State of Vermont
Agency of Human Services

Global Commitment to Health
11-W-00194/1

Annual Report
for FFY 08
October 1, 2007 to September 31, 2008

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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 Organization (MCO). AHS will pay the MCO a lump sum premium payment for the provision of all Medicaid services in the state (with the exception of the Long-Term Care Waiver, managed separately). A Global Commitment to Health Waiver Amendment, approved October 31st 2007 by CMS, allows Vermont to implement the Catamount Health Premium Subsidy Program with the corresponding commercial Catamount Health Program (implemented by state statute October 1, 2007). The Catamount Plan is a new health insurance product offered in cooperation with Blue Cross Blue Shield of Vermont and MVP Health Care. It provides comprehensive, quality health coverage at a reasonable cost no matter how much an individual earns. The intent of this program is to reduce the number of uninsured citizens of Vermont. Subsidies are available to those who fall at or below 300% of the federal poverty level (FPL). Vermont claims federal financial participation for those uninsured Vermonters who fall at or below 200% of the FPL. For those individuals who fall between 200 and 300% Vermont provides subsidies through general fund revenue. Benefits include doctor visits, check-ups and screenings, hospital visits, emergency care, chronic disease care, prescription medicines and more.

The Global Commitment and its newest amendment provide the state with the ability to be more flexible in the way it uses its Medicaid resources. Examples of this flexibility include new payment mechanisms (e.g., case rates, capitation, combined funding streams) rather than fee-for-service, to pay for services not traditionally reimbursable through Medicaid (e.g., pediatric psychiatric consultation) and investments in programmatic innovations (e.g., the Vermont Blueprint for Health). The managed care model will also encourage inter-departmental collaboration and consistency across programs.

One of the Terms and Conditions of the Global Commitment Waiver requires the State "to submit progress reports 60 days following the end of each quarter. This is the annual report for the third waiver year, fiscal year 2008.

II. Highlights and Accomplishments

MCO Work Plan & Requirements:

As a Managed Care Organization (MCO), the OVHA must adhere to federal rules 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 Organization (MCO) to its Medicaid enrollees.

The scope of the external quality review consisted of the following activities:

- Review of compliance with structural and operational standards. HSAG conducted a review to determine the MCO'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 MCO. The validation also determined the extent to which Medicaid-specific performance measures calculated by the MCO followed specifications established by AHS; and
- Validation of performance improvement projects (PIPs). HSAG reviewed the MCO'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 MCO 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 MCO 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 MCO. 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 December 2008, over 11,500 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 MCO 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 MCO 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.

Several notable changes in key AHS/OVHA leadership were made since the beginning of waiver year three. Robert Hofmann was appointed AHS Secretary effective November 23, 2008 and Susan Besio, PhD was appointed as Director of OVHA effective December 8, 2008.

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, 2008, there were 5384 individuals enrolled in Catamount Health premium assistance and 1146 individuals enrolled in the ESI component (including those eligible for VHAP-ESI). An additional 785 individuals were enrolled in Catamount Health with no premium assistance.

The 2007/2008 legislative session produced only minor changes to the premium assistance programs. They are as follows:

- Catamount Health and ESI premium assistance program premiums were increased as of July 1, 2008. The following table shows the premiums before and after July 1:

Program	% FPL	Monthly Premium Before 7/1/08	Monthly Premium After 7/1/08
Catamount Premium Assistance	0-175%	$ 60.00	60.00
Catamount Premium Assistance	175-200%	$ 60.00	65.00
Catamount Premium Assistance	200-225%	$ 90.00	110.00
Catamount Premium Assistance	225-250%	$ 110.00	135.00
Catamount Premium Assistance	250-275%	$ 125.00	160.00
Catamount Premium Assistance	275-300%	$ 135.00	185.00

- A $400 earned income disregard was applied effective July 1 to higher-income premium assistance households to cover the higher job-related costs of this group.
- An exception to the 12-month waiting period was added for individuals who lost their prior insurance due to domestic violence. This change is subject to approval of a waiver amendment, which has not yet been submitted to CMS.
- An exception to the waiting period was added for individuals enrolled in private insurance with a deductible of $10,000 or more. This exception applies only to people applying for Catamount Health coverage without premium assistance.
- OVHA was required to submit a request to amend the waiver to decrease the waiting period from twelve to six months. OVHA did not submit this waiver amendment during Waiver Year 3, and it is the intent of the Administration to request this provision to be struck in the 2009 budget adjustment and 2010 budget process.

Chronic Care Management:

The OVHA's commitment to Chronic Care Management for Medicaid beneficiaries identified with a chronic condition is supported by legislation (Act 191), which specifically authorizes a Chronic Care Management program. This initiative, referred to as the Chronic Care Initiative (CCI), is designed to

fulfill the following mission: identify and assist Medicaid beneficiaries with chronic health conditions in accessing clinically appropriate health care information and services; coordinate the efficient delivery of health care to this population by attempting to remove barriers, bridge gaps, and avoid duplication of services; and educate, encourage and empower this population to eventually self-manage their chronic conditions. The goal is to improve health outcomes of Medicaid beneficiaries through addressing the increasing prevalence of chronic illness in this population. The CCI uses a holistic approach of evaluating both the physical and behavioral conditions, as well as the socioeconomic issues, that often are barriers to health improvement. The OVHA CCI emphasizes evidence-based, planned, integrated and collaborative care for beneficiaries who exhibit high-prevalence chronic disease states, high-expense utilization, high medication utilization, and/or high emergency room and inpatient utilization. Ultimately, the CCI aims to improve health outcomes by supporting better self-care and lowering health care expenditures through appropriate utilization of health care services.

