State of Vermont
Agency of Human Services

Global Commitment to Health
11-W-00194/1

Section 1115
Demonstration Year: 9b
(1/1/2014 – 12/31/2014)

Quarterly Report for the period
October 1, 2014 – December 31, 2014

Submitted Via Email on February 27, 2015

Table of Contents

I. Background and Introduction 3
II. Enrollment Information and Counts 6
III. Outreach Activities 6
IV. Operational/Policy Developments/Issues 7
V. Expenditure Containment Initiatives 9
VI. Financial/Budget Neutrality Development/Issues 23
VII. Member Month Reporting 24
VIII. Consumer Issues 25
IX. Quality Improvement 26
X. Compliance 29
XI. Demonstration Evaluation 30
XII. Reported Purposes for Capitated Revenue Expenditures 30
XIII. Enclosures/Attachments 31
XIV. State Contact(s) 31

I. Background and Introduction

The Global Commitment to Health is a Demonstration Waiver authorized pursuant to Section 1115(a) by the Centers for Medicare and Medicaid Services (CMS), within the Department of Health and Human Services (HHS).

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 1989 implementation 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 (CHIP) 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); the 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 converted the (then Office) Department of Vermont Health Access (DVHA), the state's Medicaid organization, to a public Managed Care Entity (MCE). The Agency of Human Services (AHS) pays the MCE 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).

The Global Commitment provides Vermont 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 also requires interdepartmental collaboration and reinforces consistency across programs.

An extension effective January 1, 2011, was granted and included modifications based on the following amendments: 2006 - inclusion of Catamount Health to fill gaps in coverage for Vermonters by providing a health services delivery model for uninsured individuals; 2007 - a component of the Catamount program was added enabling the State to provide a premium subsidy to Vermonters who had been without health insurance coverage for a year or more, have income at or below 200 percent of the Federal Poverty Level (FPL), and who do not have access to cost effective employer-sponsored insurance, as determined by the State; 2009 - CMS processed an amendment allowing the State to extend coverage to Vermonters at or below 300 percent of the FPL; 2011 - inclusion of a palliative care program for children who are at or below 300 percent of the FPL, and have been diagnosed with life limiting illnesses that would preclude them from reaching adulthood. This program allows children to receive curative and palliative care services such as expressive therapy, care coordination, family training and respite for caregivers.

In 2012, CMS processed a cost-sharing amendment providing the authority for the State to eliminate the $75 inpatient co-pay and to implement nominal co-pays for the Vermont Health Access Plan (VHAP).

In 2013, CMS approved Vermont's Waiver Renewal for the period from October 2, 2013-December 31, 2016. AHS and DVHA have been working closely with Vermont's Medicaid Fiscal Agent HP to support all ACA reporting requirements, including identification of those services reimbursed at a different Federal match rate and in support of the revised MEG bucketing effective with the latest STC package.

In 2013, CMS approved Vermont's correspondence, dated November 19, 2013, which requested authorization for expenditure authority for the period from January 1, 2014-April 30, 2014, to ensure temporary coverage for individuals previously eligible and enrolled as of December 31, 2013, in coverage through VHAP, Catamount Premium Assistance, and pharmacy assistance under Medicaid demonstration project authority.

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 fourth quarterly report for waiver year 9b, covering the period from October 1, 2014 through December 31, 2014 (QE1214).***

i. *Global Commitment to Health Waiver: Renewal*

The Global Commitment Waiver renewal process was started in February 2013 with the commencement of the public process conducted pursuant to 42 CFR 431.408: the public comment period was from February 14 through March 22, 2013. On February 13, the draft *Global Commitment to Health* Waiver Renewal Request, the public notice, and executive summary of the draft, were posted online. Materials were available on the following websites: DVHA, the Agency of Human Services, the Agency of Administration Health Care Reform home pages. Also, the draft was distributed simultaneously to the Medicaid and Exchange Advisory Board, the committees of jurisdiction in the Vermont legislature, the DAIL Advisory Board, Department of Children and Families (DCF) District Offices, Dual Eligible Demonstration Stakeholders, DMH, VDH and other external stakeholders as well as internal management teams from across AHS.

On February 14, 2013, a public notice was published in the Burlington Free Press noticing the availability of the draft renewal request, two public hearing dates, the online website, and the deadline for submission of written comments with contact information. Additionally, all district offices of the Department for Children and Families' Economic Services Division, the division responsible for health care eligibility had notice posted and proposal copies available, if requested. The Burlington Free Press is the state's newspaper with the largest statewide distribution and paid subscriptions. Between February 16-20, additional public notices were published in Vermont's other newspapers of record, including the Valley News, The Caledonian Record, St. Albans Messenger, Addison Independent, The Bennington Banner, Newport Daily Express, The Islander, Herald of Randolph, and the News and Citizen. This distribution list represents all geographic regions of the state.

On March 1, 2013, a public notice and link to the renewal documents was included on the banner page for Vermont's Medicaid provider network.

The State posted a comprehensive description of the draft waiver request on February 13, 2013 on the

above-cited websites. The document included: program description, goals and objectives; a description of the beneficiary groups that will be impacted by the demonstration; the proposed health delivery system and benefit and cost-sharing requirements impacted by the demonstration; estimated increases or decreases in enrollment and in expenditures; the hypothesis and evaluation parameters of the proposal; and the specific waiver and expenditure authorities it is seeking. In addition to the draft posted for public comment, an Executive Summary and the PowerPoint presentation used during each public hearing was also posted to the same state websites noted above.

The State convened to two public hearing on the Global Commitment to Health 1115 Waiver renewal request.

On February 19, 2013, a public hearing was held using videoconferencing at Vermont Interactive Television (VIT) sites in Bennington, Brattleboro, Johnson, Lyndonville, Middlebury, Newport, Randolph Center, Rutland, Springfield, St. Albans, White River Junction, Montpelier, and originating in Williston.

On March 11, 2013, a public hearing was held during the Medicaid and Exchange Advisory Board meeting in Winooski, with teleconferencing available for individuals who could not attend in person.

On March 14, 2013, an informational presentation (with a question/answer period), was given at the Department of Disabilities, Aging, and Independent Living (DAIL) Advisory Board meeting in Berlin, Vermont.

The comment period concluded on March 23, 2013; the AHS compiled and considered the comments and questions received, made changes to the waiver renewal document as appropriate, generated responses to the comments/questions and made the document publicly available.

The AHS submitted its waiver renewal request to the HHS Secretary on April 23, 2013: the request packet included the transmittal letter, public notice, renewal request including budget neutrality documents, interim evaluation plan, and a summary of the Choices for Care Waiver. On May 17, 2013, AHS submitted an updated waiver renewal request with the evaluation plan.

AHS received CMS approval of its Waiver renewal request effective as of October 2, 2013. The approval allows Vermont to sustain and improve its ability to provide coverage, affordability, and access to health care by making changes that conform to the new coverage opportunities created under the Affordable Care Act, such as adoption of the new adult group in the Medicaid State Plan, and the authority to provide hospice care concurrently with curative therapy for adults.

CMS and AHS continue to collaborate on review of Vermont’s requests related to use of modified adjusted gross income (MAGI) for MAGI exempt beneficiaries.

AHS and CMS came to successful resolution regarding Vermont’s waiver consolidation request, to move the Choices for Care demonstration under the Global Commitment 1115 waiver, with a final effective date of January 30, 2015. AHS notes that CHIP consolidation remains an outstanding issue that will require focus during renewal discussions for 1/1/2017.

II. Enrollment Information and Counts

Key updates from QE1214:
- No enrollment fluctuations >5% seen in any of the Demonstration Populations.

Table 1 presents point-in-time enrollment information and counts for Demonstration Populations for the Global Commitment to Health Waiver during the first quarter of federal fiscal year (FFY) 2015. Due to the nature of the Medicaid program, beneficiaries may become retroactively eligible and may move between eligibility groups within a given quarter or after the end of a quarter. Additionally, since the Global Commitment to Health Waiver involves most of the State's Medicaid program, Medicaid eligibility and enrollment in Global Commitment are synonymous, with the exceptions of the Choices for Care Waiver and the Children's Health Insurance Program (CHIP).

