State of Vermont
Agency of Human Services

Global Commitment to Health
11-W-00194/1

Annual Report
for FFY 09
October 1, 2008 to September 30, 2009

Submitted via email on
April 28, 2010

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I. 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 Entity (MCE). AHS will pay 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). A Global Commitment to Health Waiver Amendment, approved October 31st 2007 by CMS, allows Vermont to implement the Catamount Health Premium Subsidy Program with the corresponding commercial Catamount Health Program (implemented by state statute October 1, 2007). The Catamount Plan is a new health insurance product offered in cooperation with Blue Cross Blue Shield of Vermont and MVP Health Care. It provides comprehensive, quality health coverage at a reasonable cost no matter how much an individual earns. The intent of this program is to reduce the number of uninsured citizens of Vermont. Subsidies are available to those who fall at or below 300% of the federal poverty level (FPL). During this reporting period, 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 an annual report. This is the report for the fourth waiver year, fiscal year 2009, which ended on September 31, 2009.

II. Highlights and Accomplishments

MCE Work Plan & Requirements:

As a Managed Care Entity (MCE), the OVHA must adhere to federal rules contained in 42 CFR 438 for Medicaid MCOs. During the first two waiver years the AHS and OVHA completed almost all activities in its initial work plan to ensure compliance with federal regulations. During year three the Agency of Human Services (AHS) contracted with Health Services Advisory Group (HSAG) to conduct an external independent review of the quality outcomes and timeliness of, and access to, care furnished by the State's Managed Care Entity (MCE) to its Medicaid enrollees.

The scope of the external quality review in Year 4 consisted of the following activities:

- Review of compliance with structural and operational standards. HSAG conducted a review to determine the MCE's compliance with eight specific State-required standards identified by AHS. The eight standards included requirements associated with federal Medicaid managed care structure and operations standards found at 42 CFR 438.214-438.230;
- Validation of performance measures. HSAG validated the performance measures required by AHS to evaluate the accuracy of the performance measures reported by the MCE. The validation also determined the extent to which Medicaid-specific performance measures calculated by the MCE followed specifications established by AHS; and
- Validation of performance improvement projects (PIPs). HSAG reviewed the MCE's PIP to ensure that it designed, conducted, and reported on the project in a methodologically sound manner, allowing real improvements in care and services and giving confidence in the reported improvements.

Summary of the external quality review findings are as follows:

- Review of compliance with Structural and Operations Standards. HSAG conducted the review using the guidelines set forth in the February 11, 2003, CMS Protocol, *Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs): A Protocol for Determining Compliance With Medicaid Managed Care Proposed Regulations at 42 CFR Parts 400, 430, et al.* Overall MCE compliance with the Managed Care Standards was **84 percent**. For two of the eight standards HSAG reviewed (i.e., Provider Selection and Subcontractual Relationships & Delegations), the MCE received overall percentage of compliance scores of 94 percent or above, with provider selection receiving a score of 100 percent. Scores for three additional standards (i.e., Appeals & State Fair Hearings, Enrollee Information, and Enrollee Grievances) received scores of 88 percent, 83 percent, and 81 percent respectively. Standards evaluating credentialing & recredentialing and confidentiality each received a score of 75 percent. The final standard, Enrollee Rights, received the lowest score (i.e., 50 percent) across the standards reviewed;
- Validation of performance measures. HSAG validated a set of six performance measures required by AHS and calculated by the MCE. HSAG conducted the validation activities as outlined in the CMS publication, *Validating Performance Measures: A Protocol for Use in Conducting External Quality Review Activities*, Final Protocol, Version 1.0, May 1, 2002 (CMS Performance Measure Validation Protocol). The performance measure specifications identified by AHS were a modified version of selected HEDIS 2007 measures. All six measures were assigned a validation finding of **fully compliant** with AHS specifications; and

- Validation of performance improvement projects (PIPs). HSAG conducted a validation of the *Fostering Healthy Families* PIP. The validation was conducted in a manner that was consistent with the CMS Protocol (*Validating Performance Improvement Projects: A Protocol for Use in Conducting Medicaid External Quality Review Activities*, final protocol, Version 1.0, May 1, 2002) and covered steps I through IV, namely review of the selected study topic, the study question(s), the selected study indicator(s), and the identification of the study population. The validation results indicated an **overall score of 100 percent** across all evaluation elements and a finding of high confidence in the result of the PIP for steps I-IV, generally referred to as the study design phase of a PIP.

Status of Vermont Health Reform Initiatives:

Access to affordable health care is a critical component of our reform efforts. Individuals who are unable to access affordable health insurance are less likely to receive appropriate primary and preventive care. When uninsured individuals' health care needs become complex and costly, the health care system and the Vermont Medicaid program bear the cost of care. The Demonstration and the public managed care model serve as the foundation for Vermont's statewide health care reform initiatives.

Starting with Acts 190 and 191 (Acts Relating to Health Care Affordability for Vermonters) and augmented by Acts 70 and 71 in 2007 and Acts 203 and 204 in 2008, Governor Douglas and the Vermont Legislature have worked across party lines to facilitate broad-based reform, designed to simultaneously achieve the following three goals:

- Increase access to affordable health insurance for all Vermonters
- Improve quality of care across the lifespan
- Contain health care costs

Entering 2009 with over 60 active (or completed) reform initiatives, projects and programs, statewide reform is well under way to improve, refine, and transform the health care delivery system, improve quality of care, expand access to coverage, and improve system performance.

Vermont is making steady strides in covering its uninsured. Between November 2007 and September 2009, over 24,500 more Vermonters enrolled in health care programs offered through Green Mountain Care, the state's family of comprehensive health coverage programs for the uninsured. As of December 2008, Vermont's uninsured rate has fallen from 9.8% of those living without health insurance to 7.6%.

Other aspects of the state's comprehensive health care reform efforts include the following:

- Starting in July 2008, Vermont launched the Blueprint multi-payer Integrated Medical Home Pilots in three areas of the state and continued the successes of the statewide Healthy Living self-management classes for people with chronic conditions. The MCE is a participant in these pilots.
- Vermont is collaborating with Maine, New Hampshire, Massachusetts and Rhode Island, with support from the Milbank Foundation, to develop a New England-wide medical home pilot initiative.
- During 2008, Vermont implemented a Health Information Technology Fee to support health care information technology for primary care providers and to further a statewide health information exchange network.