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

The CCI focuses on beneficiaries identified as having a specified chronic health condition who are eligible for Medicaid under the Vermont Health Access Program with approval by the Centers for Medicaid and Medicare, and who are not eligible for Medicare. Those specifically targeted for enrollment in the CCI programs have at least one chronic condition including, but not limited to: Arthritis, Asthma, Chronic Obstructive Pulmonary Disease (COPD), Chronic Renal Failure, Congestive Heart Failure (CHF), Depression, Diabetes, Hyperlipidemia, Hypertension, Ischemic Heart Disease, and Low Back Pain. Eligible beneficiaries are identified using Adjusted Clinical Group predictive modeling provided by the Center for Health Policy and Research (CHPR), a part of the University of Massachusetts Medical School. CHPR also stratifies beneficiaries into those at highest risk and most likely to benefit from intensive care coordination services, and those for whom less intensive disease management services are sufficient. Through targeting predicted high opportunity beneficiaries, resources can be allocated where there is the greatest cost savings opportunity. Especially among beneficiaries at highest risk, chronic conditions and their management are often complicated by co-occurring mental health and substance abuse conditions, as well as challenges due to financial insecurity such as food security, availability of safe and affordable housing, and availability of transportation.

In 2006, the OVHA began providing face-to-face intensive care coordination to the highest risk, most medically complex beneficiaries with a chronic condition, using nursing and medical social worker teams employed by the OVHA. Care coordination services achieved statewide field presence in early 2008, with teams located in eight geographic districts covering the state. OVHA staff is now embedded in the local communities, has strong relationships with local providers and hospital partners, and is co-located within the AHS district offices, facilitating a holistic approach by simultaneously addressing health, behavioral, and socioeconomic issues to support sustainable changes. The OVHA considerably expanded operations to provide a full spectrum of care coordination and disease management services beginning in July 2007 when contracted services with APS Healthcare began; from October 2007 through September 2008, some level of chronic care intervention services were provided to over 25,000 beneficiaries with one or more of the eleven chronic conditions. The focus of all these services is to assist beneficiaries in understanding the health risks of their conditions, engage them in changing their own behavior, and facilitate their effective communication with their primary care provider. The intention ultimately is to support the person in taking charge of his or her own health care.

The services APS Healthcare began providing to beneficiaries in July 2007 included Health Risk Assessment (HRA) administration to all Medicaid beneficiaries with a chronic condition, some level of disease management intervention services (IVS) for eligible beneficiaries, and outreach and education with beneficiaries, medical providers, and other relevant stakeholders within AHS and local communities. While CHPR identifies the highest risk beneficiaries for intensive care coordination, APS stratifies the remaining intervention population into risk levels using predictive modeling along with clinical assessment, in accordance with national evidence-based, disease-specific clinical guidelines. All beneficiaries determine to be at lower risk were provided with printed educational and self-management materials. Beneficiaries at moderate to high risk receive predominantly telephonic health education and coaching services provided through contracted APS Healthcare nurse health coaches. The highest risk beneficiaries receive intensive face-to-face outreach and support, including home visits, from OVHA care coordination field staff. Care coordinators help facilitate a medical home and effective communication among service providers, support the primary care provider in achieving the clinical plan of care, and work to increase beneficiaries' success by, for example, addressing issues such as lack of transportation that may interfere with keeping scheduled medical appointments. The CCI is designed to enable seamless transition between service tiers as a beneficiary's needs change.

During the first year implementing the APS disease management contract, activities included securing office space and related equipment in Williston, Vermont, hiring and training staff, and establishing local relationships throughout the health care system. The APS clinical staffing model includes eight RN Health Coaches (five located in health care facilities throughout the state and the remaining located in the Williston office), four disease management coordinators, and one social worker. APS maintains a call center in Vermont to provide incoming and outgoing nurse telephone contact with both patients and providers during business hours and limited extended hours. During implementation, protocols and file layouts were established for efficiently transferring large data sets between OVHA and APS, including monthly paid Medicaid claims, Medicaid eligibility files, provider files, third party insurance and state aid updates, and quarterly population selection updates. APS also made their proprietary disease management database and patient tracking software, CareConnection, available for use by OVHA's care coordination staff, facilitating ease of communication between OVHA and APS, as well as seamless transition of patient information as beneficiaries transition between service levels.

Beneficiaries with scores above a predetermined cutoff on the HRA, and all beneficiaries identified for care coordination, complete a detailed general assessment with their APS nurse health coach or OVHA care coordinator; most also complete one or more disease-specific assessments. Assessment findings are integral to developing, in collaboration with the beneficiary's health care provider, a detailed Plan of Care (POC) with specific actions and goals.

