State of Vermont
Agency of Human Services

Global Commitment to Health
11-W-00194/1

Annual Report
for FFY 10
October 1, 2009 to September 30, 2010

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I. Background and Introduction

The Global Commitment to Health is a Demonstration Initiative is 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) up to 200 percent of the Federal Poverty Level. The Catamount Plan is a 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 percent of the Federal Poverty Level (FPL). On December 23, 2009 a second amendment was approved that allowed Federal participation for subsidies up to 300 percent of the Federal Poverty Level. Additionally, this amendment also allowed for the inclusion of Vermont's supplemental pharmaceutical assistance programs in the Global Commitment to Health Waiver.

The Global Commitment provides 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 also requires inter-departmental collaboration and encourages 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 fifth waiver year, fiscal year 2010, which ended on September 30, 2010.

II. Highlights and Accomplishments

MCE Work Plan & Requirements:

As a Managed Care Entity (MCE), the DVHA 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. The Agency of Human Services (AHS) contracts 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 5 consisted of the following activities:

- Review of compliance with access standards. HSAG conducted a review to determine the MCE's compliance with seven specific State-required standards identified by AHS. The seven standards included requirements associated with federal Medicaid managed care access standards found at 42 CFR 438.206-438.210 and 438.226;
- 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 Access 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 **97 percent**. For four of the seven standards HSAG reviewed (i.e., Availability of Services, Cultural Competence, Coordination & Continuity of Care, and Emergency & Poststabilization Services), the MCE received overall percentage of compliance scores of 100 percent. Scores for two additional standards (i.e., Coverage & Authorization of Services and Furnishing of Services) received scores of 95 percent and 93 percent respectively. The final standard, Enrollment & Disenrollment, received the lowest score (i.e., 83 percent) across the standards reviewed;
- Validation of performance measures. HSAG validated a set of eleven 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 2008 measures. All eleven 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 VIII, namely review of the selected study topic, the study question(s), the selected study indicator(s), the identification of the study population, sampling, data collection procedures, data analysis, and interpretation of results. The validation results indicated an **overall score of 96 percent** across all evaluation elements and a finding of high confidence in the result of the PIP for steps I-VII.

III. Project Status

Healthcare Reforms & Benefit Changes:

During 2009 the State submitted several amendment requests to CMS as required by the State legislature. CMS approved the following request:

- The provision of premium assistance in the Catamount Health and Employed Sponsored Insurance programs for adults up to and including 300 percent of the Federal poverty level (FPL)
- The extension of pharmacy benefits for low income Medicare beneficiaries from 175 percent up to and including 225 percent of the FPL.
- A change in the timeframe certain individuals must be uninsured from 12 months to 6 months for the Catamount premium assistance Program and VHAP.
- The provision of immediate coverage for individuals who are victims of domestic violence

However, approval was not given for the following requests:

- Expansion the scope of pharmacy benefits to include cost sharing obligations for Part D drugs.
- An exception to the 12-month waiting period for a self-employed individual who lost his or her business and is no longer able to work in the same line of business, and recognition of depreciation as an allowable business expense when calculating income for eligibility purposes in Vermont's expansion programs.

In the amendment requests Vermont noted that an August 18, 2009 Joint Fiscal Committee decision rescinded the allocated funding to implement the depreciation allowance and the waiting period changes. DVHA submitted a report to the legislature in January of 2010 on the estimated costs of implementing the depreciation change and in February of 2010 on the estimated costs of changing the waiting period. The Budget Adjustment bill which was passed by the General Assembly deferred the implementation of the depreciation provision to July 1, 2011; it will be revisited during the 2011 legislative session. The legislature did not move forward on the waiting period changes.

Enrollment in the Catamount Health premium assistance program continues to grow. As of the end of September, 2010 there were 9891 individuals enrolled in Catamount Health premium assistance and 1641 individuals enrolled in the ESI component (including those eligible for VHAP-ESI). Enrollment in the Employer Sponsored Insurance (EDI) premium assistance program has been flat, partially due to the fact that employers continue to increase the deductibles in their plans in an effort to keep premiums down, and Vermont's ESI premium assistance program is not permitted by law to approve ESI plans if the deductible is more than $500. An additional 2483 individuals were enrolled in Catamount Health with no premium assistance.

To ensure the solvency of the Catamount Fund, the legislature passed a change to the Catamount Health benefit structure that would increase the deductible from $250 to $500 and increase co-pays for brand-

name and non-preferred drugs by $5. The two Catamount Health carriers filed rates and forms to reflect this change, in addition to the changes required by the Affordable Care Act (ACA). The higher deductible and co-pays, as well as the ACA changes, were effective on October 1, 2010.

Beginning January 1, 2011, the two Catamount Health carriers, Blue Cross Blue Shield of Vermont (BCBS) and MVP Health Care (MVP), will have very different monthly premiums. For unknown reasons, MVP's claims experience has resulted in a premium that will be significantly higher than BCBS's premium. Since enrollees are by law required to pay the difference in price between the higher- and lower-cost plans, we expect to see many of MVP's customers migrate to BCBS.

DVHA considered the option under the Affordable Care Act to expand Medicaid to 133% FPL, but decided there was no financial advantage in doing so since Vermont already covers adults in VHAP up to 150% FPL.

In August of 2010 Vermont applied for and received a $1 million planning grant for the Exchange under ACA.