Table 1 is populated based on reports run the Monday after the last day of the quarter, in this case on January 5, 2015. Results yielding ≤5% fluctuation from quarter to quarter are considered as illustrating normal deviations reflecting retroactive eligibility determinations and expected terminations. Results reflecting >5% fluctuation between quarters are reviewed by staff from DVHA and AHS to provide further detail and explanation of the changes in enrollment. The explanation of any substantial fluctuations observed in Demonstration Populations during QE1214 would be in Section VII: Member Month Reporting. During this quarter, there were no substantial enrollment fluctuations >5% seen in any of the Demonstration Populations.

Table 1. Enrollment Information and Counts for Demonstration Populations*, QE1214

Demonstration Population	Current Enrollees Last Day of Qtr 12/31/2014	Previously Reported Enrollees Last Day of Qtr 9/30/2014	Percent Variance 9/30/2014 to 12/31/2014	Variance by Enrollee Count 9/30/2014 to 12/31/2014
Demonstration Population 1:	95,490	96,272	-0.81%	(782)
Demonstration Population 2:	54,255	54,779	-0.96%	(524)
Demonstration Population 3:	11,187	11,289	-0.90%	(102)
Demonstration Population 4:	N/A	N/A	N/A	-
Demonstration Population 5:	2,080	2,145	-3.03%	(65)
Demonstration Population 6:	0	0	0.00%	0
Demonstration Population 7:	0	0	0.00%	0
Demonstration Population 8:	9,752	9,707	0.46%	45
Demonstration Population 9:	2,466	2,453	0.53%	13
Demonstration Population 10:	N/A	N/A	N/A	-
Demonstration Population 11:	0	0	0.00%	0
	175,230	176,645	-0.80%	

* Demonstration Population counts are person counts, not member months.

III. Outreach Activities

i. Member Relations

Key updates from QE1214:

- A banner reminding providers of waiting time standards and access to care requirements was published.
- Member handbooks are currently under review.
- The annual Green Mountain Care Member Newsletter is being drafted and will include plan renewal information.
- The Medicaid and Exchange Advisory Board met three times this quarter.

The Provider and Member Relations (PMR) Unit is responsible for member relations, outreach and communication, including the GreenMountainCare.org member website. The PMR Unit ensures an adequate network of providers, enrolls providers, manages the provider network, and has responsibility for the Medicaid Non-Emergency Medical Transportation Program.

A banner reminding primary care providers of case management, waiting time standards and access to care requirements was published on November 28. The banner includes information on the following:

- Requirements for 24-hour/seven days-per-week coverage that will assure practitioner availability in person or by phone.
- Requirements of office-visiting hours at least four days per week for at least twenty-five hours per week.
- Appointment waiting time standards as set out in the Medicaid Rule, including immediate access to emergency care.
- Standard waiting times for non-emergent care.

Member handbooks are currently under review to address clarifications that will assist members in understanding their Medicaid coverage and benefits.

The publication of the Green Mountain Care Member Newsletter, scheduled for Spring 2015, is planned to communicate health care renewal update information for all members, along with health and preventative care information.

The Medicaid and Exchange Advosory Board (MEAB) held meetings on October 20, November 10 and December 8. Agendas and minutes are publicly posted at http://gmcboard.vermont.gov/meetings.

IV. Operational/Policy Developments/Issues

In December 2014, the DVHA Policy Unit transitioned to AHS Central Office in order to more effectively serve as a resource for all Medicaid policy issues throughout all Agency departments.

i. Vermont Health Connect

Key updates from QE1214:

- During calendar year (CY) 2014, more than 115,000 Vermonters used Vermont Health Connect to enroll into coverage for at least part of the year. The Household Health Insurance Survey announced this month that Vermont's uninsured rate was cut nearly in half over the past two years. The 3.7% rate puts Vermont second in the nation in health insurance coverage.
- Due to issues with successfully transitioning Medicaid renewals from the State's legacy ACCESS system to the Marketplace, VHC has temporarily halted these renewals. Vermont has submitted a renewals and verification plan to CMS and is working with federal partners to finalize the approach. 2015 verifications are targeted to begin in January, and Medicaid renewals will begin in April.
- VHC opened for 2015 enrollment on November 15, and is continuing to process renewals.
- New enrollments are coming in ahead of projections.

Vermont Health Connect's second open enrollment period for qualified health plans (QHPs) kicked off on November 15, 2014 and will close on Sunday, February 15, 2015. Vermonters who are new to the Marketplace began signing up for 2015 health coverage, while existing QHP customers requested changes or auto-renewed for 2015 coverage. As of December 31, a total of 23,356 renewing individuals have been checked out into 2015 health plans. In addition, 6,881 individuals who were new to VHC checked out a plan. Nearly three out of five (58%) of these new applicants qualified for Medicaid or Dr. Dynasaur.

VHC's expected renewal pool is limited to the 38,704 individuals who are either enrolled in QHPs or else are members of a mixed household (households with both QHP and Medicaid members). The State received permission from CMS to delay renewals for Medicaid-only households until automated Change of Circumstance (CoC) functionality is delivered in April. Vermonters who are eligible for Medicaid or Dr. Dynasaur and those who experience a qualifying event—such as having a baby, getting married or losing their prior insurance—continued to be enrolled in 2014 coverage through November and December.

Customer Service Representatives continued to receive calls from Vermonters who qualify to be covered for the final weeks of 2014 and provided guidance on next steps to ensure that they recieved this coverage as promptly as possible. Due to continued functional constraints, Vermont Health Connect worked with insurance carriers to facilitate direct enrollment for these individuals. VHC maintains responsibility for determining eligibility for benefits and financial help and remains the system of record for individual and family customers.

VHC continued to utilize Optum agents to augment manual processes throughout QE1214. The State ramped up to a high of 170 Optum agents in October and November to process both the backlog of Change of Circumstance requests and VHC renewals. Due to the complexity of the remaining manual work, the State decided to reduce its pool of contract resources to 30 highly trained Optum agents beginning December 31st. These agents will continue to process remaining renewals, as well as assist the State in keeping the 2015 CoC backlog at manageable levels. The State continues to pursue a contract with Optum for systems integrator (SI) delivery and deployment for FFY 2015. This first major deployment is scheduled for April 30 and will include renewal functionality and automated processing of CoCs.

Maximus continues to manage the VHC Customer Support Center (call center), currently utilizing 90 customer service representatives. The call center serves Vermonters enrolled in both public and private health insurance coverage, providing Level 1 call center support, which includes phone applications, payment, and basic coverage questions. Maximus is also the entry point for individuals requiring greater levels of assistance with case resolution. They transfer calls to the State's Health Access Eligibility Unit for resolution and log service requests, which are escalated to the appropriate resolver group. Throughout QE1214, the system's performance continued to be stable and operated as expected. The Customer Support Center managed incoming call volume, receiving more than 106,000 calls over the quarter and answering more than nine out of ten calls (93%) in less than 30 seconds.

V. Expenditure Containment Initiatives

i. Medicaid Shared Savings Program

Key updates from QE1214:

- As of November, 47,000 Medicaid beneficiaries are attributed to two Accountable Care Organizations (ACOs) through the Vermont Medicaid Shared Savings Program (VMSSP).
- Selected additional quality measures to be included in the VMSSP in year two.
- Selected additional cost categories to be included as optional in the VMSSP Total Cost of Care (TCOC) in exchange for enhanced sharing rate; ACOs to decide on optional track by December 31, 2014.

The Vermont Medicaid Shared Savings Program (VMSSP) is a three-year program to test if the accountable care organization (ACO) models in Vermont can meet the Triple Aim goals of improving health and quality while also reducing cost. In a shared savings program, the provider network allows the State to track total costs and quality of care for the patients it serves, in exchange for the opportunity to share in any savings achieved through better care management. This program is supported by a State Innovation Model (SIM) testing grant and overseen by the Green Mountain Care Board (GMCB) and the Agency of Human Services (AHS). Vermont Medicaid is currently working toward an approval from CMS for a State Plan Amendment for the VMSSP.