The CCI provides ongoing outreach, education and support to the primary care providers (PCPs) of participating beneficiaries. PCPs are notified whenever one of their patients decides to participate in care coordination or disease management services, as well as when their patients are selected but can't be reached or decline services. In addition to collaborating with OVHA care coordinators or APS nurse health coaches in developing a customized plan of care (POC) for their patients, PCPs are provided periodic updates on patients' progress in completing goals established through the POC. In addition, OVHA pays an enhanced rate to PCPs for collaborating with OVHA care coordinators working with their highest risk patients. Participating providers are reimbursed $55 for meeting with care coordination teams when one of their patients is enrolled in care coordination services, and are reimbursed another $55 for a "discharge" meeting to emphasize the importance of a smooth transition to a less intense level of service. During patients' participation in care coordination services, PCPs receive an enhanced capitated payment rate of $15 per month for each care coordination participant.

Chronic Care Management Achievements:

- Emergency room use declined by 7.2%, inpatient admissions declined by 8.3%, and inpatient length of stay declined by 7% through June 2008 compared with the baseline period. Preliminary data for July through October 2008 indicate inpatient admissions were 11% lower than during the same months of the baseline period. However, final results will not be available until after the 6 months claims run out period.
- Over 35,000 introductory letters were sent to beneficiaries describing the CCI and providing contact information. 41,000 follow-up letters also were sent. Member brochures with detailed information about the CCI and tips for beneficiaries about working effectively with their PCP were sent to 15,200 members. Quarterly newsletters with healthy living tips and disease specific information were sent to all beneficiaries during SFY'08 (July 2007 through June 2008). The total number sent was 91,600. As a result of the state budget rescission, quarterly newsletters were discontinued effective October 1, 2008.
- Over 24,000 health risk assessments (HRAs) were completed with beneficiaries. Quality Metric's nationally standardized SF-8 was used. The HRA function has been discontinued effective October 1, 2008, due to the state budget rescission.
- 4,400 detailed general assessments were completed.
- Over 3,000 beneficiaries received care coordination or disease management health coaching services.
- Evidence-based Clinical Guidelines, Touch Levels, and Action Plans were developed and are in place for all 11 chronic conditions to guide CCI staff interventions. Clinical content is coordinated with other state health improvement and chronic disease initiatives to ensure a standardized approach to consumer and provider audiences.

FFY'09 Plans:

Vermont's state budget rescission for State Fiscal Year 2009 included elimination of $872,720, or approximately 25%, from the funds budgeted for the APS Healthcare contract. As a result, the OVHA negotiated a contract amendment with APS, refocusing resources and changing services for some beneficiaries effective October 1, 2008. Specifically, the CCI has refocused efforts predominantly on the very high and high risk beneficiaries, in particular those who will benefit from face-to-face intensive care coordination services and telephonic disease management health coaching. Medium and low risk individuals may still request information and educational materials and will be contacted twice each year via Interactive Voice Recognition software. If they express interest in speaking directly with a CCI staff member, they will immediately be transferred to an RN Health Coach or Disease Management Coordinator at APS Healthcare**.** In addition, the initial health risk assessment and quarterly disease management newsletters, both previously provided to all eligible beneficiaries, were discontinued. All beneficiaries will receive a Healthy Living Action Plan instead, and those actively engaged in the program will still receive educational materials in the form of disease-specific Individual Action Plans to help improve health literacy. Concurrent with the APS funding reduction, two OVHA care coordination medical social worker positions were eliminated, requiring expansion of geographic coverage areas for remaining staff to assure critical services remain available statewide.

A minimum of 4,000 beneficiaries will receive either care coordination or health coaching services during SFY'09 (July 2008 through June 2009), and an additional 4,000 during SFY'10 (July 2009 through June 2010). The minimum savings target for SFY'09 is $7,380,074.

Buprenorphine Program:

The Office of Vermont Health Access in cooperation with the Vermont Department of Health (VDH) Alcohol & Drug Abuse Program (ADAP), the Department of Corrections (DOC), and the commercial insurers, aims to increase access for patients to Buprenorphine services, increase the number of physicians in Vermont licensed to prescribe Buprenorphine and to support practices caring for the opiate dependent population.

In 2006, the OVHA was appropriated $500,000 by the legislature to implement the Buprenorphine Program. Throughout FFY '07 and '08, the OVHA, in collaboration with ADAP, utilized these funds to establish and maintain the capitated payment program. The reimbursement system is structured to increase reimbursement to physicians in a step-wise manner depending on the number of patients treated by a physician who was enrolled in the program.

The Capitated Payment Methodology is depicted below.

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

Many physicians limit the number of opiate dependent patients because of the challenging nature of caring for this population (i.e., missed appointments, diversion, time spent by office staff). The end result is that most physicians see far fewer patients than they could. In FFY '08, the Buprenorphine Program paid a total of $448,568.47 of the $500,000 appropriation to 34 enrolled providers who treated approximately 420 patients.

CPTOD FFY 2008 Payment Summary	
Oct-07	$ 27,968.12
Nov-07	$ 30,492.75
Dec-07	$ 38,872.44
Jan-08	$ 45,163.01
Feb-08	$ 40,366.07
Mar-08	$ 41,590.23
Apr-08	$ 40,309.54
May-08	$ 37,456.37
June-08	$ 35,864.01
July-08	$ 40,542.79
Aug-08	$ 33,406.08
Sep-08	$ 36,537.06
Total	$ 448,568.47

In November 2007, the funding for VDH/ADAP was reduced which resulted in the cancellation of the Coordination of Office Based Medication Assisted Therapy (COB-MAT) program. Despite this setback, OVHA and ADAP continued to collaborate to ensure that providers who were enrolled in OVHA's capitated plan continued to receive support in the management of patients being treated with Buprenorphine for opioid dependence.