As required by the Vermont appropriations act for State Fiscal Year 2011, Vermont will be seeking CMS input and approval to implement a palliative care program that would allow Medicaid children with life-limiting illnesses to receive concurrent curative and palliative care.

Vermont Chronic Care Initiative:

The goal of the DVHA'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 DVHA'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 with their 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 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 and are enrolled in Medicaid, VHAP, PCPlus or Dr. Dynasaur under the Vermont Health Access Program with

approval by the Centers for Medicaid and Medicare Services; 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 are identified and risk stratified by the DVHA's disease management vendor, APS Healthcare, using a proprietary disease identification and stratification system based on Adjusted Clinical Group predictive modeling. Referrals from physicians, hospitals, and other community agencies also are accepted. Beneficiaries at highest risk are referred to DVHA care coordinators for intensive face-to-face case management services and those considered at lower risk for complications are assigned to APS Healthcare for telephonic disease management provided by a RN health coach. 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 DVHA's care coordinators began providing face-to-face intensive 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 DVHA 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.

In July 2007, the DVHA considerably expanded operations beyond care coordination to provide a full spectrum of disease management interventions using contracted services from APS Healthcare. At that time, the DVHA 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 case management. 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. DVHA care coordinators or APS nurse health coaches collaborate with the beneficiary and their PCP to develop a customized plan of care (POC), and PCPs are provided periodic updates on patients' progress in completing goals established through the POC.

Vermont's state budget rescission for State Fiscal Year 2009 included elimination of approximately 25% from the funds budgeted for the APS Healthcare contract; as a result, efforts were refocused 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 information and educational materials, and are contacted twice each year to assess current needs. From July 1, 2009 through June 30, 2010, 3,226 beneficiaries received face-to-face case management services or telephonic disease management health coaching from a registered nurse.

Effective July 1, 2010, DVHA expanded its direct care coordination capacity in two areas of the state through the Challenges for Change initiative. The two trial areas were selected based on, among other factors, high disease prevalence and high health system utilization. The initiative adds three additional DVHA care coordination staff (two RNs and 1 Licensed Clinical Social Worker) in each of the two areas (Rutland and Franklin Counties). These staff will be co-located within doctors' offices and local hospitals, and will integrate closely with existing care coordination staff, Blueprint for Health Community Health Teams, and other community resources. Five of the six staff have been hired and are providing services in their designated areas. All staff in the Challenges for Change initiative has caseloads and they are currently embedded in both ED and PCP's offices

UVM Report on Medical Record Reviews for VCCI

The DVHA has contracted with the University of Vermont (UVM) Vermont Child Health Improvement Program (VCHIP) for VCCI program evaluation, and for assistance with identifying and implementing quality improvement projects

The population of interest was DVHA beneficiaries who were eligible for VCCI. The beneficiaries had at least one of the following interventions: a health education mailing, disease management coaching by telephone, or an interaction with a case manager. An initial list of eleven chronic conditions was considered and reduced to two conditions of primary interest: diabetes and hypertension.

The plan was to review approximately 1001 medical records of enrolled individuals, half of whom had a primary diagnosis of diabetes and the other half, hypertension.

A data collection tool was developed between VCCI and DVHA, and VCHIP conducted medical record reviews for three points in time: Baseline (7/1/06-6/30/07, Measurement period 2 (7/1/07-6/30/08 and measurement period 3 (7/1/08-6/30/09.

The DVHA team developed an access database (expanding on VCHIP's Blueprint electronic medical record abstraction tool) and produced a randomized list of patients who had:

- Some intervention from chronic care
- A primary diagnosis of either hypertension or diabetes, and
- Been a DVHA beneficiary throughout the three measure periods.

The VCHIP team:

- created procedures for the order of site selection, data quality assurance and monitoring, and maintaining confidentiality of protected health information
- sorted patient lists by practice, diagnosis, and geography
- trained chart auditors to complete the chart reviews
- reconstructed the Access database tool to perform functions to merge and query data at the end of the data collection process, and
- submitted the overall plan to UVM's Institutional Review Board and received approval in August, 2009

Observations

In general, the VT Medicaid clients sampled received care similar to that of patients in the Vermont *Blueprint for Health* practices as measured by chart audits using comparable measurements. The impact of the OVHA Chronic Care Initiative/Case Management interventions on HEDIS and other measurements utilized in this study was not quantifiable due to the small numbers of persons receiving CCI interventions among the sampled VT Medicaid clients and the inability to analyze data by the specific intervention(s) received.

Lessons learned for the future:

- Initiatives aimed at improving practice processes and health outcomes need to be designed along appropriate time frames. An initiative to improve a practice process might be expected to generate measurable change relatively quickly, whereas a long-term improvement in health outcomes promoted by the practice process improvement (and associated cost savings resulting) might well be expected to take many years to produce desired outcomes.
- Future analyses of chronic disease management interventions should measure outcomes for all intervention clients, along with a robust control group, in order to generate results that will withstand appropriate statistical analysis
- Analysis of disease-focused processes and/or outcomes for Medicaid patients by individual practice is unlikely to yield statistically significant results due to small absolute numbers

Future Directions:

The State of Vermont has an ambitious agenda for universal healthcare reform (Vermont's Blueprint for Health). This agenda includes disease specific clinical standards; IT support in practices for physician case planning, patient tracking and population profiling; payment reform; all payer claims database; and an outcomes evaluation plan. Most agree that the VCCI initiative can be integrated into a broader healthcare reform effort.