- In addition, Vermont:
  - ✓ Implemented a 340B Pharmacy program to decrease the pharmaceutical cost for FQHC patients;
  - ✓ Initiated an information technology project that makes patient medication history data available to providers in approved hospital emergency departments;
  - ✓ Made significant progress on public health and prevention efforts related to promoting healthy weight for Vermonters;
  - ✓ Promulgated rules to allow Vermont health insurance carriers to offer cost sharing discounts for enrollee adherence to health promotion and disease prevention programs, as well as rules to facilitate the availability of transparent price and quality information for health care consumers;
  - ✓ Initiated its implementation of a multi-payer claims database to facilitate understanding of our health care utilization, expenditures, and performance across all payers and services; and
  - ✓ Implemented an outreach tracking tool to further assist our Green Mountain Care enrollment efforts.
- Vermont is participating in two external two-year evaluations (funded by the Robert Wood Johnson Foundation) regarding the success of our efforts to improve access and affordability for health care coverage.

The Director of OVHA now has responsibility for assuring that Vermont's comprehensive health care reform initiatives are coordinated across state government and with other public and private partners, fostering a collaborative, inclusive approach to the implementation of health care reform to ensure its consistency and effectiveness.

Vermont believes that the success of statewide reform is dependent upon the successful development of public-private partnerships. Reform efforts include collaboration with such entities as private insurance carriers, health care advocacy organizations, health care providers and hospitals, Vermont Information Technology Leaders, University of Vermont Medical School, the business community and many others.

Technical Assistance from CMS Regional Office:

Vermont has relied on CMS regional staff for technical assistance in areas ranging from quality assurance and evaluation to fiscal reporting processes and formats. Regional staff have been very responsive, timely and helpful in providing technical assistance, supporting materials and helping Vermont understand and implement 42 CFR 438 requirements in the context of a state government system.

Collaborations with the Joint Fiscal Office:

The State has continued its collaborative process with which to develop consensus documents and agreements between the Executive and Legislative branches related to Global Commitment budgets, trends and projections. This detailed level of fiscal consensus building is the first of its kind between the branches of state government and has yielded a productive and collaborative discussion of the pressures on our public and private health care delivery systems.

III. Project Status

Healthcare Reforms & Benefit Changes:

Enrollment in the Catamount Health and Employer-Sponsored Insurance (ESI) premium assistance programs continues to grow. As of the end of September, 2009 there were 8802 individuals enrolled in Catamount Health premium assistance and 1668 individuals enrolled in the ESI component (including those eligible for VHAP-ESI). An additional 1,516 individuals were enrolled in Catamount Health with no premium assistance.

The 2008/2009 legislative session produced only minor changes to the premium assistance programs. They are as follows:

- OVHA was required to submit a request to amend the waiver to decrease the waiting period from twelve to six months. OVHA submitted the request to CMS on March 5, 2009, as part of its request for FFP for the premium assistance groups up to 300% FPL. Also in the waiver amendment request was the exception to the waiting period for victims of domestic violence. (Vermont received an official CMS response to our amendment request on December 28, 2009 which will be included in our FY'10 report.)
- Act 61, passed by the Vermont legislature in May, 2009 required OVHA to seek a waiver amendment for two changes to the eligibility criteria for Catamount/ESI premium assistance and VHAP programs:
    - allow depreciation as a business expense deduction from countable income for the self-employed, and
    - allow an exception from the waiting period for self-employed individuals who have been insured in the nongroup market but lose their coverage because their business closes.

    OVHA submitted a waiver amendment request for these two changes on August 25, 2009. In September of 2009 the Joint Fiscal Committee rescinded the funds for these two changes, although the full legislature will have to decide whether to strike the provisions from the law during its 2010 session.

Vermont Chronic Care Initiative:

The goal of the OVHA's Vermont Chronic Care Initiative (VCCI) is to improve health outcomes of Medicaid beneficiaries through addressing the increasing prevalence of chronic illness. Specifically, the program is designed to identify and assist Medicaid beneficiaries with chronic health conditions in accessing clinically appropriate health care information and services; coordinate the efficient delivery of health care to this population by attempting to remove barriers, bridge gaps, and avoid duplication of services; and educate, encourage and empower this population to eventually self-manage their chronic conditions.

The VCCI uses a holistic approach of evaluating both the physical and behavioral conditions, as well as the socioeconomic issues, that often are barriers to health improvement. The OVHA's VCCI emphasizes evidence-based, planned, integrated and collaborative care for beneficiaries who exhibit high-prevalence chronic disease states, high-expense utilization, high medication utilization, and/or high emergency room and inpatient utilization. Ultimately, the VCCI aims to improve health outcomes by supporting better self-care and lowering health care expenditures through appropriate utilization of health care services. Through targeting predicted high cost beneficiaries, resources can be allocated where there is the greatest cost savings opportunity. The VCCI focuses on helping beneficiaries understand the health risks of their

conditions; engage in changing their own behavior, and by facilitating effective communication between the beneficiary and primary care provider. The intention ultimately is to support the person in taking charge of his or her own health care.

The VCCI supports and aligns with other State health care reform efforts, including the Blueprint for Health and the Capitated Office-Based Medically Assisted Treatment (COBMAT) for Opioid Dependence initiative (see below). VCCI staff partner with providers, hospitals, community agencies and other Agency of Human Services (AHS) departments to support a patient-focused model of care committed to enhanced patient self-management skills, healthcare systems improvement, and efficient coordination of services in a climate of increasingly complex health care needs and scarce resources.

The VCCI focuses on beneficiaries identified as having a specified chronic health condition who are enrolled in Medicaid, VHAP, PCPlus or Dr. Dynasaur under the Vermont Health Access Program with approval by the Centers for Medicaid and Medicare; beneficiaries are not eligible for the VCCI if they receive Medicare or other third party insurance. Those targeted for enrollment in VCCI programs have at least one chronic condition including, but not limited to: Arthritis, Asthma, Chronic Obstructive Pulmonary Disease (COPD), Chronic Renal Failure, Congestive Heart Failure (CHF), Depression, Diabetes, Hyperlipidemia, Hypertension, Ischemic Heart Disease, and Low Back Pain. Eligible beneficiaries were identified during FFY 2009 by OVHA's Data Unit using Adjusted Clinical Group predictive modeling; the eligible population was then stratified by the VCCI vendor APS Healthcare into those at highest risk and most likely to benefit from intensive case management services, and those for whom less intensive disease management services appear sufficient. Service level needs are ultimately determined through both predictive modeling and clinical assessment, in accordance with national evidence-based, disease-specific clinical guidelines. The VCCI is designed to enable seamless transition between service tiers as a beneficiary's needs change.

The OVHA began providing face-to-face intensive care coordination case management services in 2006 to the highest risk, most medically complex beneficiaries. Especially among these high risk beneficiaries, chronic conditions and their management are often complicated by co-occurring mental health and substance abuse conditions, as well as challenges due to financial insecurity such as availability of food, safe and affordable housing, and transportation. The OVHA care coordinators, which include registered nurse case managers and medical social workers, facilitate a medical home, support the primary care provider in achieving the clinical plan of care, facilitate effective communication among service providers, and remove barriers to beneficiary success.