As of the close of FFY '08, the program successfully increased provider access for beneficiaries to receive treatment. Providers who were enrolled in the program consistently increased their patient loads incrementally each month. This program will continue to strive for 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.

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 reduce the bed day current used at 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:

In preparation of the State of Vermont's October 1, 2007 launch of health care reform, all public health care programs were rebranded under the umbrella name "Green Mountain Care" with the tag line, "A Healthier State of Living." This necessitated the development of a logo, promotional materials, a web site, and a highly-successful advertising campaign that helped us achieve 69% brand recognition for Green Mountain Care within three months of launching. We created an Outreach and Enrollment Steering Committee, comprised of stakeholders from a wide variety of interests in both the public and private sectors to help us to reach uninsured Vermonters. Lastly, we provided training to close to 2,000 people by the end of the first quarter.

During the first 12 months, we made improvements to the website, provided updates due to legislative changes, and added a greeting in eight languages to direct non-English speakers for assistance. We also branded the first of two of our primary applications under Green Mountain Care and made it more user-friendly. Materials used in Vermont public schools were also rebranded under Green Mountain Care.

The legislature passed a provision providing amnesty for preexisting condition exclusion under the Catamount Health plan. This created the need to educate the public about this time-limited offer to have all conditions covered without waiting periods if they applied before November 1, 2008. We did this through trainings, listservs, state government emails, a mailing in partnership with the Vermont Department of Labor to all 22,000 private sector employers in Vermont and by updating the image of our web button link which existed on over 20 partnering websites. The three rotating images of our Green Mountain Care web link icon highlighted the "amnesty message" and converted back to its general message at midnight on October 31.

We utilized two temporary Ambassadors to help during a fall push to market "amnesty" specifically and Green Mountain Care in general. Ambassadors staffed job fairs, ski area recruitment events, went door to door in densely populated business districts, stocked pharmacies, had a weekly table at a grocery store, and distributed information at special events.

Simultaneous with the Amnesty Campaign we ran a successful "Senior Campaign" from April to June to reach college graduates and their parents. Public and private colleges showed unprecedented support by allowing us to market directly to 6,250 college seniors and 3,600 facility and staff. We also used email to reach 6,240 state employees, 600 employees of the City of Burlington, and a business consortium of 300 restaurants and hotels.

Specific to this effort we hosted a concert in partnership with a local radio station which gave us over 120 on-air promotions over four weeks plus advertisement in two newspapers that target 18 – 34 year olds. There was an on-line link from the concert promotion to our Green Mountain Care website. Each week during May, the disc jockey congratulated seniors at the college that was holding graduation and encouraged them to check out Green Mountain Care. This effort dovetailed very well with a separate campaign run by Blue Cross Blue Shied of Vermont, which also targeted this age group.

Green Mountain Care outreach has become an increasingly integral part of the Vermont Department of Labor's (DOL)'s response to lay offs. The OVHA and DOL has also developed a training curriculum for employers that explains everything an employer needs to know from paying the Catamount assessment to the health benefits available to uninsured Vermonters who qualify.

Quality Assurance and Performance Improvement Activities:

During FFY08, the Quality Assurance/ Performance Improvement (QA/PI) Committee continued to review Federal Quality Assessment and Performance Improvement Standards, prioritized agency-wide performance measures, and reviewed the VT Medicaid Managed Care Quality Strategy. The Quality Improvement Manager continued to work with agency-wide representatives to identify how and where the MCO standards contained in the CFR are applicable to Vermont's public MCO. This involved completing templates for each standard (i.e., access, structure & operations, and measurement & improvement) that identified the following items: the key elements contained in the CFR for each standard, how and where the elements were relevant to each Department/Division, information regarding monitoring and oversight activities, and specific contact information for all applicable elements. This activity will lead to the development of a MCO Quality Plan. During this year, the Committee spent time

reviewing the Review of Compliance with Standards Documentation Request and Evaluation Form created by the Health Services Advisory Group (HSAG). In addition to reviewing the MCO Federal Quality Assessment and Performance Improvement Standards contained in the CFR, the group also reviewed the related State standards. During this year, the Committee finalized their review of the Review of Compliance with Standards Documentation Request and Evaluation Form created by HSAG. Also, the committee recommended that the EQRO review the Measurement and Improvement standards found in the CFR and AHS OVHA IGA during year three. These standards include the following: use of practice guidelines, QAPI Program, Health Information System, and Utilization Management activities.

Also during this year, the QAPI committee continued to prioritize agency-wide performance measures. The Committee recommended 21 agency-wide MCO performance measures for year three of the waiver. The measures include 17 HEDIS measures and 4 experience of care measures (i.e., getting needed care, getting care quickly, customer service, and overall rating of health plan) that should be reported by the MCO on a regular basis. In addition to the 4 CAHPS measures, the group recommended that the MCO continue to collect and report the 17 HEDIS measures discussed above. For the sake of trending, these measures are the same measures that the MCO reported during the first two years of the waiver.

While there was much discussion regarding additional Performance Improvement Projects for next year, no recommendations for new projects were made. However, the committee did recommend that the MCO continue with the current project, Fostering Healthy Families. Year three project activities should focus around the following activities: reviewing sampling methods, reviewing data collection procedures, assessing improvement strategies, reviewing data analysis and interpreting study results, assessing the likelihood that reported improvement is "real" improvement, and assessing whether improvements are sustained.