Highlights of the Vermont Chronic Care Initiative for FFY 2010

- A clinical performance improvement project (PIP) is being developed targeting congestive heart failure. The PIP will be implemented during 1st quarter FFY 2011.
- DVHA care coordinators expanded meetings and electronic data exchange systems with hospital emergency departments (EDs) for increased collaboration regarding emergency room utilization among VCCI beneficiaries.
- 3,226 unique beneficiaries were served by either DVHA care coordinators or APS disease management health coaches during FFY 2010 (10/01/2009 through 09/30/2010).
- During FFY 2010, 51 buprenorphine patients who were part of the Capitated Program for the Treatment of opiate Dependency (CPTOD) program received case management services from DVHA care coordinators (see below).

Buprenorphine Program

The DVHA, in collaboration with the Vermont Department of Health's Alcohol and Drug Abuse Programs (ADAP), maintains a Capitated Program for the Treatment of Opiate Dependency (CPTOD). The CPTOD provides an enhanced remuneration for physicians in a step-wise manner depending on the number of beneficiaries treated by a physician enrolled in the program. The Capitated Payment Methodology is depicted in **(Figure 1)** below:

(Figure 1)

Complexity Level	**Complexity Assessment**	**Rated Capitation Payment**	+	**BONUS**	=	**Final Capitated Rate (depends on the**

III.	Induction	$366.42		**number of patients per level, per provider)**
II.	Stabilization/Transfer	$248.14		
I.	Maintenance Only	$106.34		

On January 1, 2010, DVHA notified all buprenorphine providers and implemented an automated payment system for the CPTOD. All claims are now submitted directly to HP Enterprise Services and processed through the MMIS, enabling the DVHA to more accurately budget and track expenditures. The billing requirements are aligned with the treatment complexity levels outlined in the Buprenorphine Provider Agreements and the Buprenorphine Practice Guidelines. The total for all quarters (October 2009-September 2010) is $422,225.88 **(Figure 2)**.

(Figure 2)

Buprenorphine Program Payment Summary FFY '10	
FIRST QUARTER	
Oct-09	$ 54,512.45
Nov-09	$ 51,177.27
Dec-09	$ 53,567.75
Quarter Total	**$ 159,257.47**
SECOND QUARTER	
Jan-10	$ 32,801.15
Feb-10	$ 31,634.36
Mar-10	$ 30,784.87
Quarter Total	**$ 95,220.38**
THIRD QUARTER	
April -10	$28,865.08
May-10	$29,446.11
June-10	$28,527.56
Quarter Total	**$86,838.75**
FOURTH QUARTER	
July-10	$40,516
Aug-10	$24,767.34
Sept-10	$15,625.94
Quarter Total	**$80,909.28**
GRAND TOTAL	**$422,225.88**

Highlights: Progression of the Buprenorphine Program (Per FFY 2010)

- At the end of the 1st quarter of FFY 2010, DVHA's Capitated Program for the Treatment of Opiate Dependency (CPTOD) had 30 enrolled providers, approximately 386 patients undergoing opiate addiction treatment, and had paid $159,257.47 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 $254,447.85 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 $341,316.6 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 $422,225.88 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.

FFY 2011 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. Ongoing strategic planning and discussions will continue with ADAP on Medication Assisted Therapy and issues around capacity.

On January 1, 2010, the DVHA and its fiscal intermediary HP Enterprise Services (formerly EDS) streamlined 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.

Review 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. The updated *Guidelines* are currently available to all providers. We will continue to review and update guidelines as needed.

The *Buprenorphine Provider Agreements* for the next FFY 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 DVHA will continue to 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:

Acute Psychiatric Inpatient Care

Per the Department of Mental Health Master Plan to replace the Vermont State Hospital (presented to the General Assembly in February, 2010), DMH has continued to explore inpatient development options with the Rutland Regional Medical Center, the Brattleboro Retreat, and the Veteran's Administration Hospital in White River Junction, Vermont. The development of new or enhanced inpatient beds in collaboration with general medical hospitals is based on the Master Plan's intent to achieve a new model of care focused on the of integration of mental health with general health care. Most recently, DMH is undertaking a review of earlier options analyses to ensure information remains current and planning considerations have been fully explored for viable treatment and facility replacement options.

Additionally, the overall design work for an inpatient care management system has included the development of a consensus medical screening protocol for all hospital emergency departments to use when referring individuals for psychiatric inpatient care. This consensus document has been approved by the five psychiatric inpatient programs, and the medical screening was implemented in November 2010.

DMH has issued an RFP to develop a "bed board" to identify inpatient and crisis bed availability state-wide for use by the emergency and inpatient providers. Proposals have been received and are undergoing review.

Secure Residential Recovery Treatment Program

In December 2010, DMH received approval from BISCHA for its Certificate of Need (CON) application to create a 15-bed, secure residential recovery treatment program. This 15-bed secure adult psychiatric treatment and recovery residential program is proposed on the grounds of the state office complex in Waterbury as described in the FFY 08 annual report and the last quarterly report. If constructed, the residential recovery treatment program will provide comprehensive, patient-centered care in a newly constructed facility. At present, the DMH has placed further development of secure residential capacity on hold pending development of a plan for full replacement of VSH beds.

