This means Advocate caseloads have been steadily growing larger and larger.

On top of the high call volume, we have had significant staff turnover during the past six months. This quarter we had two new Health Care Advocates start, replacing two people who left the previous quarter. Then our most experienced Advocate left in early June. We are not able to replace him due to funding constraints. Thus, we are now operating with just four Advocates, two of whom are brand new, where previously we had five. In addition, the lag time between staff departure and replacement, and the lengthy training requirements for new Advocates, have created challenges.

To compound our staffing issues, the office no longer has a full time staff attorney. Our full time staff attorney left in October 2007. During the legislative session, which ended early May, we had a half time attorney. We hope to continue to manage with a half time staff attorney, but it is and will be difficult.

Finally, the nature of the calls we must deal with has steadily been changing over the past few years, mainly due to the Medicare Modernization Act (Medicare Part D) and the expansion of Vermont's health care programs (Catamount Health and Premium Assistance). These programs, while expanding coverage for many people, have complex hybrid designs that mean the untangling of related problems can take many phone calls and hours of work. Our database does not track the amount of time we spend on individual cases.

II. Disposition of cases

We closed 286 OVHA cases this quarter.

- 8% (24 calls) of the OVHA calls were resolved in the initial call;
- 64% (182 calls) were resolved by advising or referring the client after analyzing the problem;
- 26% (72 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 316 OVHA cases:

- 26% (81 calls) involved access to care, compared to 26% (85 calls) last quarter;
- 25% (78) involved eligibility issues, up from 21% (67 calls) last quarter;
- 21% (66 calls) involved billing or coverage problems, down from 23% (74 calls) last quarter;
- 3% (9 calls) were coded as OVHA consumer education;
- 26% (81) involved other issues.

#### A. Access to Care

We received 81 OVHA-related access to care calls, down from 85 last quarter.

- 21 calls in this category involved access to prescription drugs, not including Part D calls, compared to 17 calls last quarter;
- 12 calls involved access to specialty care, same as last quarter;
- 8 calls involved access to dental care, down from 13 last quarter;
- the categories of behavioral health, durable medical equipment (DME) and medical supplies, and transportation tied with 5 calls each.

#### B. Billing/Coverage

We received 66 calls in this category, down from 74 last quarter.

- 25 calls involved Medicaid/VHAP managed care billing, compared to 35 last quarter;
- 18 calls involved hospital billing, up from 14 calls last quarter.

#### C. Eligibility

We received 78 calls in this category, up from 67 last quarter.

- 40 calls involved Medicaid eligibility, compared to 37 last quarter;
- 15 calls involved VHAP, up from 12 last quarter;

- 5 involved Catamount Health and Premium Assistance. However, these cases are sometimes difficult to categorize and 39 of these eligibility cases showed up in our “all cases/all coverages” statistics. Last quarter we reported 9 of these cases as OVHA cases, when we had 48 of these coming up in our “all cases/all coverages” stats.

D. Medicare Part D/Prescription Drug Problems

- 39 calls involved Medicare Part D or VPharm, in the OVHA statistics, compared to 45 last quarter.
- 60 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 65 last quarter.

IV. Uninsured Callers

In addition to the 316 OVHA callers, the HCO received an additional 47 calls from uninsured individuals, slightly down from the 50 calls last quarter. We discussed Catamount Health and Premium Assistance with many of these callers as well, but they weren't coded as OVHA callers.

State of Vermont - Office of Vermont Health Access  
 Summary Listing - MCO Investments  
 State Fiscal Year 2008: draft

Dept.	Investment Description	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	Encourage the formation and maintenance of public-private partnerships in health care
Department of Education	School Health Services		●		
BISHCA	Health Care Administration	●		●	●
VITL	Vermont Information Technology Leaders			●	●
VVH	Vermont Veterans Home		●		
Vermont State Colleges	Health Professional Training		●		
University of Vermont Medical School	Vermont Physician Training		●		
VDH	Emergency Medical Services		●	●	
VDH	TB Medical Services		●		
VDH	Epidemiology			●	
VDH	Health Research and Statistics	●	●		
VDH	Health Laboratory			●	
VDH	Tobacco Cessation			●	
VDH	Family Planning		●	●	
VDH	Physician/Dentist Loan Repayment Program		●	●	
VDH	Renal Disease		●		
VDH	Newborn Screening		●	●	
VDH	WIC Coverage		●	●	
VDH	Substance Abuse Treatment		●		
VDH	Recovery Centers		●		
VDH	Maple Leaf		●		
VDH	Grace House		●		
VDH	Vermont Blueprint for Health		●		●
VDH	Vermont Area Health Education Centers		●	●	●
VDH	Community Clinics	●	●		
VDH	FQHC Lookalike			●	●
VDH	Patient Safety			●	●
VDH	CHAMPPS		●		
DMH	Emergency Mental Health for Children and Adults		●	●	
DMH	Respite Services for Youth with SED and their Families		●		
DMH	Special Payments for Medical Services		●		
DMH	MH Outpatient Services for Adults		●		
DMH	Mental Health Elder Care		●		
DMH	Mental Health Consumer Support Programs		●		●
DMH	Mental Health CRT Community Support Services		●		
DMH	Mental Health Children's Community Services		●		
DMH	CRT Staff Secure Transportation		●		
DMH	Peer Supports - FUTURES		●		
DMH	Recovery Housing		●		
OVHA	Buy-In	●	●		
OVHA	HIV Drug Coverage		●		
OVHA	Civil Union	●	●		
DCF	Family Infant Toddler Program			●	
DCF	Medical Services		●		
DCF	Residential Care for Youth/Substitute Care		●		
DCF	Aid to the Aged, Blind and Disabled CCL Level III		●		
DCF	Aid to the Aged, Blind and Disabled Res Care Level III		●		
DCF	Aid to the Aged, Blind and Disabled Res Care Level IV		●		
DCF	Essential Person Program		●		
DCF	GA Medical Expenses		●		
DCF	VCRHYP		●		
DDAIL	Mobility Training/Other Svcs.-Elderly Visually Impaired		●		
DDAIL	DS Special Payments for Medical Services		●		
DDAIL	Flexible Family/Respite Funding		●		
DDAIL	Quality Review of Home Health Agencies		●	●	●
DDAIL	Caregiver Registry		●	●	
DOC	Return House		●		
DOC	Intensive Substance Abuse Program (ISAP)		●		
DOC	Intensive Sexual Abuse Program		●		
DOC	Intensive Domestic Violence Program		●		
DOC	Women's Health Program (Tapestry)		●		
DOC	Community Rehabilitative Care		●		

DEPARTMENT OF HEALTH & HUMAN SERVICES  
Centers for Medicare & Medicaid Services  
7500 Security Boulevard, Mail Stop S2-26-12  
Baltimore, Maryland 21244-1850



Center for Medicaid and State Operations

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Mr. Joshua Slen  
Director-Office of Health Access  
Department of Social Welfare  
Agency of Human Services  
312 Hurricane Lane, Suite 201  
Williston, VT 05495

Dear Mr. Slen,

We are in receipt of Vermont's new Medicaid Managed Care Quality Strategy dated June 5, 2008 which, we are advised, has been through your State's public comment process. CMS has reviewed the Strategy thoroughly and we are pleased to advise you that it is approved.

CMS commends you on your innovative and thoughtful Strategy and your commitment to assuring the quality of care provided to your State's Medicaid beneficiaries. It has been a pleasure working with your very capable staff.

Sincerely,

/s/

Gary Jackson  
Division of Quality, Evaluation, and Health Outcomes  
Center for Medicaid and State Operations

cc: Shawn Skaflestad