Beginning in July 2007, the OVHA expanded operations beyond care coordination to provide a full spectrum of disease management interventions using contracted services from APS Healthcare. At that time, the OVHA VCCI implemented a tiered intervention protocol with services along a continuum from printed education and self-management information to telephonic health coaching and disease management services, to intensive face-to-face care coordination. This comprehensive model includes hospital-based nurses, community-based nurse case managers and medical social workers, as well as centrally located nurse, disease management, and social work staff. All staff shares the same vertically and horizontally integrated web-based chronic care data management system, APS CareConnection®. In addition to being a case tracking system and repository for information on every beneficiary served, the APS CareConnection® system enables secure communications among staff regarding co-managed beneficiaries, and also is accessible by medical providers as a means to be informed about a patient's activities, goals and progress.

The VCCI provides ongoing outreach, education and support to the primary care providers (PCPs) of participating beneficiaries. OVHA care coordinators or APS registered nurse health coaches collaborate

with the beneficiary and their PCP to develop a customized plan of care (POC), and PCPs are provided periodic updates on patients' progress in completing goals established through the POC. OVHA pays an enhanced rate to PCPs for collaborating with OVHA care coordinators working with their highest risk patients. During FFY 2009, participating providers were reimbursed $55 for meeting with care coordination staff when one of their patients enrolled in care coordination services, $55 for a discharge meeting to emphasize the importance of a smooth transition to less intensive services, and an enhanced capitated payment rate of $15 per month for each care coordination participant.

July 1, 2009, marked the beginning of the third year of expanded operations. During the first two years, some level of intervention services was provided to over 25,000 beneficiaries. Vermont's state budget rescission for State Fiscal Year 2009 included elimination of $872,720, or approximately 25%, from the funds budgeted for the APS Healthcare contract. As a result, resources were refocused and services changed for some beneficiaries effective October 1, 2008. Specifically, efforts focused predominantly on very high, high and moderate risk beneficiaries most likely to benefit from face-to-face intensive care coordination services and/or telephonic disease management health coaching. Lower risk individuals are sent information on the program, may request health information and educational materials, and are contacted twice each year to assess current needs. During the second full year of operation, from July 1, 2008 through June 30, 2009, 3,189 beneficiaries received face-to-face case management services or telephonic disease management services from a registered nurse or medical social worker. The goal for Project Year 3 is to provide the same level of services to an additional 4,000 members.

During the third quarter of FFY 2009, the OVHA contracted with the University of Vermont (UVM) for VCCI program monitoring, evaluation, and identification of quality improvement projects. UVM began a thorough evaluation of VCCI administrative (claims) data and a Medical Record Review during the fourth quarter. 1,001 randomly selected charts of VCCI beneficiaries with diabetes and/or hypertension were audited. Based on findings, UVM will assist OVHA in identifying clinical quality measures amenable to performance improvement activities likely to have the greatest impact on the VCCI managed population.

Highlights of the Vermont Chronic Care Initiative

- During Project Year 2 (7/1/08-6/30/09), preliminary analysis indicates hospital utilization among the VCCI population declined from the baseline period (7/1/06-6/30/07) as follows: inpatient admissions declined by 12.2% and emergency room use declined by 4.3%. Savings trend data for this time period are not yet available.
- During the fourth quarter of FFY 2009, OVHA care coordinators began providing case management to buprenorphine patients from five pilot provider practices. CareConnection® was enhanced to accommodate tracking of identified buprenorphine measures and data are transferred monthly from APS to the buprenorphine evaluation team at UVM.
- The average monthly caseload during FFY 2009 was 3,339. Monthly caseload includes beneficiaries in active outreach by VCCI staff, as well as those successfully engaged and receiving care coordination or health coaching services.
- 2,963 unique beneficiaries were served by either OVHA care coordinators or APS disease management health coaches during FFY 2009. Beginning July 1, 2009, additional services were required before a beneficiary could be considered "served." During the second full project year (7/1/08 to 6/30/09), the VCCI provided care coordination and/or health coaching services to 3,189 different beneficiaries.

FFY 2010 Strategic Planning

- A minimum of 4,000 beneficiaries are targeted to receive either care coordination or health coaching services during SFY 2010 (7/1/09 through 6/30/10). The minimum savings target for this period is $6,468,466, for which a portion of APS Healthcare's payment is at risk.
- For enhanced efficiency, responsibility for identifying VCCI eligible beneficiaries will be transferred from OVHA's Data Unit to APS Healthcare, which will also continue to provide the risk stratification.
- Based upon provider feedback regarding the enhanced PCP care coordination payment methodology, PCPs will be paid only once, at the time the beneficiary completes care coordination services.
- Using administrative data and findings from the MRR, UVM will assist the OVHA with identifying, implementing and evaluating quality improvement initiatives.
- A provider satisfaction survey will be completed and improvement action plans developed.
- OVHA care coordinators will develop enhanced collaboration protocols with practices participating in the Blueprint Integrated Pilot sites, including finalizing a Business Associates Agreement to enable OVHA care coordinator access to the Blueprint's data management and reporting system, DocSite.
- OVHA care coordinators will implement regular meetings and electronic data exchange systems with the emergency departments (EDs) of several hospitals for increased collaboration regarding emergency room utilization.
- OVHA will extend the VCCI contract with APS Healthcare for one additional year (7/1/10-6/30/11).

Buprenorphine Program:

Many physicians limit the number of opiate dependent patients they treat because of the challenging nature of attending to the needs of this special population (e.g., motivation and readiness to change, adherence to treatment plans, potential of relapse, diversion, and other complex medical needs). 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 needing buprenorphine treatment and other support services. The OVHA increases access to these services by strategically utilizing licensed physicians in Vermont who recognize the value of both prescribing buprenorphine and integrating other specialty/support services such as mental health, substance abuse counseling, and in some instances chronic care case management support into their service delivery system.

In July 2008, the Vermont legislature appropriated an additional $500,000 for SFY 2009 (7/1/08-6/30/09) to continue the Buprenorphine Program. The OVHA, in collaboration with ADAP, utilized these funds to maintain the capitated payment program, which increases reimbursement to physicians in a step-wise manner depending on the number of patients treated by a physician enrolled in the program.