Contracts were signed between Vermont Medicaid and the two participating ACOs in February 2014 with a retrospective year-one performance period starting on January 1, 2014. Eligible Medicaid beneficiaries are attributed to one of two ACOs in Vermont, OneCare Vermont (OCVT) and Community Health Accountable Care (CHAC), based on their relationship with their primary care provider (PCP). The ACOs vary in terms of geographic spread and patient mix—OCVT is statewide, includes both the University of Vermont Medical Center and Dartmouth Hitchcock Medical Center and has a larger presence in Vermont's urban areas, while CHAC is FQHC-based (Federally Qualified Health Center) and includes more rural practice sites.

In its first year, the VMSSP began ramping up its implementation activities, including:

- Notifying beneficiaries of their providers' participation in the shared savings program and providing them with the opportunity to opt out of having their claims data shared between DVHA and the ACOs; beneficiaries had the option of calling the ACO's call center, the Department of Vermont Health Access's dedicated call center line, or the Office of the Health Care Advocate for assistance related to the notifications.

- Notifying all newly attributed beneficiaries through a quarterly mailing process.
- Sharing claims data with OCVT and CHAC on a monthly basis, beginning in August 2014 and October 2014 respectively.

Beneficiary attribution in the VMSSP continues to increase as new providers are added to participating ACO entities, with over 880 providers participating in the program, resulting in 47,000 total beneficiaries attributed—approximately 27,000 lives in OCVT and 20,000 lives in CHAC.

In the VMSSP program, performance on quality measures plays a role in determining the final shared savings rate and amount. Quality measure selection is done through a multi-stakeholder process under the SIM grant, known as the Vermont Health Care Innovation Project (VHCIP). A key milestone in year-one is that the stakeholders recommended and voted to pass new measures for year-two of the VMSSP program. The additional measures set will include two payment measures, one additional measure each for reporting and monitoring/evaluation, as well as some reclassification of measures between the monitoring/evaluation and reporting categories.

Over the course of the three-year program, the VMSSP seeks to expand the scope of accountability in care to go beyond traditional medical services. This expansion aims to include pharmacy, non-emergency transportation, long term care services and supports, mental health and substance abuse services, and other social services that are commonly sought by Medicaid beneficiaries. In year-two of the VMSSP, there is an optional track where the ACOs that elect to take on Total Cost of Care (TCOC) expansion in year-two of VMSSP would receive an increase in shared savings percentage—from 50% to 60%. DVHA selected pharmacy and non-emergency medical transportation as the two additional services to be included in the year-two TCOC. ACOs were notified of this option, and the deadline for participating in this track is 12/31/14.

In the coming year, VMSSP staff will be focusing on the expansion of the quality measure set and TCOC for year-three, and will also work closely with the analytics team to study the outcomes of the first year.

ii. Vermont Chronic Care Initiative (VCCI)

Key updates from QE1214:

- The Enterprise Medicaid Management Information Systems/Care Management review process concluded with a successful vendor selection.
- DVHA, VCCI and IT leaders met with APS Healthcare to review and discuss the DVHA-APS data transition plan requirements to support successful on-boarding of the new MMIS Care Management vendor and to ensure continuity of VCCI business operations.
- VCCI and OneCare Vermont, co-presented to joint staff on the Medicaid ACO contract and opportunities for collaboration to ensure integration and referral requirements for high cost/risk members, without service redundancy. A leadership meeting to vet recommendations into year-two ACO contracts is scheduled for early QE0315.
- DVHA leadership initiated bi-weekly meetings between the VCCI and the Blueprint for Health to ensure collaboration administratively and locally toward integrated models of care. This will include VCCI participation on local 'Regional Clinical Planning Committees' and data driven intervention strategies with internal and contracted partners (i.e. ACOs).

The goal of the VCCI is to improve health outcomes of Medicaid beneficiaries by addressing the

increasing prevalence of chronic illness through various support and care management strategies. Specifically, the program is designed to identify and assist Medicaid members 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 VCCI uses a holistic approach of evaluating and supporting improvement in medical and behavioral health, as well as socioeconomic issues that are often barriers to sustained health improvement. Medicaid members that are eligible for the VCCI account for the top 5% of service utilization, or are on a trajectory to become 'super-utilizers' of services. The VCCI's strategy of embedding staff in high-volume hospitals and primary care sites continues to support population engagement at the point-of-need in areas of high service utilization. By targeting predicted high-cost members, resources can be allocated to areas representing the greatest opportunities for clinical improvement and cost savings.

The VCCI had expanded the embedded staffing model with licensed staff in high volume Medicaid primary care sites and hospitals that experience high rates of ambulatory care sensitive (ACS) Emergency Department (ED) visits and inpatient admissions/readmissions. The VCCI remains embedded in 6 primary care practice sites and 2 hospitals, and it is continuing to collaborate with hospital partners to expand on-site staffing. The VCCI will continue collaborating with provider/hospital network partners to enhance the number of participating hospitals providing File Transfer Protocol (FTP) data feeds.

The VCCI supplemented its embedded model with a nurse 'liaison' model, given space constraints at provider and hospital sites. All 14 hospitals have a designated VCCI staff 'liaison' assigned who will meet regularly with hospital case managers to support the reduction of ACS ED utilization and support transitions from inpatient to outpatient care to avoid 30-day readmission rates. Liaisons will also meet with large Medicaid practices to support referrals and communication on high risk/high cost members. These efforts will facilitate communication and support mutual goals of the VCCI and Medicaid ACO partners.

The VCCI believes that the embedded approach offers several advantages, and it hopes that the liaison role may garner similar benefits. First, it fosters strong provider relationships and direct referral for high-risk populations. Second, it encourages 'real time' case findings at the point-of-service within PCP and hospital sites to assist in reducing hospital readmission rates in high-risk populations. The VCCI has access to hospital data on inpatient and ED admissions through data sharing from partner hospitals (via secure FTP site transfers). While the VCCI currently receives electronic data from 5 partner hospitals, the goal is to have electronic census data from all hospitals in FFY 2015. While some hospitals have not supported these strategies in the past, the advent of Medicaid ACOs may help facilitate new relationships based on common goals and financial incentives. Third, the embedded staffing model provides an opportunity for enhanced coordination and care transitions with hospital partners and primary care sites, as well as with home health agencies that may be delivering skilled nursing care post-discharge. This enhanced service coordination is a goal of the VHCIP Care Management and Care Models (CMCM) workgroup, which is launching an integrated care management learning collaborative in 3 pilot locations—Rutland, Burlington and St. Johnsbury—starting in QE0315.

Due to their Medicaid knowledge and case management experience, VCCI nurse care managers have

been frequently hired by partners of the VCCI, and at a higher pay scale than provided by the State. The VCCI is continuing to work with senior DVHA leadership, and an AHS leadership team is currently assessing a market factor adjustment for nursing positions to support both recruitment and retention. This is targeted for completion prior to QE0615 and would be implemented in QE0915.

The VCCI remains strategically aligned with the Blueprint for Health, which is further described in *Section V.iii*.

High Risk Pregnancy Care Management (Pregnancy Care Connection):
The VCCI launched its initial pilot program for the High Risk Pregnancy (HRP) Case Management service in October 2013. While strides were made, the clinical team recommended that 2 registered nurses (RNs) were not indicated as a centralized resource, and a better model to support clinical and quality goals could be achieved via one HRP expert functioning as a liaison with other state and community partners and as an expert consultant to the VCCI field staff receiving high risk pregnancy referrals. Subsequently, one high risk pregnancy position was converted into a field based nurse case manager. In QE1214 the VCCI successfully recruited and hired a high risk pregnancy nurse with experience in labor and delivery as well as neonatal intensive care. This combination of knowledge and skill makes this candidate a unique member of the team as she understands both the risks as well as results of these risks on the newborn. This skilled paractitioner is scheduled to join the VCCI in QE0315. Data supports the opportunity to positively impact pregnancy outcomes for high risk women, particularly those with mental health and substance use/abuse diagnoses.

APS Contract:
APS Healthcare provides several services to support the VCCI, including supplemental professional staffing and data analytics. APS Healthcare delivers enhanced information technology and sophisticated decision-support tools to assist case management staff in doing outreach to the most costly and complex beneficiaries. Additionally, APS Healthcare provides supplemental population-based reports on gaps in care to PCPs, which support ACO providers and case managers working with patients who are considered high utilizers and/or at risk to become so.