The Master Plan and the CON application for the Secure Recovery Residence are available at the DMH website: http://mentalhealth.vermont.gov/

Community System Development

In collaboration with Vermont's network of community mental health centers DMH has implemented several new community-based crisis stabilization and rehabilitation treatment services. These programs have demonstrably reduced the average daily census at Vermont State Hospital by providing clinically appropriate, lower cost alternatives to hospitalization for Medicaid enrollees. The Department of Mental Health is close to finalizing a contract with Deerfield Health Systems to secure access to the LOCUS (Level of Care Utilization System) for all admissions to acute care (crisis beds) and residential beds. Vermont plans to begin statewide implementation of the web-based application in early summer 2011 as part of the earlier referenced care management system.

Most recently, Vermont Psychiatric Survivors, Inc., an adult mental health consumer organization, is working with a newly established board of directors to finalize plans to create a peer-run alternative to traditional crisis stabilization services. The board of directors of the planned program is working with Vermont Psychiatric Survivors and the Department of Mental Health (DMH) to establish a start up budget and timeline to begin operations in July, 2011. This new program will be called "Alyssum."

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 third year of operation, Vermont was still experiencing a weak economy, yet according to the most recent data published by the Vermont Department of Banking, Insurance, Security and Health Care Administration (January 2010), Vermont's uninsured rate held steady at 7.6%. Data from our Green Mountain Care enrollment reports also showed an increase of 12,004 covered lives during FY10.

During this fiscal year, we partnered with the Vermont Department of Labor (DOL) at 14 layoffs and six job fairs to inform over 1100 people about their health insurance options under Green Mountain Care. These are large numbers for a rural state, but half the number from the previous year.

The DVHA also worked with DOL to respond to requirements under the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) which directed employers to notify their employees through a "model letter" about premium assistance under Medicaid and the Children's Health Insurance Program. The DVHA worked with the Vermont Association of Human Resources to alert them to this model letter which was posted to the DOL website and mailed to over 20,000 employers.

Fiscal year 2010 began with significant momentum directed at a campaign to reach the largest group of uninsured Vermonters, namely those between the ages of 18 – 24 years. The DVHA embarked upon a semester long project with over 80 marketing students at the University of Vermont and Champlain College. The initial purpose was to conduct research, focus groups and produce videos to reach this age group. Regardless of the fact that this campaign needed to be pulled due to the passage of federal health care reform, it is important to note that Vermont's largest bank, Chittenden Bank, had agreed to program their ATM machines with messages directed to students who would be loosing their health insurance upon graduation. Additionally, one of Vermont's largest marketing firms, JDK Design donated its space for focus groups, and students produced 19 videos to reach their peers. Twenty of Vermont's 22 colleges prepared to do outreach to approximately 5,000 college seniors. After passage of federal health reform, the majority of insurance companies in Vermont provided extended coverage to graduating seniors. It therefore became imperative that we redirect our efforts and develop new strategies going forward. It was possible to edit two of the videos so they are still relevant. One that features a snowboarder is especially effective in reaching this age group and is currently featured on the home page of www.GreenMountainCare.org, while we link to the other on Face Book.

The DVHA began the process of positioning itself as a trusted source for information on how federal health care reform dovetails with health insurance options under Green Mountain Care. Commissioner Susan Besio, along with the Deputy Commissioner of Banking, Insurance, Security and Health Care, and Governor Douglas of Vermont, joined the CEO of Blue Cross Blue Shield of Vermont at a briefing about extended coverage for young adults up to age 26. Students from the University of Vermont were present and showed their videos.

The DVHA ran a two-page "info ad" about extended coverage in the publication, Seven Days, which is popular with a younger demographic. The cost of the ad was shared with DVHA's Catamount Health partners, Blue Cross Blue Shield of Vermont and MVP Health Care and directed readers to our website. A related editorial by Commissioner Susan Besio was picked up by an on-line news source known as Vermont Digger, as well as small community newspapers which is an important way in which to reach people in a rural state. Vermont's largest Chamber of Commerce (The Lake Champlain Regional Chamber of Commerce) ran the editorial in their ENewsletter that was sent to 4,500 businesses.

The DVHA took advantage of the back-to-school shopping week to promote Green Mountain Care on two radio stations (WDEV and WLVB) that have reach into the county with the highest rate of uninsured in the state (Lamoille at 11.4%). A week of 78 spots featured beneficiaries on Green Mountain Care plans and culminated in an event at the Berlin Wal-Mart which services that region. Live interviews included outreach personnel from CMS's Boston office carrying a message from the Secretary of Health and Human Services. Also partnering in this effort were Bi-State Primary Care (a trade association for Federally Qualified Health Centers and Rural Health Clinics) and DVHA's two Catamount Health partners, Blue Cross Blue Shield of Vermont and MVP Health Care.

A television program on Green Mountain Care was taped on public access Channel 17. It featured a panel of three self-employed entrepreneurs who shared their experience enrolling in Green Mountain Care. The show was posted the Channel 17 site as well as the Green Mountain Care site and picked up by over 10 additional public access stations, thereby giving us reach at no cost statewide. Some stations aired the show for a week, while others aired it for two months. Green Mountain Care beneficiaries also volunteered to write articles and letters to the editor, which were published in seven local papers.