The Capitated Payment Methodology is depicted below (**Figure 1**):

Figure 1

Level	Complexity Assessment	Rated Capitation Payment				Final Capitated Rate (depends on the number of patients per level, per provider)
III.	Induction	$348.97	+	**BONUS**	=	
II.	Stabilization/Transfer	$236.32				
I.	Maintenance Only	$101. 28				

Buprenorphine Program Payment Summary FFY '09	
Oct-08	$ 34,942.14
Nov-08	$ 34,723.02
Dec-08	$ 36,569.72
Jan-09	$ 40,406.92
Feb-09	$ 39,303.34
Mar-09	$ 35,056.95
April-09	$ 36,993.53
May-09	$ 49,150.85
June-09	$ 43,934.51
July-09	$ 65,686.23
Aug-09	$ 58,996.59
Sept-09	$ 55,450.68
Total	$ 531,214.48

Highlights: Progression of the Buprenorphine Program (Per FFY 2009 Quarter)

- At the end of the 1st quarter of FFY 2009, OVHA's Capitated Program for the Treatment of Opiate Dependency (CPTOD) had 30 enrolled providers, approximately 386 patients undergoing opiate addiction treatment, and had paid $106,234.88 to participating providers.
- By the end of the 2nd quarter, the CPTOD had 30 enrolled providers, approximately 397 patients, and had paid a total of $221,002.09 to providers for the first two quarters.
- By the end of the 3rd quarter, the CPTOD had 33 enrolled providers, approximately 412 patients, and had paid a total of $351,080.98 to providers for the first three quarters.
- At the end of the 4th quarter, the CPTOD has 32 enrolled providers, approximately 496 patients undergoing treatment, and had paid a total of $531,214.48 to providers for the year. The program continues to be successful at increasing patient access to providers who are licensed to prescribe buprenorphine in Vermont.

Highlights: Integration of Chronic Care Initiative and Buprenorphine Service Delivery

With the goal of providing an optimum environment for Medicaid beneficiaries to receive treatment for opiate addiction while also providing support to the medical offices that care for this challenging population, the OVHA began a pilot program with OVHA VCCI care coordinators (described above) providing case management support to selected buprenorphine patients. Results for FFY 2009 follow:

- Initially, the OVHA assigned case managers to four provider practice sites; a fifth site was added in September 2009.
- APS Healthcare, the VCCI vendor, updated their case management software to enable the care coordinators to record all data that will be used by the University of Vermont (UVM) to conduct an evaluation of the CPTOD. Additionally, APS provides UVM with monthly data updates on eligible beneficiaries.
- The OVHA, ADAP, and UVM meet bi-monthly to review the work plan and identify areas for program improvement.
- Meetings also occur among the OVHA, ADAP, and the five practice sites to review program metrics and clinical expectations of the providers, based on evidence-based buprenorphine practice guidelines.

FFY 2010 Strategic Planning

The Office of Vermont Health Access will continue collaboration with its partners (VDH/ADAP, DOC, and others) to ensure infrastructure stability and enhanced program development through system integration, science to service implementation, data collection, and evaluation.

Effective January 1, 2010, the OVHA and its fiscal intermediary HP Enterprise Services (formerly EDS) will streamline its billing process and procedures for the CPTOD. Total payment to providers will not change **(see Figure 1)** and providers will remain eligible for a bonus if they have 16 or more participants during the month. The streamlined process will enable enhanced data analysis for program evaluation.

Development of the Vermont *Buprenorphine Practice Guidelines* has been a collaborative effort with the Vermont Department of Health, Division of Alcohol and Drug Abuse Programs (VDH/ADAP), as well as local treatment providers. A comprehensive review and revision of these *Guidelines* began during FFY 2009 and will be completed by January 1, 2010. The updated *Guidelines* will be made available to all providers.

At the same time, the *Buprenorphine Provider Agreements* will be updated to align with the revised *Practice Guidelines* and distributed for signature by all providers participating in the CPTOD.

With the assistance of VDH/ADAP, local treatment providers and other experts, the OVHA will conduct thorough reviews of complex and difficult buprenorphine cases and provide ongoing Technical Assistance and Education to providers as needed to maintain and enhance service delivery and integrity. Great emphasis will be placed on assisting providers to adhere to best practices as outlined in the *Buprenorphine Practice Guidelines*.

Mental Health – Vermont Futures Planning:

The Department of Mental Health (DMH) has fully engaged Vermont's Certificate of Need review process for major health care projects and has received a Conceptual Certificate of Need for Planning (Docket #06-013-H: April 12, 2007) to replace the Vermont State Hospital. In collaboration with Vermont's network of community mental health centers we have implemented several new community-based crisis stabilization and rehabilitation treatment services. These have demonstrably reduced the average daily census at Vermont State Hospital by providing clinically appropriate, lower cost alternatives to hospitalization for Medicaid enrollees. DMH is engaged in negotiations with general hospital programs to expand and enhance programming capability to meet the acute psychiatric inpatient treatment needs of Vermonters with mental illness.

In addition to these efforts, DMH also proposes to create a 15-bed secure (locked) adult psychiatric treatment and recovery residential program on the grounds of the State Office Complex in Waterbury. It is expected that the program will be state licensed as a Level III Community Care Home and seek accreditation from the Commission of the Accreditation of Rehabilitation Programs. The program will be state-run, operate independently from other state programs (including Vermont State Hospital) and have its own governance, management team, medical director, clinical team, operating policies and procedures, and business office.

The clinical services provided as part of the 24-hour care will include evidence-based psychiatric rehabilitation services and psychosocial treatment delivered in a positive behavioral support framework to assist individuals to engage in their own recovery and to develop the necessary skills to move to less intensive services and achieve a higher level of independent living. The anticipated length of stay in the program ranges from approximately three months to two years or more. This level of care is unique and not currently available in the Vermont system of care. As proposed, it will provide a clinically appropriate lower cost option to hospital-level care.

Outreach/Innovative Activities:

Vermont is making steady strides in covering its uninsured through a family of health insurance plans known as Green Mountain Care. In our second year of operation since the launch of Green Mountain Care we faced an unprecedented economic downturn, yet we maintained our uninsured rate overall at 7.6%. We were particularly successful with our campaigns to reach young adults between the ages of 18 - 24 as their rate of uninsured decreased from 21.5% in 2008 to 17.4% in 2009 (24.7% in 2007).

We began the 2009 federal fiscal year with a final push to reach the public about a time-sensitive offering that the Vermont State legislature created under the Catamount Health plan; namely that all pre-existing conditions would be covered without a waiting period for those who apply before November 1, 2008. We programmed our Green Mountain Care web button, which is an icon link with a message about "amnesty." This icon appeared on over 20 websites within and outside of government and at midnight on October 31, 2008 the icon reverted back to its general message.

We also utilized two temporary Ambassadors in October to intensively market "amnesty." During the rest of the fall they marketed Green Mountain Care broadly by staffing job fairs, ski area recruitment events and special events. They also went door to door in densely populated business districts, staffed a table weekly at a popular downtown grocery store, and stocked pharmacies and human service agencies with outreach material. They ensured that State agencies such as the Department of Labor, Transportation and Libraries had Green Mountain Care posters and brochures prominently displayed at all location.

During this fiscal year, the OVHA partnered with the Vermont Department of Labor at over 50 layoffs and informed over 3800 people about their health insurance options under Green Mountain Care. We also staffed three job fairs and two events built around the America's Recovery and Reinvest Act reaching a total of 3126 people.