During this year, the QAPI Committee began to define its role in monitoring the QAPI activities of the MCO. For example, the group reviewed a sample grievance, appeal, and State fair hearing report to determine the types of information that it should receive on a regular basis in order to determine the quality of care provided to MCO enrollees. Recommendations for additional reports were discussed. As this oversight/monitoring role evolves, the committee will need to identify additional functions and reports to be reviewed.

Also during this year, the QAPI Committee continued to discuss the MCO Quality Plan. This document will mirror the quality framework established in the Quality Strategy and identify how OVHA and its IGA partners will assess and improve the quality of care for Medicaid enrollees/beneficiaries.

External Quality Review: During FFY08, a new External Quality Review Organization (EQRO) contract was put in place. After a competitive bid process, Health Services Advisory Group (HSAG) was retained as the new Medicaid Managed Care EQRO. Contract deliverables include the three required activities of EQR (i.e., validate performance measures, validate performance improvement projects, and conduct audits to determine compliance with Federal/State MCO quality standards). Monthly update calls were initiated with HSAG and standing agenda items were developed around the three required activities of the EQRO and include the following: compliance monitoring, performance measures, and performance improvement projects. The AHS Quality Improvement Manager worked with HSAG to develop a Review of Compliance with Standards Documentation Request and Evaluation Form for the MCO. This work centered on identifying requirements for each of the Structure and Operation Standards found in 42 CFR 438 and the AHS/OVHA Intergovernmental Agreement. Additionally, The AHS Quality Improvement Manager worked with the MCO and the previous EQRO, VPQHC, to calculate 15 performance measures for baseline and year one of the GC to Health Waiver and deliver a final report to AHS and OVHA.

Efforts continued on the Year 2 Performance Improvement Project (PIP): Fostering Healthy Families. Agenda items included the following: a description of the project, a review of the CMS Validating PIP Protocol, and a review of the EQRO PIP data collection tool. Numerous discussions with HSAG took place to better understand the relationship between their data collection tool and the CMS protocol. AHS worked collaboratively with OVHA to submit the Performance Improvement Project (PIP) Summary Form. This tool was used by HSAG to review the MCO's current PIP, Fostering Healthy Families. The proposed approach is to develop and document the study design components of the CMS PIP activities (i.e., identification of study topic, study question, study indicator(s), and eligible population).

Finally, the AHS worked with OVHA and HSAG to better understand and prepare for the Performance Measure Validation Process. Topics of discussion included the following: overview of service data processing, membership/eligibility data, provider data, data integration, and primary source verification. During the year, mutual expectations for Performance Measure Validation will be established and desk/on-site review procedures were finalized.

During the final quarter of FFY08, HSAG conducted three of its mandatory activities: validation of Performance Improvement Projects (PIP), validation of Performance Measures (PM), and a review of the MCO's ability to comply with the Quality Assessment and Performance Improvement (QAPI) standards found in the Code of Federal Regulations (CFR) and the AHS/OVHA IGA. The validation of the PIP was conducted via desk review, while the validation of Performance Measures and compliance review was conducted via a desk and an on-site review. During this year, HSAG provided feedback on the PIP information submitted via the PIP Summary Form. Feedback focused on the specific research questions and the indicators associated with them. The AHS met with the MCO PIP team and participated in a conference call to discuss the feedback. Finally, the AHS worked with the PIP team to modify the MCO PIP summary form. During a three day site visit, HSAG validated 6 HEDIS measures that the MCO is required to report to the AHS on an annual basis. Finally, the AHS QI Manager participated in HSAG's onsite review to determine the MCO's ability to comply with MCO QAPI standards. During this three day review, HSAG interviewed key OVHA staff and reviewed documents to determine the MCO's ability to comply with the Medicaid MCO Structure and Operations standards.

Quality Strategy: The AHS spent time eliciting feedback from QAPI committee members, members of the Health Access Oversight Committee, and the OVHA Medicaid Advisory Board on the proposed Quality Strategy. Final feedback was elicited via the public hearing process. Modifications were made to the document and a copy was submitted to CMS. The document was approved by CMS and praised for a being a model for other programs to follow. The Quality Framework contained in this document will be used by the QAPI Committee to guide the development of the MCO Quality Plan (discussed above). The Quality Improvement Manager will review the Quality Strategy on a regular basis and discuss any necessary modifications with the QAPI committee as needed.

Evaluation Activities: AHS and other agency-wide stakeholders revised the GC waiver evaluation plan. Performance measures were discussed and needed to be recommended in three major areas: access, cost, and quality. Measures contained in the Quality Strategy were transferred to the GC Evaluation plan, while cost and access measures still need further conversation. The QAPI committee continued to inventory applicable access and cost measures across the agency and specify appropriate targets.

A new request for proposal (RFP) for the evaluation of the GC Waiver was initiated. This document is a request by the Vermont Agency of Human Services (AHS) for proposals from qualified entities to conduct an evaluation of the "Global Commitment to Health" Waiver. The evaluation will answer four fundamental questions:

1. To what degree did the demonstration achieve its purposes, aims, objectives, goals, and quantified performance targets?
2. What lessons were learned as a result of the demonstration? What would the state recommend to other states which may be interested in implementing a similar demonstration?
3. In what ways, and to what extent, were outcomes for enrollees, providers, and payers changed as a result of the demonstration?
4. Did the reallocation of resources in the demonstration generate greater "value" for the state's program expenditures?