During the FY 10, the Department of Vermont Health Access turned its attention to aligning health care material that consumers receive from various departments within the State of Vermont. A marketing style guide was produced to centralized photos, logos, and art files in one location to be easily accessed across

departments. It provides boilerplate descriptive language, font, color and logo placement so the look and feel of the program is consistent across state government. The DVHA was also involved in an agency-wide effort to redesign the web portal to the Agency of Human Services, again to ensure that services are consistently described in consumer-friendly manner. In an effort to align health care materials and customer "touch points" the DVHA insurance cards, previously known as AIM and PC Plus Cards were rebranded as Green Mountain Care cards. This project also included removing beneficiary's social security numbers and consequently required coordination across several agencies with significant involvement from IT personnel. This year-long effort culminated with mass mailings to over 150,000 people so that the they would receive their new card prior to 10/1/10.

Significant updates were made to our website in order to drive more web traffic from uninsured Vermonters to our site. Vermont's two United States Senators and Congressman posted the Green Mountain Care web button link on their websites. Not only do these sites give Green Mountain Care important exposure, they are trusted sites with enormous credibility and as such they enhance the Google rating and "search- ability" of the Green Mountain Care site.

Quality Assurance and Performance Improvement Activities:

During this year, the Quality Assessment and Performance Improvement (QAPI) Committee discussed the scope of this year's Compliance Review (i.e., Medicaid Managed Care Access Standards). The members of the committee talked specifically about the coverage & authorization of service and coordination and continuity of care requirements contained in the Code of Federal Regulations. The Committee reviewed the specific items associated with these requirements including but not limited to the following: written criteria and mechanism to ensure consistent application of criteria.

The group also continued its monitoring/oversight of the QAPI activities using the newly developed reporting/review format. In order to do so, the group reviewed a reporting template for the monitoring/oversight. It was agreed that other staff would be invited to future meetings to present the results of their work. A schedule was distributed which identifies which specific activity will be discussed during each month. The following activities were reviewed/discussed during this year: Confidentiality (including privacy and security), Performance Measures, and Availability of Services. A DVHA representative joined the committee to discuss the HEDIS measures being reported this year and to provide an overview of the certified software vendor being used to calculate the measures. Also, a DVHA staff member joined the group to discuss the provider mapping capabilities currently being used to satisfy the availability of services requirement.

The group continued to develop a list of sample measures to support an Agency-wide performance management system. This discussion is consistent with the State-wide focus on the use of performance measures to track the success of activities initiated by the Challenges for Change legislation. In addition to developing a list of measures, the group began the process of identifying Key Concepts of Quality. This approach is also in line with a broader State-wide support for the use of performance measures and establishing a performance management system. In addition, the group began a discussion re: performance-based contracting/granting. Like some of the other activities initiated by the Challenges Legislation, this concept will require the use of performance measures to help contractors/grantees focus on outcome/results.

Finally, during this year, the group discussed the committee structure and format. It was agreed that the current structure/format of the committee needed to be modified to best address the monitoring/oversight needs of the Agency, as well as, DVHA quality assessment and performance improvement needs. It was decided that DVHA would convene staff four times per year to discuss specific delegated QAPI activities

while the broader group would meet four times per year to review the MCE performance on all QAPI activities. The impact of this change will be evaluated at the quarterly AHS meetings.

External Quality Review

During this year, the Performance Improvement Project (PIP) work group continued to prepare for this year's External Quality Review Organization (EQRO) PIP validation. Baseline data collection was completed at the beginning of the year and a technical assistance call was held with the EQRO to discuss this year's reporting requirements. During the year, the Managed Care Entity's (MCE) 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 included information associated with Activities I through VIII of the protocol and focused on analysis of baseline data and interpretation of results. After an initial review, the EQRO provided the group with three points of clarification. The PIP work group decided to address these points of clarification, modify their initial submission, and resubmit the modified document to the EQRO for final review. Once this was done, the External Quality Review Organization (EQRO) reviewed the MCE's modified Performance Improvement Project (PIP) submission form and produced a final report detailing the findings of their Performance Improvement Project validation activities. The validation covered steps I through VIII, which involved review of the selected study topic, study questions, and study indicators, and identification of the study population, and data collection procedures. The EQRO conducted their validation 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. The validation finding for DVHA's PIP showed an overall score of 96 percent, a critical element score of 100 percent, and a *Met* validation status indicating high confidence in the results of the PIP for steps I-VIII.

AHS staff also met with DVHA staff responsible for calculating and reporting the set of measures that will be used to monitor performance during this year. The performance measure specifications identified by AHS were HEDIS 2009. At the beginning of the year, a conference call between the EQRO and the DVHA was convened to determine how the use of a certified software vendor will impact this year's Performance Measure Validation Review. Also during this year, 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 DVHA. During their visit, the EQRO completed 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. During their review, the EQRO validated a set of 11 performance measures calculated by the DVHA 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. The performance measures were reported and validated for the measurement period of calendar year 2009 (i.e., January 1, 2009 through December 31, 2009). All 11 measures were assigned a validation finding of fully compliant with AHS specifications. Also during this year, the EQRO produced a final report detailing the findings of their Performance Measure Validation activities.