During the spring and summer, Green Mountain Care launched a marketing campaign to reach college seniors who were about to age off their parent's plan. This campaign was designed to reach both the dependent and their parents. We secured Vermont's largest bank, Chittenden Bank, as a corporate sponsor and utilized all 47 branches as outlets for material. The bank's President wrote an article about Green Mountain Care for its newsletter to 9,000 customers, and over 50 ATM machines included a screen message about Green Mountain Care.

Eighteen (18) of Vermont's 21 colleges provided information on Green Mountain Care to 5541 students and 8778 faculty and staff through email, e-postings, career offices, COBRA letters, Human Resource departments and where caps and gowns were dispensed.

The OVHA partnered with other state agencies around this campaign. The state homepage posted a widget with a "graduation image" that linked directly to the Green Mountain Care website and the Department of Human Resources sent information to over 3600 employees. Both the Departments of Liquor and the Lottery printed messages on their receipts and distributed material in 74 Liquor stores and over 100 outlets where lottery tickets are sold.

Businesses and trade associations joined the "Graduate Campaign" by sending electronic updates to over 12,477 businesses, 1400 members of a payroll company, 5000 direct care workers, and 234 municipalities.

Aligning materials, applications, websites and messaging under the Green Mountain Care brand continues to be a high priority especially within state government. This is a complicated endeavor and critical importantly in order to consistently brand material and messaging and to be easily understood by consumers.

Quality Assurance and Performance Improvement Activities:

During FFY09, the Quality Assessment and Performance Improvement (QAPI) Committee reviewed the definitions of those Medicaid beneficiaries identified by the State as having special health needs (i.e., children enrolled in the community mental health system identified with severe emotional disturbance, adults enrolled in the Community Rehabilitation and Treatment Program, adults enrolled in developmental disability services, and adults enrolled in the Traumatic Brain Injury Program). The group also spent time discussing how the MCE conducts assessments and treatment/service planning for this group as well as how it assesses the appropriateness of services provided to them. In addition, the group discussed MCE authorizations and the MCE's use of practice guidelines.

Also during the year, this group discussed the mechanism to detect under/over utilization of services. This discussion was followed up by a presentation by the MCE Program Integrity Manager. During the year, the group discussed the mechanism that the MCE uses to detect under/over utilization of services and the types of utilization management reports that would be necessary in order for the group to help monitor over/underutilization of services.

The QAPI Committee continued to develop a MCE Quality Plan. It was agreed that OVHA will have a "master" plan and that the IGA Partners will have separate, yet related plans. Reports were identified to help the group monitor the MCE's ability to conduct these activities. This information was added to the MCE Quality Plan and reports will be developed and/or identified during the next year to help the group monitor these processes. The MCE Quality Plan was finalized and as a final step, the group cross-walked their quality plans with OVHA's quality plan to ensure that shared activities were consistent and that any unique activities were identified. This type of planning will help to ensure a timely completion of MCE quality assessment and performance improvement deliverables.

The current set of performance measures that OVHA calculates and reports to AHS was reviewed and discussed. The QAPI Committee agreed that there might be some utility in modifying the current list of measures. The AHS Quality Improvement Manager met with OVHA staff to discuss the suitability of the current measures. It was agreed that a total of fourteen measures would be calculated and reported for this year. Additionally, it was agreed that the three utilization measures reported this year would not be

carried over to next year due to their limited ability to help the Agency and the EQRO assess the quality, timeliness, and accessibility of services. Finally, the role that performance measures play was discussed as part of the performance management system. The group agreed to recommend and discuss possible performance measures to be used in an Agency-wide dashboard. This approach appears to be in line with broader State-wide support for the use of performance measures.

The Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey was reviewed. Topics covered included the following: the timing of the survey and how it would be used to obtain feedback on beneficiary's experience of care including timeliness of service delivery.

The Office of Vermont Health Access's (OVHA) responsibility to monitor administrative MCE functions that it delegates to its Inter-Governmental Partners was a topic of discussion and more clarity was created across AHS. The MCE Monitoring Toolkit was reviewed and a process for implementation developed. The tool was piloted and feedback was used to modify the toolkit before full implementation. The results of the recent EQRO activities, the findings and associated Corrective Action Plans (CAP), were reviewed. All parties agree to work together to address requirements determined to be partially or not met during the review. The group discussed the role that the AHS/EQRO would play re: CAP follow-up activities. The group recommended that the AHS should take the lead in following up on the CAPs identified during the review.

During this year, the Quality Assessment and Performance Improvement (QAPI) Committee discussed the pending MCE Compliance Review. This discussion focused on the three Measurement & Improvement sub-standards (i.e., practice guideline, quality assessment and performance improvement program, and health information systems). The Committee reviewed the requirements associated with each sub-standard and discussed its role in helping OVHA to comply with them. The scope of next year's MCE Compliance Review focused on the four Access sub-standards contained in the Code of Federal Regulations (i.e., availability of services, assurances of adequate capacity and services, coordination and continuity of care, and coverage and authorization of services). The Committee reviewed the requirements associated with each sub-standard and discussed its role in helping OVHA to comply with them.

The group discussed the committee purpose and evaluated its membership. Now that the Evaluation Plan, Quality Strategy, and Quality Plan are in place, the group discussed a need to focus more on MCE monitoring and oversight activities. The QAPI agreed to review the aforementioned activities during the year and prioritized their completion. In addition to reviewing results of performance measures and performance improvement projects, the group agreed to conduct a self assessment at least annually. It was agreed that the current structure of the committee was adequate to address the monitoring/oversight needs of the Agency as well as the quality assessment and performance improvement needs of the MCE. It was agreed that other MCE staff would be invited to future meetings to present the results of their work. The QAPI role in assessing the performance of MCE investments was identified, but work continues on expectations and activities associated with this review.

External Quality Review During FFY09, the Performance Improvement Project (PIP) work group met to discuss the remaining steps of the project and to prepare for this year's External Quality Review Organization (EQRO) PIP validation. The steps discussed included the following: use of sampling techniques, reliably collect data, implement intervention and improvement strategies, analyze data and interpret study results, and plan for real improvement. A work plan was developed and agreed upon by members of the group. As the year progressed, the work plan was reviewed and anticipated barriers were discussed. The AHS Quality Improvement Manager continued to support the work group as they

prepared for this year's performance improvement project validation by the EQRO. The EQRO also finalized the Performance Improvement Project Validation documents (e.g., MCE letter, summary form, etc). These documents were sent to the MCE in anticipation of their submission. The Performance Improvement Project (PIP) work group submitted the initial PIP summary form to the External Quality Review Organization (EQRO) for review. This year's document focused on steps five and six of the CMS protocol (i.e., reviewing sampling methods and reviewing data collection methods). After an initial review, the EQRO provided the group with two points of clarification. The PIP work group decided to address these points of clarification, modify their initial submission, and resubmit the modified document to EQRO for review.