After reviewing and discussing the responses to the state bid, two finalists were identified for follow-up questions. Follow-up involved a discussion with the proposed project director and interviews with professional references. Based on the information contained in the proposals and the additional information gathered, the committee recommended that Pacific Health Policy Group (PHPG) be awarded the contract. The contract was signed and the evaluation of the waiver initiated during the last quarter of this year.

While many of the above questions cannot be answered until the end of the demonstration period, the evaluation plan includes on-going information on the incremental progress of the demonstration. The State intends to use the results of the evaluation to inform its future policy decisions with respect to the evolution of its healthcare system and policy planning efforts.

IV. Utilization Data

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 Unit* (PI). OVHA'S Program Integrity (PI) unit has oversight responsibility for the detection of fraud, abuse, waste and misuse. Efforts to detect prevent, and control fraud and abuse rely on a partnership with departments, across the Agency of Human Services.

Program Integrity is central to program management and ensuring a program's effectiveness and efficiency. Each state has primary responsibility for protecting its Medicaid program's integrity. This includes, but is not limited, to provision of medically necessary, appropriate and evidenced based healthcare service, accurate reimbursement to qualified providers, efficient administration, and prevention of inappropriate services and reimbursement. Vermont is taking several steps to meet this challenge and understands it's obligation to ensure the program integrity. This is a complex undertaking that involves all aspects of program management, from policy development to day-to-day operations.

This unit is supervised by an OVHA Deputy Director, a PI Manager and a Program Operations Administrator. Staffing consist of Program Operations Auditor's, a Nurse Case Manager, Medicaid Fiscal Analyst's and Health Data Analyst's.

PI has brought together the representatives from departments across *The Agency of Human Services* (AHS) to use the collective resources and knowledge across the agencies departments to address program integrity issues. The *Fraud Abuse Control Team* (FACT) team a cross agency collaborative is in its development phase for the purpose of sharing data in an effort to identify patterns of aberrant billing practices. Building cooperative and collaborative relationships, across departments who, in turn, have

established cooperative relationships with providers, consumers, and law enforcement will strengthen the capacity in which to conduct utilization management activities.

Utilization Review Processes: A goal of the PI unit is to monitor consistent adherence to the compliance with State and Federal regulatory standards. The PI unit has established procedures and monitoring activities towards formal utilization review processes. These utilization review processes, include but may not be limited to, the following random and/or focused review categories,

- Pre-service Review
- Concurrent Review
- Post Service Review

Utilization Management Approaches:

- Decision Support System(DSS) Selection Process
- Provider Profile Reporting
- Beneficiary Profile Reporting

Enhancements 2008-2009:

- OVHA uses Milliman ,nationally accredited, Clinical Criteria
- OVHA has purchased a license to access Hayes – a medical research Company
- Procured a vendor to conduct Post Payment Review
- Have continues to review for implementation of additional Claims Check prepayment edit and audits– prepayment audit software
- OVHA uses Ingenix to supplement the Program Integrity Unit in applying algorithms to claims data to detect possible Fraud, Waste and Abuse.

HEDIS Utilization measures for FFY07 for three draft measures are as follows: These measures will be reviewed by the EQRO for validation during FFY09. Due to the timing of the report, there is not enough run out for FFY08 data.

1. Outpatient Drug Utilization – HEDIS®

   The HEDIS, *Outpatient Drug Utilization* measure, summarizes the utilization of drug prescriptions (i.e., total cost of prescriptions, average cost of prescriptions per member month, total number of prescriptions, and average number of prescriptions per member per year) during the measurement period stratified by age. The measure uses the 2008 HEDIS criteria for both the numerator and denominator. The draft results, as follows, are based on prescriptions dispensed during Federal Fiscal Year (FFY) 2007.

   Member Months (Denominator):

AGE	Member Months
0-9	343,431
10-19	306,461
20-44	334,105
45-64	153,828
65-74	4,367
75-84	1,370
85+	730
Unknown	-
Total	1,144,292

Outpatient Drug Utilization:

AGE	Total Cost of Prescriptions	Average Cost of Prescriptions PMPM	Total Number of Prescriptions	Average Number of Prescriptions PMPY
0-9	$ 9,584,584	$ 60.52	158,382	0.46
10-19	$ 17,039,702	$ 87.43	194,890	0.64
20-44	$ 38,761,176	$ 69.03	561,497	1.68
45-64	$ 36,000,793	$ 69.36	519,033	3.37
65-74	$ 401,021	$ 67.53	5,938	1.36
75-84	$ 122,510	$ 60.41	2,028	1.48
85+	$ 37,615	$ 59.61	631	0.86
Unknown	$ -	$ -	-	-
Total	$ 101,947,401	$ 70.68	1,442,399	1.26

2. Inpatient Utilization – General Hospital/Acute - HEDIS®

The HEDIS, *Inpatient Utilization – General Hospital/Acute* measure, summarizes the utilization of acute inpatient discharges (i.e., discharges, discharges/1,000 member months, days, days/1,000 member months, and average length of stay) in the following categories: total acute care discharges, medicine, surgical, and maternity. Non-acute care, mental health and chemical dependency discharges, and newborn care are excluded. The measure uses the 2008 HEDIS criteria with a slight variation due to the availability of required data fields for both the numerator and HEDIS criteria for the denominator. The draft results, as follows, are based on discharges rendered during Federal Fiscal Year (FFY) 2007.