In 2011, the VCCI implemented a combination of individual- and population-based strategies for disease management, with a primary focus on the top 5% of beneficiaries accounting for the highest service utilization. That same year, DVHA's contract with APS Healthcare was 100% risk-based with a guaranteed 2:1 return on investment (ROI). In state fiscal year (SFY) 2012, the VCCI delivered a net $11.5 million ROI, which included both the APS and DVHA staff efforts. In SFY 2013, the VCCI significantly exceeded its 2012 results, with a $23.5 million net savings over anticipated expense for this population. Consistent with these results, the VCCI demonstrated a 17% reduction in ACS ED usage, a 37 % reduction in ACS hospitalizations, and a 34% reduction in 30-day readmission rates among the top 5% of members. SFY 2013 was the first year that it was feasible to conduct a comparative analysis on the top 5% of members. Results for SFY 2014—the last year of a fully risk based contract with APS—are pending the 6 month claim run out and will be available in the QE0315 report.

To assure continuity of the VCCI business operations during the Medicaid Management Information Systems (MMIS)/Care Management (CM) procurement process, the DVHA extended its contract with APS Healthcare through June 30, 2015. This was to allow for a thoughtful procurement, contracting and onboarding process. APS did not submit a bid in response to the MMIS/CM request for proposals (RFP). A formal transition plan and related discussions on data requirements has been initiated between APS and DVHA staff. Challenges with APS staffing continue, given the impending

termination of the contract. The data reporting specialist assigned to the VCCI since contract inception tendered her resignation, as did the full time data analyst.

There were no Provider Health Registries (PHRs) developed/released this quarter; however a coronary artery disease (CAD) PHR is scheduled for dissemination in early QE0315 due to several APS data challenges limiting capacity to deliver this tool in QE1214.

Activities supported by APS in QE1214 include:

- Collaboration on the 'data transition' plan required to support data migration to the new CM vendor and prevent interruption of VCCI services to Medicaid members.
- A flu vaccine mailing was completed and disseminated.
- A 'healthy eating during the holidays' mailing was sent to high risk members with CAD, diabetes, congestive heart failure and chronic obstructive pulmonary disease.
- A targeted pharmacy mailing to support improvement in medication adherence.
- Average VCCI caseload (DVHA/APS): 732; unique members: 443, or roughly 25% of VCCI's annual goal of 2000 members.

iii. Blueprint for Health

The Blueprint for Health is described in statute as "*a program for integrating a system of health care for patients, improving the health of the overall population, and improving control over health care costs by promoting health maintenance, prevention, and care coordination and management.*[1]"

The Blueprint program works with practices, hospitals, health centers, and other stakeholders to implement a statewide health service model in Vermont. The model includes advanced primary care in the form of patient centered medical homes (PCMHs), multi-disciplinary support services in the form of community health teams (CHTs), a network of self-management support programs, comparative reporting from statewide data systems, and activities focused on continuous improvement (Learning Health System). The program is intended to ensure that all citizens have access to high quality primary care and preventive health services and to establish a foundation for a high value health system in Vermont.

Current Operations:
As of December 2014, there are 124 primary care practices are operating in Vermont as patient centered medical homes (PCMHs) supported by multi-disciplinary community health teams (CHTs). In this program, each practice is scored against the National Committee for Quality Assurance Patient Centered Medical Home (NCQA PCMH) recognition program standards for high quality patient centered care.

Community health teams provide medical home patients with more direct and unhindered access to diverse staff such as nurse coordinators, social workers, counselors, dieticians, health educators, and others.

Medical homes and CHT staff are intended to strengthen network interactions with a larger array of medical and non-medical providers in their community and to help people link more seamlessly with the services they need. The implementation and expansion of the model has been supported with a

[1] 18 VSA Chapter 13.

locally organized transformation infrastructure including program managers, CHT leaders, practice facilitators, multi-stakeholder workgroups, and shared learning forums.

Key design principles of the model include: local leadership and organization; consistent statewide quality standards (NCQA PCMH) and measurement of performance against those standards; close coordination between primary care, CHT staff, and community based services; and an emphasis on prevention, improved control of established health problems, and healthier lifestyles.

Hub and Spoke Initiative:

Key updates from QE1214:

- The Hub and Spoke program has established statewide operations, and caseload expansion has begun to slow; serving 2,542 Vermonters as of December 30, 2014.
- The programmatic enhancement of allowing Hubs to also dispense buprenorphine continues to be important with 823 Hub patients receiving buprenorphine as of the end of calendar year 2014.
- The Chittenden Center Hub program formally submitted an application to the National Committee for Quality Assurance for recognition under the Patient-Centered Specialty Practice program.
- A new series of Learning Collaboratives for Spoke practices began this quarter. Twenty-seven practices are sending teams to the in-person events, are reporting on common measures and sharing quality improvement initiatives.
- A series of four webinars for the entire Hub and Spoke provider network has begun, with the first topic, management of Hepatitis C, completed.
- The Spoke staff and practices are actively using a web-based platform (Basecamp) to share information, post documents, and develop discussions on topics of interest to the community.

As part of the Blueprint, the Hub and Spoke Initiative creates a framework for integrating treatment services for opioid addiction. This Initiative represents AHS and DVHA's efforts, referred to as the Alliance for Opioid Addiction, to collaborate with community providers to create a coordinated, systemic response to the complex issues of opioid addictions in Vermont. The Hub and Spoke Initiative is focused on beneficiaries receiving Medication-Assisted Treatment (MAT) for opioid addiction. MAT is the use of medications, in combination with counseling and behavioral therapies, to provide a whole patient approach to the treatment of substance use disorders. The two primary medications used to treat opioid dependence are methadone and buprenorphine. Buprenorphine is typically prescribed by specially licensed physicians in a medical office setting, and methadone is provided only in specialty opioid treatment programs. Both of these treatment regimens are associated with substantial service fragmentation as providers are not well integrated into the larger health care and mental health care systems.

As part of the Initiative, five regional Hubs were established, which build upon the existing methadone opioid treatment programs, and provide buprenorphine treatment to a subset of clinically complex patients (Table 2). These Hubs serve as the regional consultants and subject matter experts on opioid dependence and treatment. Hubs are replacing episodic care based exclusively on addiction illness with comprehensive health care and continuity of services.

In addition to Hubs, Spoke staff is embedded directly in the prescribing practices to allow more direct

access for patients to mental health and addiction services, promote continuity of care and support the provision of multidisciplinary team care. Spoke staff provide service free of cost to patients receiving MAT. Spokes include a physician prescribing buprenorphine in office-based opioid treatment and the collaborating health and addictions professionals who monitor adherence to treatment; coordinate access to recovery supports and community services; and provide counseling, contingency management, care coordination and case management services. Registered nurses and licensed addictions/mental health clinicians, who are part of the Blueprint CHTs, also provide support to the Spoke providers and their patients receiving MAT.

For updates from QE1214, please see the above “Key Updates.” Blueprint practice facilitators continue to work extensively with Hub and Spoke providers on common measurement, practice-level quality improvement, and implementation of evidence-based care. In addition, the practice facilitators are working with the Hub programs on preparing to meet the NCQA Patient-Centered Specialty Practice standards. This will further align these specialty addictions programs with the PCMH primary care providers.

Spoke staffing is scaled at 1 registered nurse and 1 licensed clinician for every 100 patients receiving MAT. The following tables present the caseloads of regional Hubs and Spoke staffing as of December 2014.