Additionally, the AHS worked with the DVHA to help them prepare for this year's compliance review. During this year, the MCE submitted documents demonstrating its ability to comply with Federal Medicaid Managed Care Access standards. After reviewing the document, the EQRO conducted an on-site review. The EQRO conducted a review of compliance with federal Medicaid managed care regulations and their associated AHS IGA/contract requirements in seven performance categories (i.e., standards). During the visit, the EQRO conducted the following activities: opening conference, review of documents, interviews with key staff, and a closing conference. The EQRO followed the guidelines 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, for the pre-on-site and on-site review activities. The DVHA received an overall compliance score of 97 percent. The EQRO also produced a final report detailing the findings of their review of compliance with managed care regulations activities.

Finally, the EQRO produced a final Technical Report that 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. This document was forwarded to CMS.

Quality Strategy:

The AHS Quality Improvement Manager and the members of the QAPI committee review the Quality Strategy on a regular basis and recommend any necessary modifications. There were no changes made to the Quality Strategy during this year.

Evaluation Activities:

During the last quarter of FFY10, the interim evaluation report of the Global Commitment to Health 1115 Waiver prepared by Pacific Health Policy Group (PHPG) accompanied the State's formal waiver extension request to CMS. By the end of the year, there was no action taken on Vermont's request. Once the outcome of the waiver extension request is known, the AHS Quality Improvement Manager 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 Single State Agency for Medicaid has delegated the responsibility for Program Integrity to the Department of Vermont Health Access (DVHA), Program Integrity (PI). The PI Unit strives to ensure that Medicaid funds are utilized appropriately by identifying and ultimately reducing fraud, waste and abuse.

Extensive collaboration exists between other DVHA units as well as with external stakeholders for the 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 the 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 results in a referral to 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 employs several methods to identify fraud, waste and abuse including:

- Referrals from providers, pharmacies, national alerts, general public, etc.
- Pre-Payment reviews
- Post-Payment reviews
- Data mining activities
- Decision Support System reports (recipient utilization profiles, provider profiles.)

Medicaid Management Information System

The Medicaid Management Information System (MMIS) is an integral component of the PI unit's utilization review activities. It is a tool that allows scrutiny of claims data 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.

Claims Data Analysis and Post Payment Review

The PI unit 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 generated from these reviews identify specific claims data and facilitate PI investigations.

Ad Hoc Queries

The PI unit also utilizes the Enhanced Vermont Ad Hoc (EVAH) system. The EVAH system is a Business Objects application that enables PI unit to create varied and comprehensive ad hoc reports from the MMIS database. EVAH is an invaluable tool employed by the PI unit auditors to advance investigations and allows them the ability to focus on individual elements within each claim.

Data gleaned from EVAH allows the PI unit to compare claims information submitted by providers. The data can be broken out by case type, which describes the type of service provided, and enables the PI unit to compare individuals to the entire peer group. This is a valuable tool in detecting under and over utilization on a global scale.

Decision Support System (DSS)/Profiler

The Decision Support System (DSS) is a tool that provides the framework for oversight of Medicaid services to ensure they are effective and efficient, adhere to policy, and meet standard of practice and billing compliance. Reports generated by the DSS allow the PI unit to compare providers with their peers by unique case types. This is a valuable tool for detecting under and over utilization as well as identifying outliers.

<u>Inpatient, Outpatient, and Emergency Department Utilization</u>

Methods. Utilization statistics for inpatient, outpatient, and emergency department services provided under Global Commitment during FFY 2010 were compiled by DVHA's Data & Reimbursement Unit in March, 2011, using paid claims data generated by DVHA's fiscal intermediary, HP Enterprise Services (HP). The scope of analysis included institutional services provided under the Medicaid program between 10/1/2009 and 9/30/2010, excluding crossover claims.[1] The following areas of utilization were the focus of this analysis:

- Total Inpatient Utilization
    - Inpatient Medicine
        - Inpatient Medicine – Alcohol and Substance Abuse Services
        - Inpatient Medicine – Psychiatric Services
        - Inpatient Medicine – All Other Services
    - Inpatient Surgery
- Total Outpatient Utilization
    - Emergency Department Utilization

Measures consisted of discharge counts and institutional length-of-stay, in days, for inpatient services, and visit counts for outpatient services. The results were broken out by age category.

Findings. The following table presents discharge counts and average length-of-stay by age for inpatient services provided in FFY 2010.

[1] Crossover claims, or claims for which the State of Vermont was the payer of last resort and paid the remainder of cost for services covered by Medicare.

Table 1. Inpatient Utilization.