Member Months (Denominator):

AGE	Member Months
<1	17,159
1-9	288,413
10-19	286,428
20-44	414,250
45-64	216,314
65-74	55,403
75-84	51,519
85+	28,047
Unknown	
Total	1,357,533

Inpatient Utilization – General Hospital/Acute:

Total Acute Discharges:

AGE	Discharges	Discharges/ 1,000 member months	Days	Days/1,000 member months	Average Length of Stay
Total Inpatient					
<1	385	22.44	2,249	131.07	5.84
1-9	629	2.18	2,201	7.63	3.50
10-19	743	2.59	2,738	9.56	3.69
20-44	3,575	8.63	12,626	30.48	3.53
45-64	1,742	8.05	9,262	42.82	5.32
65-74	58	1.05	290	5.23	5.00
75-84	12	0.23	48	0.93	4.00
85+	7	0.25	28	1.00	4.00
Unknown					
Total	7,151	5.27	29,442	21.69	4.12

Medicine Discharges:

AGE	Discharges	Discharges/ 1,000 member months	Days	Days/1,000 member months	Average Length of Stay
Medicine					
<1	308	17.95	1,458	84.97	4.73
1-9	477	1.65	1,138	3.95	2.39
10-19	249	0.87	918	3.20	3.69
20-44	538	1.30	2,983	7.20	5.54
45-64	1,062	4.91	4,981	23.03	4.69
65-74	44	0.79	167	3.01	3.80
75-84	10	0.19	41	0.80	4.10
85+	5	0.18	15	0.53	3.00
Unknown					
Total	2,693	1.98	11,701	8.62	4.34

Surgery Discharges:

AGE	Discharges	Discharges/ 1,000 member months	Days	Days/1,000 member months	Average Length of Stay
Surgery					
<1	77	4.49	791	46.10	10.27
1-9	152	0.53	1,063	3.69	6.99
10-19	252	0.88	1,189	4.15	4.72
20-44	1,196	2.89	5,375	12.98	4.49
45-64	675	3.12	4,265	19.72	6.32
65-74	14	0.25	123	2.22	8.79
75-84	2	0.04	7	0.14	3.50
85+	2	0.07	13	0.46	6.50
Unknown					
Total	2,370	1.75	12,826	9.45	5.41

Maternity Discharges:

AGE	Discharges	Discharges/ 1,000 member months	Days	Days/1,000 member months	Average Length of Stay
Maternity					
10-19	242	0.84	631	2.20	2.61
20-44	1,841	4.44	4,268	10.30	2.32
45-64	5	0.02	16	0.07	3.20
Unknown					
Total	2,088	1.54	4,915	3.62	2.35

3. Ambulatory Care – HEDIS®

The HEDIS, *Ambulatory Care* measure, summarizes utilization of ambulatory care (i.e., visits/procedures/stays and visits/procedures/stays per 1,000 member months) in the following categories: outpatient visits, emergency department visits, ambulatory surgery/procedures performed in hospital, outpatient facilities, or freestanding surgical centers, and observation stays. The measure uses the 2008 HEDIS criteria for both the numerator and denominator. The draft results, as follows, are based on services rendered during Federal Fiscal Year (FFY) 2007.

Member Months (Denominator):

AGE	Member Months
<1	17,159
1-9	288,413
10-19	286,428
20-44	414,250
45-64	216,314
65-74	55,403
75-84	51,519
85+	28,047
Unknown	
Total	1,357,533

Ambulatory Care:

	Outpatient Visits		ED Visits		Ambulatory Surgery/Procedures		Observation Room Stays Resulting in Discharge	
AGE	Visits	Visits/1,000 Member Months	Visits	Visits/1,000 Member Months	Visits	Visits/1,000 Member Months	Visits	Visits/1,000 Member Months
<1	21,349	1244.19	1157	67.43	251	14.63	95	5.54
1-9	126,510	438.64	12320	42.72	2311	8.01	326	1.13
10-19	79,843	278.75	12333	43.06	2313	8.08	222	0.78
20-44	131,209	316.74	29800	71.94	8268	19.96	798	1.93
45-64	82,966	383.54	8043	37.18	5479	25.33	579	2.68
65-74	3,025	54.60	259	4.67	162	2.92	23	0.42
75-84	298	5.78	34	0.66	23	0.45	5	0.10
85+	63	2.25	7	0.25	0	0.00	0	0.00
Unknown								
Total	445,263	327.99	63,953	47.11	18,807	13.85	2,048	1.51

V. Policy and Administrative Difficulties

Fiscal & Operational Management:

Development of the financial aspects of the waiver continued to receive significant attention during waiver year three. On April 1, 2008, AHS entered into a new contract 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. After discussion with CMS revised final Year 1 and Year 2 IGAs were submitted to CMS on March 14, 2008, the IGA for Waiver Year 3 was submitted to CMS on May 16, 2008, and the IGA for Waiver Year 4 – and associated actuarial certification – was submitted to CMS on December 15, 2008. CMS approved the IGA and actuarial PMPM rates for Waiver Year 1 on April 29, 2008 and AHS has completed final WY1 reporting on the CMS-64. Effective January 1, 2009, AHS began paying OVHA the PMPM capitation payment prospectively; AHS has trued up its capitation payment obligations to OVHA per the PMPM rates for FFY08 and FFY09 to-date. The PMPM payments will continue to be adjusted per retroactive changes in enrollment with a 12-month runout period. On February 6, 2009 AHS received guidance from CMS pertaining to resolution of the CRT reporting issue. AHS will subsequently work with CMS to update the CMS-64 reports on MBES to contain actual PMPM expenditure information for waiver years two, three and four.