Table 2. Hub Caseload: December 30, 2014

Region (Counties in Vermont)	Start Date (Month/Year)	Total Number of Clients (Buprenorphine and Methadone)	Number of Clients Receiving Buprenorphine	Number of Clients Receiving Methadone
Chittenden, Franklin, Grand Isle & Addison	1/2013	945	287	658
Washington, Lamoille, Orange	7/2013	275	116	159
Windsor, Windham	7/2013	455	145	310
Rutland, Bennington	11/2013	399	157	242
Essex, Orleans, Caledonia	1/2014	468	118	350
Total		**2542**	**823**	**1719**

Table 3. Spoke Staffing: December 2014

Region	Providers Serving 10 or more Medicaid Beneficiaries	Staff FTE Funding	Staff FTE Hired	Medicaid Beneficiaries
Bennington	6	4.5	2.4	207
St. Albans	6	6.5	4.8	307
Rutland	5	5.0	3.1	242

Chittenden	14	8.0	8.2	392
Brattleboro	9	4.5	4.5	217
Springfield	1	1.5	1.5	56
Windsor	3	2.5	2.0	112
Randolph	3	2.0	1.8	100
Barre	7	5.5*	4.5	238
Lamoille	4	3.0	3.6	131
Newport & St Johnsbury	3	2.0	1.0	93
Addison	1	1.5*	1.5	30
Upper Valley	1	0	.5	7
Total	**62**	**47**	**39**	**2,132**

iv. Behavioral Health

Key updates from QE1214:

- Established clinical criteria for authorization of applied behavioral analysis services.
- Authorization of opioid replacement therapy was transitioned to Goold Health Systems.

The DVHA behavioral health team offers a comprehensive approach for behavioral health care coordination. The team is responsible for concurrent review and authorization of inpatient psychiatric and detox services for Medicaid primary beneficiaries. The team works closely with discharge planners at the inpatient facilities to ensure timely and appropriate discharge plans. The team authorizes payment for opioid treatment medications and coordinates its MAT efforts with the Hub and Spoke Initiative, the VCCI, and the Pharmacy Unit to provide beneficiary oversight and outreach. The team also manages the Team Care Program (lock-in) for Medicaid beneficiaries.

During this quarter, the new Autism Specialist developed the utilization process for authorization of applied behavioral analysis (ABA) services. Staff researched and chose a clinical criteria set for authorizations. Work continued on the development of outcome measures for these services, developing a provider manual, researching best practices, and creating ABA tools within the electronic record-keeping system. Staff worked with the AHS Medicaid Policy Unit on the upcoming State Plan Amendment submission.

The behavioral health staff continued to collaborate with the Department of Mental Health in performing concurrent review and authorization for all inpatient psychiatric and detoxification services. Staff throughout the unit were provided an orientation to the Team Care program as part of the transition of this responsibility to all staff. In the next quarter, the Team Care program components (i.e. criteria, documentation process, etc.) will be reviewed and updated. A dedicated phone line for Team Care beneficiaries will be available by January 2015.

Team members continued to facilitate authorization of opioid replacement medications, while transitioning this responsibility to Goold Health Systems is slated to begin January 1, 2015. Team members also continue to work closely with the Vermont Department of Health's Alcohol and Drug Abuse Program (ADAP) around the Hub and Spoke system of care. Working with ADAP, team

members developed policies regarding lab services in the Hubs and have drafted criteria for authorization of buprenorphine over 16mg.

v. Pharmacy and 340B Drug Discount Program

Key updates from QE1214:

- Vermont has realized $465,290.82 net cost savings for this reporting period and year-to-date net cost savings of $1,096,054.10 through Medicaid participation of a relatively small number of eligible covered entities.

The 340B Drug Pricing Program resulted from enactment of the Veterans Health Care Act of 1992, which is codified as Section 340B of the Public Health Service Act. The 340B Drug Pricing Program is a federal program managed by the Health Resources and Services Administration (HRSA), Office of Pharmacy Affairs. Section 340B requires drug manufacturers to provide outpatient drugs to eligible health care centers, clinics and hospitals (termed "covered entities") at a significantly reduced price. The 340B price is a "ceiling price," meaning it is the highest price that the covered entity would have to pay for select outpatient and over-the-counter drugs and the minimum savings that the manufacturer must provide to covered entities. The 340B ceiling price is at least as low as the price that state Medicaid agencies currently pay for select drugs. Participation in the program results in significant savings estimated to be 20% to 50% on the cost of outpatient drug purchases for 340B covered entities. The purpose of the 340B Program is to enable these entities to stretch scarce federal resources, reach more eligible patients, and provide more comprehensive services.

Only federally designated covered entities are eligible to purchase at 340B pricing, and only patients of record of those covered entities may have prescriptions filled by a 340B pharmacy.

Covered entities can utilize contract pharmacy services under a "ship to-bill to" arrangement where the covered entity retains legal title of the drugs purchased under 340B and has their drugs shipped to the contract pharmacy. The covered entity retains legal title to all drugs purchased under 340B and must pay for all 340B drugs. The contract pharmacy is subject to audits to identify and prevent diversion and/or duplicate discounts (accessing the 340B discount and Medicaid rebate on the same drug).

Vermont has made substantial progress in expanding 340B availability since 2005. This expansion was aided by federal approval of the statewide 340B network infrastructure, which is operated by five federally qualified health centers (FQHCs) in Vermont. In 2010, DVHA aggressively pursued enrollment of 340B covered entities made newly eligible by the ACA and as a result of the Challenges for Change legislation passed in Vermont. As of October 2011, all but two Vermont hospitals and some of their owned practices were eligible for participation in 340B as covered entities.

DVHA expanded its 340B program to encourage enrollment of both existing and newly eligible entities within Vermont and to encourage covered entities to include Medicaid in their 340B programs. In 2012, the DVHA received federal approval for a Medicaid pricing 340B methodology. To encourage participation in the Vermont Medicaid 340B program, providers receive an incentive payment (described below). The methodology for the 340B incentive payment is the lesser of 10% of the total Medicaid savings or $3 per claim for non-compound drugs and $30 per claim for compound drugs. Claims are paid at the regular rates, and a

monthly true-up process calculates the 340B acquisition cost, dispensing fees, savings, and what is owed back to the State with payments due 30 days after the invoices are mailed. DVHA continues to encourage Medicaid enrollment with the goal of enrolling all eligible and HRSA-enrolled covered entities in Vermont.

In Vermont, the following entities participate in the 340B Program. **Boldfaced** entities also participate in Medicaid's 340B initiative (although this is not an exhaustive list of entities enrolled in Medicaid's 340B initiative):

- Vermont Department of Health, for the AIDS Medication Assistance Program, Sexually-Transmitted Disease Drugs Programs, and Tuberculosis Program; all of these programs are specifically allowed under federal law.
- **Planned Parenthood of Northern New England's Vermont clinics**
- **Vermont's FQHCs**, operating 41 health center sites statewide
- **Brattleboro Memorial Hospital**
- **Central Vermont Medical Center**
- Copley Hospital
- **University of Vermont Medical Center and its outpatient pharmacies**
- Gifford Hospital
- Grace Cottage Hospital
- **Indian Stream Health Center (New Hampshire)**
- North Country Hospital
- Northeastern Vermont Regional Hospital
- Notch Pharmacy
- Porter Hospital
- Rutland Regional Medical Center
- **Springfield Hospital**

340B Reimbursement and Calculation of Incentive Payment:
DVHA identified the following goals in establishing its proposed 340B reimbursement methodology:

- Reduce Medicaid program expenditures;
- Encourage broad participation in the 340B program, thereby increasing potential savings to the Medicaid program;
- Acknowledge that 340B pharmacies will be covering their operating costs solely through the dispensing fee, since acquisition cost savings essentially are "passed through" to the Medicaid program; and
- Recognize pharmacies' additional administrative costs related to 340B inventory management and reporting.

Vermont researched available resources regarding pharmacy dispensing costs, which included consultation with local pharmacists. Vermont determined that a reasonable estimate of pharmacy dispensing costs falls in the range of $12.00 to $15.00 per prescription. DVHA also determined that pharmacies' additional costs associated with 340B program management would equal $3.00 per prescription. Therefore, Vermont determined that a reasonable 340B dispensing fee would range from $15.00 to $18.00 per prescription. Vermont's proposed reimbursement methodology established a flat rate payment at the low end of this range ($15.00) and presents the opportunity, subject to demonstrated Medicaid program savings, for entities to share in Medicaid savings.