The AHS Quality Improvement Manager met with MCE staff to identify the set of performance measures that would be used to monitor MCE performance. It was agreed that the MCE would report on 4 of the 6 measures reported last year and calculate and report 10 additional measures. The AHS Quality Improvement Manager also worked with the EQRO to finalize the Performance Measure Validation documents (e.g., MCE letter, submission document, etc.). Because some source code modifications were identified by the EQRO prior to their on site visit, the submission was held until after the EQRO Performance Measure Validation work finished. The MCE submitted Performance Measure (PM) source code and supporting documentation to help inform the EQRO PM Validation activities. After reviewing the documents, the EQRO conducted an on-site review of the MCE. During the visit, the EQRO conducted the following: opening meeting, evaluation of system compliance, review of ISCAT and supporting documentation, overview of data integration and control procedures, primary source verification, and a closing conference.

The AHS Quality Improvement Manager worked with the EQRO to develop a review tool that will be used by the EQRO to assess OVHA's ability to comply with Federal and State Medicaid MCO standards. This document was used to help OVHA prepare for this year's compliance review. The AHS Quality Improvement Manager worked with the EQRO to develop a review tool that will be used by the EQRO to assess the MCE's ability to comply with Federal and State Medicaid MCO Measurement and Improvement standards (i.e., practice guidelines, quality assessment & performance improvement program, and health information systems). The MCE submitted documents demonstrating its compliance with Federal Medicaid MCO Measurement & Improvement standards. After reviewing the documents, the EQRO conducted an on-site review of the MCE. During the visit, the EQRO conducted the following: opening conference, review of documents, interviews with key staff, and a closing conference.

Finally, the AHS Quality Improvement Manager reviewed a draft copy of the EQRO annual technical report. This document combines the results of all three external quality review activities and identifies strengths and challenges associated with the three activities as well as making recommendations to improve the timeliness, access, and quality of services provided by the MCE.

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

Evaluation Activities: During this year, the AHS Quality Improvement Manager worked with AHS staff to review the Global Commitment to Health Waiver Evaluation Plan develop by Pacific Health Policy Group (PHPG). Their plan is a revision of the original document sent to CMS during waiver implementation. The revised plan was developed in accordance with CMS guidelines contained in *Evaluating Demonstrations: A Technical Assistance Guide for States* (September 2008) and contains the following items: background information on the demonstration and its principles, goals, and objectives,

detailed evaluation design, and information on the evaluation report to be provided to CMS during the lifetime of the demonstration and at its conclusion. After incorporating AHS staff feedback into the plan the revised Global Commitment to Health Waive Evaluation Plan was submitted to CMS.

During this year, a number of evaluation activities took place. A telephone survey of beneficiaries was initiated in January, with two PHPG staff member dedicated to this activity throughout the year. With approximately 200 household contacts and 60 completed surveys per month, this activity is on target to achieve 350-400 completed surveys by July 2009, in accordance with the evaluation plan timeline. During this year, Pacific Health Policy Group (PHPG) completed their telephone survey of beneficiaries. Of the 2,500 names provided, 1,537 were contacted with 383 completing the survey for a response rate of approximately 24.9 percent.

In addition, the 2009 CAHPS survey was sent to beneficiaries in February, with follow-up to respondents in March.

Also, an online Provider Survey was prepared, and a secure database for responses has been created; primary care physicians who do not respond to the online survey will receive follow-up phone calls from PHPG staff. PHPG also continued surveying primary care providers (PCPs) to assess their satisfaction with program policies and procedures, payment rates, specialist physician capacity and care coordination. PHPG selected approximately 326 PCP's, who have provided care to at least fifty Medicaid enrollees over the previous 12 months, to complete a mail survey.

During this year, PHPG began preparing an interim evaluation report which must accompany the State's formal extension waiver request. The AHS Quality Improvement Manager (QIM) reviewed the interim evaluation report of the Global Commitment to Health 1115 Waiver prepared by Pacific Health Policy Group (PHPG). Feedback was given and modifications were made to the document. At the end of the year, the document accompanied the State's formal waiver extension request to CMS. Once the outcome of the waiver extension request is known, the AHS QIM will meet with the PHPG project manager to modify the current evaluation work plan to correspond with the time period agreed upon in CMS's response to the request.

IV. Utilization Data

Program Integrity Unit

The Office of Vermont Health Access (OVHA) has been designated as the office with primary responsibility for program integrity. A unique unit was formed in 2005 as the *Surveillance and Utilization Review Unit* (SURS) and renamed in 2006 as *The Program Integrity* (PI) *unit*. The PI unit was established to investigate and prevent fraud, waste and abuse through the development of reasonable, consistent and effective systems. The application of effective systems will result in the following outcomes:

- Protect public funds
- Maintain accountability
- Encourage compliance, and
- Support awareness and responsibility

The PI unit coordinates and collaborates with internal and external stakeholders for referrals and investigation of fraud, waste and abuse. Cases of suspected provider fraud are referred to the Medicaid Fraud and Residential Abuse Unit (MFRAU) located in the Vermont Attorney General's Office. Beneficiary eligibility fraud is referred to and investigated by Department of Children and Family

Services (DCF). Identified quality or process improvement needs are brought to the attention of other AHS Departments at the Quality Assurance Performance Improvement (QAPI) Committee meetings.

The PI unit uses claims analysis to detect aberrant billing practices, identify potential findings and perform preliminary investigations. Potential findings are selected for validation through a variety of investigative approaches. The results of more extensive reviews help to determine if the findings are:

- Suspected provider fraud, which is pursued by working with (MFRAU);
- Suspected beneficiary eligibility fraud, which is referred to the DCF;
- An unintentional error by the billing entity;
- Errors that indicate a need for education/training and/or clarification of rules, procedures and policy; or
- Determined to be without findings.

The PI unit uses several methods to identify fraud, waste and abuse. Post-payment reviews are conducted for Medicaid provided services and allow PI unit staff to investigate the following:

- Recipient utilization profiles
- Provider service profiles
- Exceptions criteria

Decision Support System (DSS) Profiler

DSS Profiler is an integral part of the PI unit's utilization review activities. It is a tool that provides data from the Medicaid Management Information System (MMIS) and includes, but is not limited to the following:

- Provider review by provider type
- Beneficiary utilization (e.g., pharmacy utilization)
- Specific codes/services
- Emergency department utilization
- Utilization by type of service (e.g., inpatient, outpatient, surgical, mental health, chiropractic services)
- Selected hospital admissions

Reports generated by the DSS Profiler allow the PI unit staff to compare claims data submitted by providers. The reports can be broken out by case type, which describes the type of service provided, and enables PI staff to compare individuals to the entire peer group. This is a valuable tool in detecting under and over utilization on a global scale.