Operational Challenges:

Challenges experienced in waiver three 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.

Issues confounding the reporting problems include the interplay and reconciliation of the States 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 MCO 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 MCO. Therefore, the MCO 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 MCO, used the capitation revenues to pay for claims incurred prior to October 1st. Ideally, the MCO 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 MCO 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 MCO compliance, quality standards and other activities in the context of State Government Agencies:

In most cases meeting the MCO 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 the first of its kind 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 per member per month rates as set for waiver three are listed below. Full PMPM payment has been made by AHS to OVHA reflecting the FFY08 enrollment run on January 15, 2009. Investments made by the MCO for State fiscal year 2008 totaled $59,918,097 which represents actual spending. Areas of capitated spending and the associated categories are outlined in Attachment 1.

FFY08 PMPMs as of January 15, 2009

Medicaid Eligibility Group	Rate	Member Months	PMPM Payment
ABD - Non-Medicare - Adult	$1,324.11	143,859	$190,485,140.49
ABD - Non-Medicare - Child	$2,343.40	42,005	$ 98,434,517.00
ABD ~ Duals	$ 908.38	170,986	$155,320,262.68
ANFC - Non-Medicare - Adult	$ 566.02	112,449	$ 63,648,382.98
ANFC - Non-Medicare - Child	$ 354.39	611,006	$216,534,416.34
GlobalExp(VHAP)	$ 488.96	307,667	$150,436,856.32
GlobalRx Dual	$ 3.18	120,463	$ 383,072.34
GlobalRx - Non Dual	$ 236.12	393	$ 92,795.16
OptionalExp(Under)	$ 211.38	13,996	$ 2,958,474.48
VHAP ESI	$ 234.15	5,378	$ 1,259,258.70
ESIA TOTAL <200%	$ 178.38	1,478	$ 263,645.64
CHAP TOTAL <200%	$ 407.94	21,301	$ 8,689,529.94
Subtotal		1,550,981	$888,506,352.07

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Attachments

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
4	Encourage the formation and maintenance of public-private partnerships in health care.

2008 Final MCO Investments

Investment Criteria #	Department	Investment Description
2	Department of Education	School Health Services
4	AOA	Blueprint Director
2	BISHCA	Health Care Administration
4	DII	Vermont Information Technology Leaders
2	VVH	Vermont Veterans Home
2	Vermont State Colleges	Health Professional Training
2	University of Vermont Medical School	Vermont Physician Training
2	VDH	Emergency Medical Services
2	VDH	TB Medical Services
3	VDH	Epidemiology
3	VDH	Health Research and Statistics
3	VDH	Health Laboratory
3	VDH	Tobacco Cessation
2	VDH	Family Planning
4	VDH	Physician/Dentist Loan Repayment Program
2	VDH	Renal Disease
3	VDH	Newborn Screening
3	VDH	WIC Coverage
4	VDH	Vermont Blueprint for Health
4	VDH	Area Health Education Centers (AHEC)
4	VDH	FQHC Lookalike
4	VDH	Patient Safety - Adverse Events
4	VDH	Coalition of Health Activity Movement Prevention Program (CHAMPPS)
2	VDH - Alcohol and Drug Abuse	Substance Abuse Treatment
4	VDH - Alcohol and Drug Abuse	Recovery Centers
2	DMH	Special Payments for Medical Services
2	DMH	MH Outpatient Services for Adults
2	DMH	Mental Health Elder Care
4	DMH	Mental Health Consumer Support Programs
2	DMH	Mental Health CRT Community Support Services
2	DMH	Mental Health Children's Community Services
2	DMH	Emergency Mental Health for Children and Adults
2	DMH	Respite Services for Youth with SED and their Families
2	DMH	CRT Staff Secure Transportation
2	DMH	Recovery Housing
1	OVHA	Buy-In
1	OVHA	HIV Drug Coverage
1	OVHA	Civil Union
4	OVHA	Hospital Safety Net Services
2	DCF	Family Infant Toddler Program
2	DCF	Medical Services
2	DCF	Residential Care for Youth/Substitute Care
2	DCF	Aid to the Aged, Blind and Disabled CCL Level III
2	DCF	Aid to the Aged, Blind and Disabled Res Care Level III
2	DCF	Aid to the Aged, Blind and Disabled Res Care Level IV
2	DCF	Essential Person Program
2	DCF	GA Medical Expenses
2	DCF	CUPS
2	DCF	VCRHYP
2	DCF	HBKF
2	DDAIL	Mobility Training/Other Svcs.-Elderly Visually Impaired
2	DDAIL	DS Special Payments for Medical Services
2	DDAIL	Flexible Family/Respite Funding
4	DDAIL	Quality Review of Home Health Agencies
2	DOC	Intensive Substance Abuse Program (ISAP)
2	DOC	Intensive Sexual Abuse Program
2	DOC	Intensive Domestic Violence Program
2	DOC	Women's Health Program (Tapestry)
2	DOC	Community Rehabilitative Care