Because of federal laws prohibiting “duplicate discounts” on Medicaid drug pricing related to the interaction of 340B and manufacturer rebate programs, Medicaid participation in 340B has been limited both in Vermont and nationally. Vermont put in place an innovative, first in the nation, methodology to maximize Medicaid participation in 340B pricing for Medicaid beneficiaries served by eligible prescribers at 340B-enrolled covered entities. Using the Global Commitment authority, the DVHA provides incentive payments to providers for their 340B participation that recognizes the additional administrative burden of the program. Because of the beneficial 340B pricing, both Vermont and CMS benefit from higher rates of 340B covered entity-employed prescribers and Medicaid beneficiary participation in the program.

For the reporting period, Vermont has realized $465,290.82 net cost savings and year-to-date net cost savings of $1,096,054.10 through Medicaid participation of a relatively small number of eligible covered entities.

v. Mental Health System of Care

The Department of Mental Health (DMH) is continuing its Post-Irene work to build capacity within the inpatient and outpatient systems; expand quality and evaluation activities; and improve transitions of care. During this quarter, fourteen Level I beds at the Brattleboro Retreat and 7 Level I beds at Rutland Regional Medical Center were fully operational, and the Vermont Psychiatric Care Hospital (VPCH) operated at close to full capacity. DMH expects VPCH to be operating at its full capacity of 25 beds in the next quarter. DMH also anticipates that Soteria-Vermont (see below) will be begin accepting admissions in the next quarter. With the completion of these two final milestones, all of the psychiatric beds conceptualized and funded[2] through Act 79 will be operational.

An overview of psychiatric beds in the system of care Pre-Irene and projected through the end of SFY 2015 was outlined in the 2015 Department of Mental Health (DMH) Act 79 report and follows below.

Chart One: Psychiatric Beds in the System of Care (below)

[2] Act 79 authorized an additional 15 intensive residential recovery beds in northwestern Vermont, but there was not adaquete funding in the state budget to develop these beds.

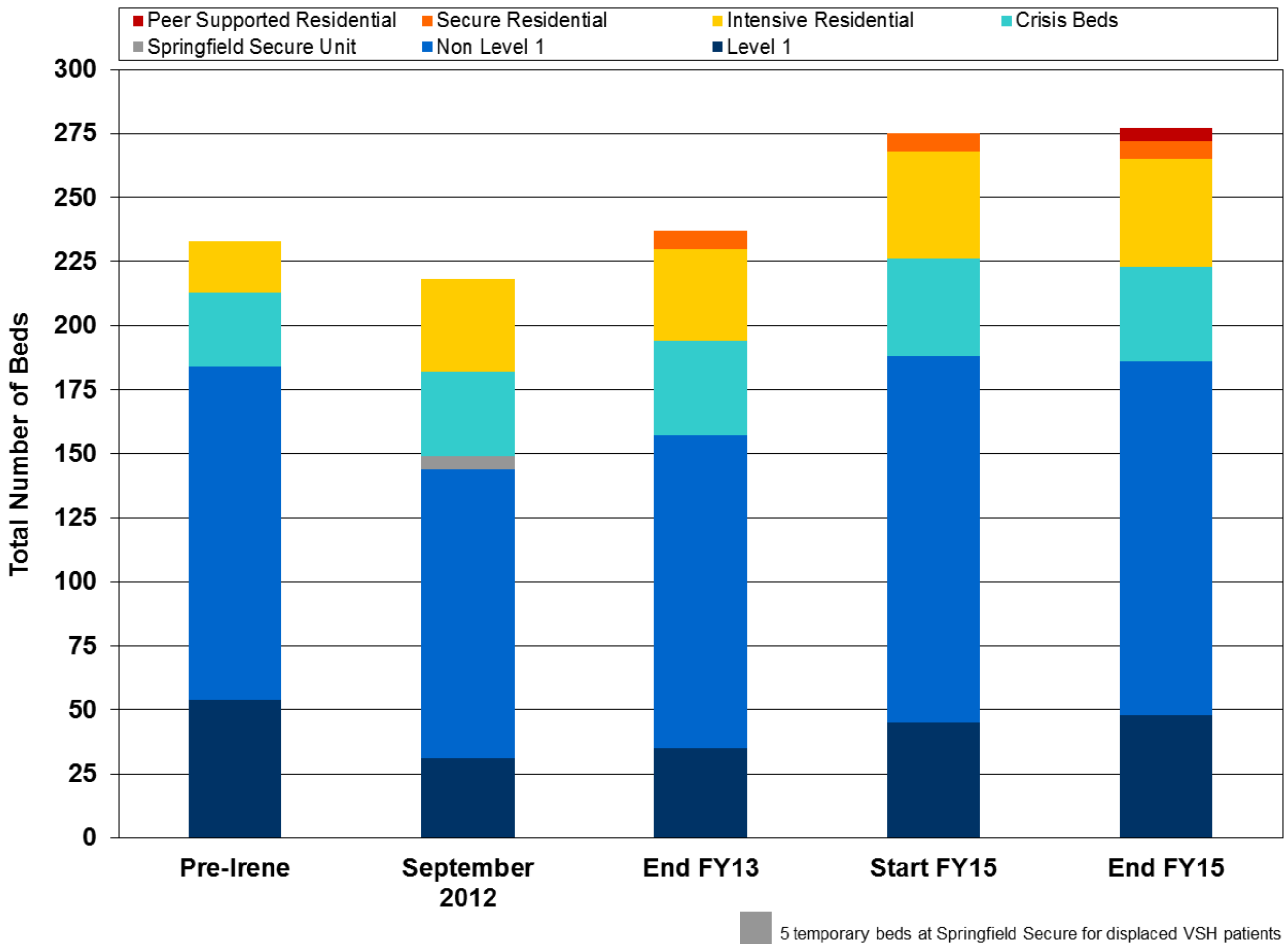

Chart 1 shows the changes in available psychiatric placements since August 2011. The total number of inpatient beds in the system at the start of SFY 2015 was 275. These include inpatient psychiatric treatment beds, residential treatment programs, crisis beds and peer–supported placements for transition.

Soteria-Vermont will be the last of the facilities conceptualized in Act 79 (and funded by the legislature) to open. The building is currently being renovated to accommodate a five-bed residence located in Burlington's Old North End. Soteria will offer a supportive environment for individuals going through an early experience of psychosis, will practice a cautious and limited use of psychoactive medications, and will provide a safe, flexible, empowering, home-like environment. Soteria-Vermont development is coming down the home stretch in terms of meeting its obligations for policies and procedures, accessible design, staffing, licensing, and a Certificate of Occupancy from the City of Burlington. Job postings have begun, and Soteria is purchasing furniture and household goods, office equipment and a house vehicle. An Open House will be planned for March of 2015.

At this time, demand for inpatient care still exceeds current capacity with some frequency. This is disruptive to the emergency care setting and not a standard that the department regards as adequate for individuals requiring inpatient care. To address this ongoing issue, DMH is continuing to monitor the functioning of the clinical resource management system to "coordinate the movement of individuals to

appropriate services throughout the continuum of care and to perform ongoing evaluations and improvements of the mental health system," as written in Act 79. This system encompasses the following functions:

- Departmental Clinical Care Managers provide assistance to crisis services clinicians in the field, Designated Agency case managers, and Designated Hospital social workers to link individuals with the appropriate level of care and services as well as acting as a bridging team for discharge planning from hospital inpatient care to community care;
- Departmental Clinical Care Managers provide support to Designated Agencies and monitor care to individuals on Orders of Non-Hospitalization (ONH);
- An electronic bed board to track available bed space is updated regularly to enable close to real time access to information for individuals needing inpatient treatment, residential treatment or crisis services;
- Patient transport services that are least restrictive have been developed and are coordinated through Admissions and Central Office;
- Supervision by law enforcement for individuals in Emergency Departments on Emergency Examination status who are awaiting admission to a Designated Hospital is ongoing and coordinated through the Department;
- Review and approval of intensive residential care bed placement within a no-refusal system;
- Access by individuals to a mental health patient representative;
- Periodic review of individuals' clinical progress.

With improvements to these care management and transition planning functions, in addition to VPCH and Soteria-VT becoming fully operational, the Department expects that pressure will be alleviated in the numbers of patients waiting for admission and the lengths of time they may spend in Emergency Departments or the Department of Corrections.