Claims Data Analysis and Post Payment Review

The PI unit in OVHA has contracted with Ingenix to provide claims data analysis and post payment review. Ingenix utilizes data mining techniques and has developed a variety of algorithms to detect aberrant utilization. Over sixty provider type code descriptions are reviewed using MMIS claims data. Reports from these reviews enable the PI unit staff to drill down the data to specific claims and helps to facilitate investigations.

Ad Hoc Queries

The PI unit staff also utilizes the Enhanced Vermont Ad Hoc (EVAH) system. The EVAH system is a Business Objects application and enables PI unit staff to create ad hoc reports from the MMIS database in many ways. EVAH is an invaluable tool for the PI unit auditors to carry out investigations. It provides PI unit staff the ability to focus on individual elements within each claim, as submitted by providers.

HEDIS utilization measures will not be included in this submission of the annual report. Internally, we have changed the process that we use to calculate and produce HEDIS measures.

During this recession period OVHA has experienced a limitation on staff resources and has opted to contract out the production of HEDIS measures. After some initial work and RFP, a vendor will be selected and OVHA staff will be responsible for building a large, claim-level data file for the vendor and ensuring that the data file matches specifications required by the vendor. A draft set of measures will be created and reviewed. We anticipate HEDIS utilization measures will be included in the State's Waiver Report for Federal Fiscal 2010 Quarter 4.

V. Policy and Administrative Difficulties

Fiscal & Operational Management:

Development of the financial aspects of the waiver continued to receive significant attention during waiver year four.

Effective January 1, 2009, AHS began paying OVHA the PMPM capitation payment prospectively; AHS has trued up its capitation payment obligations to OVHA per the PMPM rates for all waiver years to-date. The PMPM payments will continue to include retroactive changes in enrollment with a 12-month runout period. On February 6, 2009 AHS received guidance from CMS pertaining to resolution of the CRT reporting issue. AHS subsequently worked with CMS to update the CMS-64 reports on MBES to contain actual PMPM expenditure information for all waiver years.

AHS submitted its IGA with the OVHA to CMS as follows: December 15, 2008 for FFY09, and August 31, 2009 for FFY10. AHS received approval from CMS for its FFY09 and FFY10 IGAs on March 22, 2010.

The passage of the American Recovery and Reinvestment Act of 2009 in February of 2009 allowed the State to retroactively claim enhanced FFP back to October 1, 2008. Over the course of FFY09, the State worked to incorporate ARRA accounting and reporting mechanisms into our existing processes.

Effective December 23, 2009, CMS approved Federal funding for expansion populations for the following MEGs: GlobalRx up to 225% FLP, Catamount, and ESIA up to 300% FPL. The State will pay the same PMPMs for this FLP expansion at the rates already selected for the existing MEGs. These three population groups, however, are not eligible to receive ARRA funding, therefore, the state draws at the regular FMAP for these populations. The State is currently working with CMS to determine how to appropriately capture these costs on the MBES reporting system.

On April 21, 2009, Monica Light, Financial Director, and Connie Harrison, Financial Administrator, attended an MBES training conducted by CMS, to learn of upcoming changes to the MBES reporting system. Subsequent to that meeting, AHS worked with OVHA and HP (formerly EDS) to restructure our CMS-64 reporting system in accordance with the new MBES requirements.

Per our PMPM payment process and its 12-month runout period, the September 1, 2009 PMPM payment included the last true-up adjustment for FFY08; no further adjustments to the FFY08 GC claim will be made past that point.

During FFY09, AHS worked with Aon Consulting for development of the FFY09 and FFY10 actuarial rate range certifications. On April 1, 2010, AHS entered into a one-year contract extension with Aon Consulting for completion of the actuarial certification of per-member-per-month capitation rates as required under the Global Commitment Waiver Special Terms and Conditions for the FFY11 period.

Operational Challenges:

Challenges experienced in waiver year four continued to be related to the areas of data and fiscal reporting that were reported last year. For example, ensuring key fiscal and policy staff understand the rate setting methodology and its impact on the state budget process and information technology systems. In September of 2008 state and regional CMS staff met to review and come to agreement on how best to handle several outstanding reporting issues. Final confirmation was received in early January 2009.

The State has made significant progress in reconciling the differences in fiscal years, while operating the Global Commitment waiver on a Federal fiscal year basis, and managing the budget in accordance with the State's fiscal year cycle (July-June).

Issues confounding the reporting problems include the interplay and reconciliation of the State's two 1115 waivers, the Long Term Care and the Global Commitment to Health mentioned above. This causes considerable complexity in reconciliations between GC and LTC waivers. Adding to the complexity of this reporting is the structure of Vermont's IT system. The IT structure supporting the AHS Healthcare programs was established in 1983 for eligibility and 1992 for the MMIS.

The Agency is in the process of an extensive MITA self assessment and RFP development process relative to modernizing the healthcare information technology.

Cost Incurred But Not Reported (IBNR):

The Global Commitment financial model relies on managed care capitation payments as the vehicle for funding Medicaid-covered services. Under a traditional managed care approach, the MCE receives prospective capitation payments in exchange for assuming the financial risk for payment of services rendered during the contract period. Services rendered prior to the start of the contract period would not be the responsibility of the MCE. Therefore, the MCE would accumulate a reserve in order to pay for claims incurred during the contract period, but paid after the contract period (i.e., "run out claims"). Capitation payments under Global Commitment began on October 1, 2005. However, OVHA, as the public MCE, used the capitation revenues to pay for claims incurred prior to October 1st. Ideally, the MCE would not have been obligated to use capitation revenues to pay for services rendered prior to the contract period and would have been permitted to build a reserve to cover any claims tail at the end of the contract period. This approach would have required the State to make "double payments" to pay for previously incurred claims as well as the prospective capitation payments. However, the State of Vermont was not in a position fiscally that would enable the Legislature to appropriate funds necessary to support both payments. Further, we did not believe that the Vermont Legislature would permit the public MCE to carry a large reserve for several years in order to cover the claims tail at the conclusion of the waiver. We believe that given the public and statewide nature of our Demonstration project, the approach taken was the most viable. However we also recognize that as we move forward with renewal discussions, the State believes that these issues warrant clarification and will work with CMS to resolve these issues.

Developing MCE compliance, quality standards and other activities in the context of State Government Agencies:

In most cases meeting the MCE requirements involve changes in internal procedures under the control of AHS or its member departments. In other areas, such as grievance and appeals, the revisions involve state regulatory/rulemaking processes which can be more lengthy and involved within the state government and legislative systems. Both processes can be inherently time consuming.