Utilization	Age	Discharges	Sum LOS Days	Avg LOS Days
TOTAL INPATIENT (IP)	<1	3,417	11,960.00	3.50
TOTAL INPATIENT (IP)	1-9	592	2,339.00	3.95
TOTAL INPATIENT (IP)	10-19	1,287	7,845.00	6.10
TOTAL INPATIENT (IP)	20-44	5,847	24,581.00	4.20
TOTAL INPATIENT (IP)	45-64	3,001	17,771.00	5.92
TOTAL INPATIENT (IP)	65-74	118	637.00	5.40
TOTAL INPATIENT (IP)	75-84	54	261.00	4.83
TOTAL INPATIENT (IP)	85+	23	86.00	3.74
TOTAL INPATIENT (IP)	Total	14,339	65,480.00	4.57
IP MEDICINE	<1	3,377	11,708.00	3.47
IP MEDICINE	1-9	483	1,797.00	3.72
IP MEDICINE	10-19	1,038	6,877.00	6.63
IP MEDICINE	20-44	4,449	18,426.00	4.14
IP MEDICINE	45-64	2,155	12,012.00	5.57
IP MEDICINE	65-74	88	499.00	5.67
IP MEDICINE	75-84	50	227.00	4.54
IP MEDICINE	85+	20	80.00	4.00
IP MEDICINE	Total	11,660	51,626.00	4.43
IP MED ALCOH/SUBST	<1	0	0.00	0.00
IP MED ALCOH/SUBST	1-9	0	0.00	0.00
IP MED ALCOH/SUBST	10-19	11	66.00	6.00
IP MED ALCOH/SUBST	20-44	400	2,228.00	5.57
IP MED ALCOH/SUBST	45-64	179	851.00	4.75
IP MED ALCOH/SUBST	65-74	1	1.00	1.00
IP MED ALCOH/SUBST	75-84	1	5.00	5.00
IP MED ALCOH/SUBST	85+	0	0.00	0.00
IP MED ALCOH/SUBST	Total	592	3,151.00	5.32
IP MED PSYCHIATRIC	<1	0	0.00	0.00
IP MED PSYCHIATRIC	1-9	32	478.00	14.94
IP MED PSYCHIATRIC	10-19	388	4,672.00	12.04
IP MED PSYCHIATRIC	20-44	809	6,780.00	8.38
IP MED PSYCHIATRIC	45-64	330	3,335.00	10.11
IP MED PSYCHIATRIC	65-74	3	24.00	8.00
IP MED PSYCHIATRIC	75-84	2	13.00	6.50
IP MED PSYCHIATRIC	85+	0	0.00	0.00
IP MED PSYCHIATRIC	Total	1,564	15,302.00	9.78
IP MED OTHER	<1	3,377	11,708.00	3.47
IP MED OTHER	1-9	451	1,319.00	2.92
IP MED OTHER	10-19	639	2,139.00	3.35
IP MED OTHER	20-44	3,240	9,418.00	2.91
IP MED OTHER	45-64	1,646	7,826.00	4.75
IP MED OTHER	65-74	84	474.00	5.64
IP MED OTHER	75-84	47	209.00	4.45
IP MED OTHER	85+	20	80.00	4.00
IP MED OTHER	Total	9,504	33,173.00	3.49
IP SURGERY	<1	40	252.00	6.30
IP SURGERY	1-9	109	542.00	4.97
IP SURGERY	10-19	249	968.00	3.89
IP SURGERY	20-44	1,398	6,155.00	4.40

IP SURGERY	45-64	846	5,759.00	6.81
IP SURGERY	65-74	30	138.00	4.60
IP SURGERY	75-84	4	34.00	8.50
IP SURGERY	85+	3	6.00	2.00
IP SURGERY	Total	2,679	13,854.00	5.17

The following table presents visit counts by age for outpatient services provided in FFY 2010, first for all outpatient services, and then for emergency department services.

Table 2. Outpatient Utilization.

Age	TOTAL OUTPATIENT (OP) Visits	OP EMERG DEPT Visits
<1	6,054	2,687
1-9	33,666	14,163
10-19	44,518	14,771
20-44	146,016	38,514
45-64	86,717	10,893
65-74	1,040	88
75-84	247	34
85+	78	10
Total	318,336	81,160

Discussion. In FFY 2010, Global Commitment, Medicaid, paid for 14,339 inpatient stays and 318,336 outpatient visits for Vermonters. Of the inpatient stays, 81% were for inpatient medicine, and 19% were for inpatient surgery. Drilling down further, psychiatric services constituted 13% of the inpatient medicine stays, and treatment for alcohol and substance abuse services constituted 5% of inpatient medicine stays. Compared to other inpatient stays, alcohol/substance-abuse stays were moderately longer in average duration (similar to that for inpatient surgery), and psychiatric stays were substantially longer. Among outpatient visits, emergency department visits constituted roughly 25%.

V. Policy and Administrative Difficulties

Fiscal & Operational Management:

The waiver's financial operations continued to receive significant attention during waiver year five.

AHS paid DVHA a prospective PMPM capitation payment on the first business day of every month during FFY10. The PMPM payments included retroactive changes in enrollment with a 12-month runout period, per our PMPM payment process.

AHS submitted its FFY10 IGA with DVHA to CMS on August 31, 2009. AHS received approval from CMS for its FFY10 IGA on March 22, 2010.

Effective December 23, 2009, CMS approved Federal funding for expansion populations for the following MEGs: GlobalRx dual/non-dual up to 225% FPL, Catamount, and ESIA up to 300% FPL. The State paid the same PMPMs for this FPL expansion at the rates already selected for the existing MEGs. These four population groups, however, are not eligible to receive ARRA funding, therefore, the state draws at the regular FMAP for these populations.

During FFY10, AHS worked with DVHA and HP to ensure that the State's reporting system supports all MBES requirements

Per our PMPM payment process and its 12-month run out period, the September 1, 2010 PMPM payment included the last true-up adjustment for FFY09; no further adjustments to the FFY09 GC claim will be made past that point.

During FFY10, AHS worked with Aon Consulting for development of the FFY10 and FFY11 actuarial rate range certifications. On April 1, 2011, AHS will enter 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 FFY12 period.