Community System Development:
Act 79 authorized significant investments in a more robust publicly funded mental health services system for Vermont. SFY 2014 and 2015 funding supported the implementation of service expansion in several support and services areas that will offer a stronger continuum of care for the public mental health system. Each new initiative carries reporting requirements to inform the Department of Mental Health (DMH) regarding overall contribution to the system of care and impacts to persons served. A full report of Act 79 funded initiatives and early outcomes was submitted to the Vermont Legislature on January 15, 2015. The report provides an overview of the significant program development areas and preliminary data collection and outcomes findings and can be found at: http://mentalhealth.vermont.gov/sites/dmh/files/report/legislative/2015-ACT79_Final_1-15-15.pdf.

Vermont's enhancement of community services was also highlighted this quarter at the Department of Mental Health's fall conference entitled *Challenges, Opportunities, and Future Directions of Vermont's Adult Mental Health System.* The conference featured 17 workshops focused on many different programs, services and innovations that have been implemented following Tropical Storm Irene, representing an investment in enhanced community and inpatient programming. As expressed by Commissioner Paul Dupre during his opening remarks, the conference demonstrated how much the system of care has changed over the last three years and the importance of how these new and enhanced programs need to work together to actively reduce and prevent the need for hospitalization. Vermont no longer has a large, centralized state hospital and we must change the way we do business to ensure this new capacity fully achieves the vision that was laid out in Act 79.

Integrated Family Services (IFS) Initiative:

The AHS continues to act on opportunities to improve quality and access to care, within existing budgets, using managed care flexibilities and payment reforms available under 42 CFR 438 and the Global Commitment (GC) waiver. This includes such items as: integration of administrative structures for programs serving the same or similar populations; opportunities to increase access to services by decreasing administrative burdens on providers; reviewing pre-GC waiver operations to determine if separate administrative and Medicaid reimbursement structures can be streamlined under GC. Several such projects have emerged in the Children's and EPSDT service area.

Specifically, children's Medicaid services are administered across the IGA partners so work continues to enhance integration. Programs historically evolved separate and distinct from each other with varying Medicaid waivers, procedures and rules for managing sub-specialty populations. These were the best approaches available at the time; however the artifacts of this history are multiple and fragmented funding streams, policies, and guidelines. Often the same provider and family will be captive to varied and conflicting procedures, reporting and eligibility requirements. With the inception of the Global Commitment and other changes at the federal level these siloed structures no longer need to exist. Global Commitment has allowed for one overarching regulatory structure (42 CFR 438) and one universal early periodic screening diagnostic and treatment (EPSDT) continuum. This allows for efficient, effective, and coordination with other federal mandates such as Title V, IDEA part B and C, Title IV-E, Federal early childhood programs and others.

The IFS Initiative seeks to bring all AHS children, youth and family services together in an integrated and consistent continuum of services for families. The premise being that giving families early support, education and intervention will produce more favorable health outcomes at a lower cost than the current practice of *waiting until circumstances are bad enough* to access funding which often result in treatment programs that are out of home or out of state. Several efforts are underway and include: performance based reimbursement projects, capitated annual budgets and flexible choices for self-managed services. Each of these is described in brief below. This integration is an ongoing process that is evolving into a very positive direction for children and families.

Annual Aggregate Budgets and PMPM for Medicaid Children's MH and Family Support Services:
The initial IFS pilot, in Addison County has finished the second full state fiscal year and we have started the second pilot region in Franklin/Grand Isle counties on April 1, 2014. The initial pilot included consolidation of over 30 state and federal funding streams into one unified whole through one master grant agreement; the second pilot also includes consolidation of several state and federal funding streams. The state has created an annual aggregate spending cap for two providers in Addison and one in Franklin/Grand Isle (this provider houses the Designated Agency and Parent Child Center). This has created a seamless system of care to ensure no duplication of services for children (prenatal to 22) and families. For Addison, the aggregate annual budget for this pilot is approximately $4M with $3M being Global Commitment covered services, and in Franklin/Grand Isle the Global Commitment covered services are near $5.4M. The pilot successes are:

- Increased ability to provide the right services to children and their families more immediately.
- Increased ability to provide services in a child's natural setting.
- Increased ability to work with a variety of providers and bring resources together to support families.

- Reduction in separate and conflicting paperwork having a positive impact on the number of hours clinicians can spend on direct services.
- A more immediate response to families who ask for help who, prior to this pilot, were “not sick enough” to meet funding criteria.
- Unified local efforts to offer a single onsite response to families combining multiple state and federal programs that would otherwise be offered at differing times and places.
- Initial numbers indicate an ability to serve more children and families with the same amount of resources.

The financial model supporting this agreement includes a monthly PMPM rate established for the reimbursement of all Medicaid-covered sub-specialty services. Member month rates are based on agreed upon annual allocations for covered services divided by the minimum Medicaid caseload expectation. The same member month rates will be paid for minimal service packages as for intensive service packages. The goal of the funding model is to ensure that beneficiaries get a package of early periodic screening diagnostic and treatment and outreach services commensurate with their functional needs within an overall annual aggregate reimbursement cap. PMPM/Case rates are not based on any one group of services being “loaded” into a claim; they are global aggregate budget/minimum caseload. Annually, providers and the state will reconcile actual financial experience to the grant.

This shift continues to be addressed both programmatically and financially. There is a review of the method used to establish the PMPM to see if there is a more effective method.

The interest in moving statewide continues. Changes in leadership at the AHS Secretary’s office and in IFS has led to a series of strategic planning activities over the past several months designed to establish clearer and broadly agreed upon population level indicators and service performance measures which grantee program accountability. IFS staff have attended meetings in four additional communities to talk about the vision for IFS and the process for communities to move toward integrated funding. Clear expansion criteria are in development and comprehensive governance agreement terms are also being refined. Additionally, IFS continues to work on statewide healthcare reform and aligning approaches to achieve an integrated behavioral health and physical health system.

VI. Financial/Budget Neutrality Development/Issues

Effective with the January 1, 2011 waiver renewal, AHS began paying DVHA a monthly PMPM estimate using the existing rates on file, in accordance with the new Special Terms and Conditions. This monthly payment reflects the State’s monthly need for Federal funds based on estimated Global Commitment expenditures for the month. Beginning with the QE0311 filing, AHS has reconciled the Federal claims from the estimated monthly PMPM payments to the underlying actual Global Commitment expenditures incurred via the usual reconciliation draw process on a quarterly basis.

In mid-October 2014, a group comprised of representatives from AHS, DVHA, State of Vermont Finance & Management, and the Legislative Joint Fiscal Committee, met to forecast GC enrollment for the remainder of SFY 2015 and the upcoming SFY 2016 budget cycle. These forecasts are essential to building both the SFY appropriations request, as well as the quarterly CMS-37 estimates.

In early October 2014, AHS received a final draft report of the PMPM rate development from contracted actuarial firm, Milliman. For FFY 2015, Milliman developed two sets of rates: one set to be used as if there were no changes to the GC Waiver, and another set to be used if the GC and Choices

for Care Waivers were combined. Per the STCs, a copy of this actuarial report was sent to CMS in November 2014.

Throughout this quarter, AHS and CMS were involved in negotiations to combine the GC and Choices for Care Waiver. As part of this negotiation, AHS was asked to answer a set of Standard Funding Questions. AHS continues to work with CMS on providing detailed answers to these questions.

AHS has worked with DVHA and CMS throughout QE1214 to ensure all the new reporting requirements per the October 2, 2013 STCs are met. The State's eligibility system has faced some difficulty with accurate beneficiary coding post-ACA implementation; AHS and DVHA are currently working through issues with the Eligibility Services unit to ensure enrollees are properly bucketed in the proper MEGs. The State is working to institute a permanent automated solution.

VII. Member Month Reporting

Key updates from QE1214:

- Minor fluctuations in enrollment led to an overall decrease in enrollment of 0.80%.

Demonstration Populations are not synonymous with Medicaid Eligibility Group (MEG) reporting in Table 5. The numbers presented in the following table may represent duplicated population counts. For example, an individual in Demonstration Population 4, which is home and community-based services, and Demonstration Population 10 may in fact be in MEG 1 or 2.