Financial planning and budgeting has been particularly challenging. Pre-waiver, many programs operated under separate and discrete waivers or other appropriations. Budgets were historically built by individual departments and combined into one overall AHS budget. Post waiver, all Global Commitment related expenditures and projections need to be combined into a single agency wide global commitment budget and the entirety of the budget needs to be built before prioritization across the agency and with individual departments can occur. The Global Commitment budget is then overlaid into the non-Global Commitment budget, cross walked with historical categories of individual departments and one total AHS budget created. Additional complexities are created by overlapping State and Federal fiscal years and the statutorily required separation of the State's "Catamount Fund" from other Medicaid funds.

Just as AHS needs to view Global Commitment across all departments as one budget, so does the rest of state government and the legislature. Work with the State Finance and Management Office as well as Vermont's Legislative Joint Fiscal Office pre-Global Commitment involved individual departmental budgets, appropriations, trends and projections. Post Global Commitment a process has been put into place to develop consensus documents and agreements between the Executive and Legislative branches on whole of Global Commitment. This detailed level of consensus building is unique between the branches of state government, and while initially a more consuming process, has yielded a much more productive and collaborative discussion of the pressures on our public and private health care delivery systems.

The inter-relationships and flexibilities that are created under Global Commitment have the potential to streamline or potentially eliminate the multiple billing and documentation requirements that currently exist. Developing more streamlined fiscal and management strategies align closely with principals of reorganization which included, in part, that the Agency structure and practices:

- support a holistic approach to serving individuals and families and ensure the coordination of services when multiple interrelated needs exist.
- ensure the efficient and effective allocation of financial and staff resources;
- establish effective data collection systems to support ongoing assessment of service quality and enhance continual organizational improvement;
- ensure maximum communication and collaborative planning when more than one service is being provided to a single consumer or family.
- provide a continuum of services capable of adapting and responding to changing needs and unique situations, including transitional stages.

The Agency continues to promote a unified management approach as we facilitate a variety of senior leadership and management meetings and ad hoc work groups to work on cross-cutting operational, fiscal, quality improvement and outcome issues. Managers are being held accountable for identifying and recommending changes that can be implemented across the agency to:

- create more efficient administrative processes and requirements;

- identify and eliminate duplicative business processes, program monitoring and reporting requirements;
- create more efficient funding mechanisms and contractual options (e.g., capitated rates, pay-for-performance and/or outcome based contracts);
- prioritize program development or expansion initiatives;
- ensure compliance with federal MCO and other waiver requirements.

VI. Capitated Revenue Spending

The PMPM rates as set for waiver year four are listed below. Full PMPM payment has been made by AHS to OVHA reflecting the FFY09 enrollment run on March 15, 2010. Investments made by the MCE for State fiscal year 2009 totaled $62,419,988. Areas of capitated spending and the associated categories are outlined in Attachment 1.

FFY09 PMPMs as of March 15, 2010

Medicaid Eligibility Group	Monthly Premium per IGA	Enrollees	PMPM paid to-date
ABD - Non-Medicare - Adult	$1,099.65	153,312	$168,589,541
ABD - Non-Medicare - Child	$2,155.76	43,588	$ 93,965,267
ABD - Dual	$1,270.88	178,789	$227,219,364
ANFC - Non-Medicare - Adult	$ 502.58	120,629	$ 60,625,723
ANFC - Non-Medicare - Child	$ 349.31	634,958	$221,797,179
GlobalExp (VHAP)	$ 405.25	353,338	$143,190,225
GlobalRx - Dual	$ 15.69	119,463	$ 1,874,374
GlobalRx - Non-Medicare	$ 227.42	170	$ 38,661
OptionalExp	$ 177.70	14,250	$ 2,532,225
VHAP ESI	$ 192.90	10,648	$ 2,053,999
ESI Premium Assistance	$ 141.86	4,405	$ 624,893
Catamount Premium Assistance	$ 373.99	62,390	$ 23,333,236
		1,695,940	**$945,844,688**

Attachments

Attachment 1

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

SFY09 Final MCO Investments

1/26/10

Investment Criteria #	Department	Investment Description
2	DOE	School Health Services
4	AOA	Blueprint Director
2	BISHCA	Health Care Administration
4	DII	Vermont Information Technology Leaders
2	VVH	Vermont Veterans Home
2	VSC	Health Professional Training
2	UVM	Vermont Physician Training
4	AHSCO	Vermont 2-1-1 Service
2	VDH	Emergency Medical Services
2	VDH	TB Medical Services
3	VDH	Epidemiology
3	VDH	Health Research and Statistics
2	VDH	Health Laboratory
4	VDH	Tobacco Cessation: Community Coalitions
3	VDH	Statewide Tobacco Cessation
2	VDH	Family Planning
4	VDH	Physician/Dentist Loan Repayment Program
2	VDH	Renal Disease
3	VDH	WIC Coverage
4	VDH	Vermont Blueprint for Health
4	VDH	Area Health Education Centers (AHEC)
4	VDH	Community Clinics
4	VDH	FQHC Lookalike
4	VDH	Patient Safety - Adverse Events
4	VDH	Coordinated Health Activity, Motivation & Prevention Programs (CHAMPPS)
2	VDH	Substance Abuse Treatment
4	VDH	Recovery Centers
2	VDH	Immunization
2	VDH	DMH Investment Cost in CAP
2	DMH	Special Payments for Treatment Plan Services
2	DMH	MH Outpatient Services for Adults
4	DMH	Mental Health Consumer Support Programs
2	DMH	Mental Health CRT Community Support Services
2	DMH	Mental Health Children's Community Services
2	DMH	Emergency Mental Health for Children and Adults
2	DMH	Respite Services for Youth with SED and their Families
1	OVHA	Buy-In
1	OVHA	HIV Drug Coverage
1	OVHA	Civil Union
1	OVHA	Vpharm
2	DCF	Family Infant Toddler Program
2	DCF	Medical Services
2	DCF	Residential Care for Youth/Substitute Care
2	DCF	Aid to the Aged, Blind and Disabled CCL Level III
2	DCF	Aid to the Aged, Blind and Disabled Res Care Level III
2	DCF	Aid to the Aged, Blind and Disabled Res Care Level IV
2	DCF	Essential Person Program
2	DCF	GA Medical Expenses
2	DCF	CUPS/Early Childhood Family Mental Health
2	DCF	HBKF/Healthy Babies, Kids & Families
1	DCF	Catamount Administrative Services
2	DCF	Therapeutic Child Care
2	DCF	Lund Home
2	DAIL	Mobility Training/Other Svcs.-Elderly Visually Impaired
2	DAIL	DS Special Payments for Medical Services
2	DAIL	Flexible Family/Respite Funding
4	DAIL	Quality Review of Home Health Agencies
2	DOC	Intensive Substance Abuse Program (ISAP)
2	DOC	Intensive Sexual Abuse Program
2	DOC	Intensive Domestic Violence Program
2	DOC	Women's Health Program (Tapestry)
2	DOC	Community Rehabilitative Care
2	DOC	Return House