FFY10, GC waiver year five, was the final year of the original Global Commitment to Health Section 1115 Demonstration. AHS and DVHA spent a considerable amount of time discussing the GC waiver renewal terms with CMS throughout FFY10 and beyond. We received three one-month extensions (October, November, December 2010) while the details for the waiver renewal were being finalized. The GC waiver extension was approved for January 1, 2011, and will end on December 31, 2013. AHS and DVHA are currently in the process of implementing new procedures and processes that will support accurate expenditure reporting in accordance with the requirements outlined in the new GC Special Terms & Conditions.

Operational Challenges:

Challenges experienced in waiver year five 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.

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. The LTC waiver was renewed effective October 1, 2010, and clarified the exclusion of individuals under the age of 18, which must be covered under the GC waiver. 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, DVHA, 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. Upon GC waiver renewal, effective January 1, 2011, the STCs were clarified to reflect IBNR resolution at waiver conclusion.

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

The State spent much of the first few years of the Global Commitment waiver ensuring compliance with the 42 CFR 438, aligning reporting and accounting practices and working with CMS staff to create revised federal reporting forms and clarity on reporting requirements. In the last year the state has begun to focus on programmatic flexibilities as it relates to the elimination of multiple and duplicative documentation requirements, unifying provider oversight practices across departments and streamlining the delivery of Medicaid program services for children and families. Additionally, the state is piloting performance based payment options in several specialty programs for children and adolescents who have mental health and other behavioral needs.

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; and
- ensure compliance with federal MCO and other waiver requirements.

Several examples of these types of initiatives have been mentioned earlier in this report with the Blueprint to Health, Chronic Care and Bupenorphine programs. In addition to these critical efforts the agency is undertaking a redesign of services and supports to address the continuum of services prenatal to age 22 for Vermont's children and families known as the Integrated Family Services Initiative.

Currently AHS children's services fall in five Departments and multiple divisions of the agency. Division and departments historically developed separate and distinct Medicaid waivers and Medicaid procedures for managing sub-specialty populations within various departments. While the best approaches available at the time, the artifacts of this history are multiple and fragmented funding streams, policies, and paperwork guidelines about our work with children and families. With the inception of the Global Commitment waiver, these separate and discrete funding and administrative structures do not need to exist.

The Integrated Family Services Initiative seeks to bring all agency children, youth and family services together in an integrated and consistent continuum of services for families. The premise being that giving

families early support, education and interventions will produce more favorable outcomes at a lower cost then the current practice of *waiting until circumstances are bad enough* to access *high end* funding streams which often result in use of more costly Medicaid options including but limited to out of home or out of state treatment placements.

Efforts across the agency over the past several years have moved in the direction that this initiative champions. For example, DCF- Family Service Division has instituted a Differential Response system which seeks to apply resources and intervention earlier to focus on mitigating risk and thus increase child safety and family unity. VDH- Children with Special health Needs, DCF- Child Development Division and DVHA have been fully integrating administrative and operational procedures for service authorization, billing and tracking for early childhood services.

The basic elements of this model under global commitment will also be integrated with the Blueprint Community Health Teams and the expanded DVHA Chronic Care initiative. The integrated family services effort will support wellness coaching. Additionally, proposals by DVHA and DMH to assure that the best clinical practices are utilized in the Medicaid program will be integral to this initiative relative to clinical practices in mental health, behavioral health, medical and medication management for children, youth and families.

VI. Capitated Revenue Spending

The PMPM rates as set for waiver year five are listed below. Full PMPM payment has been made by AHS to DVHA reflecting the FFY10 enrollment run on November 15, 2010. Investments made by the MCE for State fiscal year 2010 totaled $55,554,314. Areas of capitated spending and the associated categories are outlined in Attachment 1.

FFY10 PMPMs paid as of December 1, 2010

Medicaid Eligibility Group	Monthly Premium PMPM per IGA	Member Months	PMPM paid to-date
ABD - Non-Medicare - Adult	**$ 1,104.49**	162,292	$ 179,249,891.08
ABD - Non-Medicare - Child	**$ 2,174.99**	43,606	$ 94,842,613.94
ABD - Dual	**$ 1,186.21**	184,821	$ 219,236,518.41
ANFC - Non-Medicare - Adult	**$ 574.25**	126,407	$ 72,589,219.75
ANFC - Non-Medicare - Child	**$ 364.88**	655,129	$ 239,043,469.52
GlobalExp	**$ 413.60**	412,024	$ 170,413,126.40
GlobalRx - Dual	**$ 9.78**	143,762	$ 1,405,992.36
GlobalRx - Non-Medicare	**$ 177.98**	157	$ 27,942.86
OptionalExp	**$ 173.62**	14,335	$ 2,488,842.70
VHAP ESI	**$ 224.86**	11,267	$ 2,533,497.62
ESI Premium Assistance	**$ 176.95**	7,757	$ 1,372,601.15
Catamount Premium Assistance	**$ 428.84**	106,339	$ 45,602,416.76
		1,867,896	**$ 1,028,806,132.55**

The above PMPM payment reflects the final PMPM for the FFY10 period. Beginning January 1, 2011, the State will be reporting and claiming Federal funds for GC based on actual cash expenditures incurred during the quarter, therefore, the final accrual PMPM payment for FFY10 under the GC waiver was made on December 1, 2010.

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