This report is run the first Monday following the close of the month for all persons eligible as of the 15th day of the preceding month. Data reported in Table 4 are not used in Budget Neutrality Calculations or Capitation Payments, as information will change at the end of the quarter. The information in this table cannot be summed across quarters. All payments are adjusted at the end of the year to reconcile expected population movement between eligibility groups. The monthly totals for each of the last four quarters are reflected in Table 4.

Table 4. Number of Recipients, by Month

	QE0314			QE0614			QE0914			QE1214		
Demonstration Population	**Jan. 2014**	**Feb. 2014**	**March 2014**	**April 2014**	**May 2014**	**June 2014**	**July 2014**	**August 2014**	**Sept. 2014**	**Oct. 2014**	**Nov. 2014**	**Dec. 2014**
Demonstration Population 1	86,074	87,603	89,867	95,507	92,966	95,001	94,779	95,436	96,272	96,985	97,466	95,490
Demonstration Population 2	45,826	46,190	46,617	48,661	47,914	51,961	53,001	53,984	54,779	55,698	56,358	54,255
Demonstration Population 3	13,485	13,627	13,780	12,280	11,466	11,718	11,682	11,169	11,289	11,502	11,567	11,187
Demonstration Population 4	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Demonstration Population 5	1,103	1,155	1,208	1,639	1,716	1,990	2,017	2,074	2,145	2,187	2,212	2,080
Demonstration Population 6	2,175	1,857	1,585	0	0	0	0	0	0	0	0	0
Demonstration Population 7	2,379	2,021	1,743	11	1	1	2	2	0	2	0	0
Demonstration Population 8	10,168	10,203	10,130	9,963	10,027	9,894	9,832	9,797	9,707	9,755	9,677	9,752
Demonstration Population 9	2,607	2,588	2,581	2,546	2,557	2,496	2,471	2,470	2,453	2,475	2,432	2,466
Demonstration	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

led to demonstrated performance improvements, notable strengths, and commendable and impressive outcomes across multiple areas and performance indicators.

X. Compliance

Key updates from QE1214:

- DVHA's final EQRO audit report was released; the overall compliance score improved to 92% during this year's cycle.
- DVHA implemented a corrective action plan to address the EQRO required actions. All corrections will be complete by March 2015.
- The Compliance Committee will expand to include all AHS Managed Care Compliance issues. The committee will be co-chaired by leaders from AHS and DVHA.

The Managed Care Compliance program is responsible for ensuring that managed care operations are in compliance with all governing policies, regulations, agreements and statutes. This is accomplished through audits and corrective actions coordinated by the Managed Care Compliance Committee. This work is coordinated across AHS through Intergovenmental Agreements (IGAs) with the departments involved in managed care programs.

EQRO Audit Results:
In October 2015, DVHA received the final report of the EQRO compliance audit. The EQRO reviewed DVHA's performance related to 93 elements across the eight standards. Of the 93 requirements, DVHA obtained a score of *Met* for 79 of the requirements and a score of *Partially Met* for 14 elements. As a result, DVHA obtained a total percentage of compliance score of 92 percent across the applicable elements. With scores at or above 90 percent in seven of the eight standard areas reviewed, DVHA demonstrated numerous performance strengths in meeting the federal structure and operations regulations and AHS contract requirements. Four of the seven standards indicated significant areas of strength, with scores of 100 percent. For the only standard area with a score below 90 percent—Beneficiary Information—DVHA scored *Partially Met* on eight of the 20 evaluation elements and, therefore, has targeted opportunities for improvement in those areas. DVHA's performance represented improvement compared to its overall performance for the EQRO's 2010–2011 review of the same standards. For that review, DVHA scored 90 percent across the eight standard areas as compared to 92 percent this year. All but one standard area either maintained the previous high performance or improved. The score for only one standard declined from the previous review—Beneficiary Information.

The audit focused on the following standards:

I. Provider Selection
II. Credentialing and Re-credentialing of providers
III. Beneficiary Information
IV. Beneficiary Rights
V. Confidentiality
VI. Grievance System—Beneficiary Grievances
VII. Grievance System—Beneficiary Appeals and State Fair Hearings
VIII. Subcontractual Relationships and Delegation

In their final report, the auditors noted that:

"*It was clear from the review of DVHA's documentation, organizational structure, and staff responses*

during the interviews that DVHA staff members were passionate about providing quality, accessible, timely care and services to members and regularly went well beyond the minimum required to ensure that they took care of the members and adequately responded to their needs, while complying with the applicable CMS and AHS requirements related to this year's compliance review activity. It was also clear that, during the year, AHS and DVHA initiated numerous new, or enhanced existing projects and programs, designed to both improve member care and access to quality, accessible, and timely services."

The audit identified several areas requiring corrective action, including:

- The Member Handbook needs to do a better job of describing confidentiality practices.
- DVHA needs to inform members that they can choose to disenroll from Medicaid/Dr. Dynasaur if they no longer want coverage.
- The Member Handbook should inform members about the appeal rights given to providers.
- Members should be informed that post-emergency stabilization services are covered, even if the hospital providing the care is not already an enrolled Vermont Medicaid provider.
- The Provider Manual needs to include information about the provider's obligation to assist during a member's appeal or fair hearing.
- DVHA needs to more consistently define the term "action" as it relates to appeals and fair hearings.
- One of DVHA's IGA partners will need to more carefully adhere to notice and decision timelines for appeals.
- DVHA and AHS need to better define what is meant by "reconsideration" and make sure this definition complies with the grievance and appeals requirements.

DVHA has a corrective action plan in place and it is anticipated that all of these corrections will be completed by March 2015.

Compliance Committee Expansion:
DVHA's Compliance Committee will expand to include all AHS Managed Care Compliance needs. This expansion will allow the State to more efficiently handle compliance issues with a broader focus across the Agency. The meetings will be chaired by leaders from AHS and DVHA.

XI. Demonstration Evaluation

During this quarter, the AHS QIM reviewed the status of the Global Commitment evaluation plan results and provided an update on its results. Highlights included the following: increased average enrollment, decrease in Vermont's uninsured rate, and improvement on numerous HEDIS and CHAPS quality measures. In anticipation of the Global Commitment and Choices for Care waiver consolidation, the AHS QIM also reviewed the status of the Choices for Care evaluation plan and provided an update on its results. Highlights included the following: increased ability to serve participants in the community, elimination of waiting lists for high needs group participants, decrease in the number of applicants waiting for eligibility and financial determination, as well as improvement on numerous consumer satisfaction measures. In addition to improved beneficiary experience, cost control initiatives under both waivers have proven very successful. Also during this quarter, the AHS QIM continued to be involved in the Vermont SIM grant evaluation design and planning.

XII. Reported Purposes for Capitated Revenue Expenditures

Provided that DVHA'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 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, health status and the quality of life for uninsured, underinsured and Medicaid-eligible individuals in Vermont; and
- Encourage the formation and maintenance of public-private partnerships in health care, including initiatives to support and improve the health care delivery system.

Attachment 6 is a summary of Managed Care Entity Investments, with applicable category identified, for SFY 2014.

XIII. Enclosures/Attachments

Attachment 1: Budget Neutrality Workbook

Attachment 2: Enrollment and Expenditures Report

Attachment 3: Complaints Received by Health Access Member Services

Attachment 4: Medicaid Managed Care Entity Grievance and Appeal Reports

Attachment 5: Office of the Health Care Advocate Report

Attachment 6: State Fiscal Year 2014 Managed Care Entity Investments

XIV. State Contact(s)

Fiscal:	Sarah Clark, CFO	
	VT Agency of Human Services	802-871-3005 (P)
	208 Hurricane Lane	802-871-3001 (F)
	Williston, VT 05495	sarah.clark@state.vt.us
Policy/Program:	Monica Light, Director	
	AHS Health Care Operations, Compliance, and Improvement	
	VT Agency of Human Services	802-871-3254 (P)
	208 Hurricane Lane	802-871-3001 (F)
	Williston, VT 05495	monica.light@state.vt.us
Managed Care Entity:	Steven M. Costantino, Commissioner	
	Department of VT Health Access	802-879-5901 (P)
	312 Hurricane Lane, Suite 201	802-879-5952 (F)
	Williston, VT 05495	steven.costantino@state.vt.us

Date Submitted to CMS: February 27, 2015

ATTACHMENTS