*State of Vermont*
*Agency of Human Services*

# Global Commitment to Health
# 11-W-00194/1

## Annual Report
**For FFY14**
**October 1, 2013 to September 30, 2014**

**Submitted via email on April 1, 2015**

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# I. Background and Introduction

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

Vermont is a national leader in making affordable health care coverage available to low-income children and adults. Vermont was among the first states to expand coverage for children and pregnant women, through the 1989 implementation of the state-funded Dr. Dynasaur program. In 1992, Dr. Dynasaur became part of the state-federal Medicaid program.

When the federal government introduced the state Children's Health Insurance Program (CHIP) in 1997, Vermont extended coverage to uninsured and under-insured children living in households with incomes below 300 percent of the Federal Poverty Level (FPL).

In 1995, Vermont implemented an 1115(a) waiver program, the Vermont Health Access Plan (VHAP); the primary goal was to expand access to comprehensive health care coverage for uninsured adults with household incomes below 150 percent (later raised to 185 percent) of FPL, through enrollment in managed care. VHAP also included a prescription drug benefit for low-income Medicare beneficiaries who did not otherwise qualify for Medicaid. Both waiver populations pay a modest premium on a sliding scale based on household income.

Implemented October 1, 2005, the Global Commitment converted the (then Office) Department of Vermont Health Access (DVHA), the state's Medicaid organization, to a public Managed Care Entity (MCE). The Agency of Human Services (AHS) pays the MCE a lump sum premium payment for the provision of all Medicaid services in the state (with the exception of the Long-Term Care Waiver, managed separately).

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

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

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

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

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

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 ninth waiver year, federal fiscal year 2014, which ended on September 30, 2014.

## II. Highlights and Accomplishments

- The Global Commitment waiver renewal was approved for October 2, 2013 through December 31, 2016. Additionally, AHS and the DVHA worked throughout FFY14 on consolidating Vermont's two 1115 waivers, Global Commitment and Choices for Care, into one waiver agreement, which became effective during FFY15 (January 30, 2015).

- Throughout FFY14, the State of Vermont put forth significant effort in continued development of Vermont Health Connect, a state-based health benefit exchange for individuals and small businesses in Vermont, which was launched on October 1, 2013. By November 1, 2014, over 140,000 Vermonters had received coverage through Vermont Health Connect.

- The enterprise MMIS RFP development was a significant effort during FFY14.

- The AHS collaborated with community providers to create a coordinated, systemic response to the complex issues of opioid addictions in Vermont, referred to as the Care Alliance for Opioid Addiction (a Hub and Spoke model).

- External Quality Review - the DVHA with its IGA partners was found to be 92% in compliance with the external quality review standards.

- The Compliance Committee was reconvened in FFY14. The group will be responsible for guiding compliance activities and will work closely with our Quality Committee, Quality Unit, Program Integrity Unit and representatives from our IGA departments.

- The DMH made significant resource investments into mental health services during FFY14, including the opening of the new Vermont Psychiatric Care facility in Berlin in July, 2014.

# III. Project Status

*i. Vermont Health Connect*

**Key updates:**

- The 2014 Vermont Household Health Insurance Survey found that Vermont's uninsured rate was cut nearly in half over the past two years. The 3.7% rate puts Vermont second in the nation in health insurance coverage.
- After many months of working with CGI to advance deployment of needed functionality and improve performance and delivery, in August, the State announced its plan to transition this work to a new systems integration (SI) vendor, Optum Insight.
- By November 1st, over 140,000 Vermonters had received coverage through Vermont Health Connect, including 32,237 enrolled in Qualified Health Plans.
- Vermont Health Connect's second open enrollment period launched successfully on November 15, 2014 and will close on Sunday, February 15, 2015.

The State of Vermont launched Vermont Health Connect (VHC), a state-based health benefits exchange for individuals and small businesses in Vermont, on October 1, 2013. By November 1, 2014, over 140,000 Vermonters had received coverage through Vermont Health Connect, including 32,237 enrolled in Qualified Health Plans (QHPs). Unexpected technological challenges in the project led the State to expand options available to Vermonters throughout calendar year (CY) 2014, including allowing small businesses to enroll directly through insurance carriers and individuals to extend their 2013 coverage until the end of March 2014. Vermont Health Connect's second open enrollment period for QHPs launched on November 15, 2014 and will close on February 15, 2015. Vermonters who were new to the Marketplace began signing up for 2015 health coverage, while existing QHP customers requested changes or auto-renewed for 2015 coverage. As of December 23, 15,173 households were mapped to 2015 health plans. In addition, VHC has received 5,195 applications for new coverage.

Through VHC, many Vermonters received financial help with their health care coverage. Nearly 60% of those shopping for private health insurance through the Marketplace as individuals were found eligible for tax credits to make their coverage more affordable. When combined with those accessing Medicaid, over 85% of individuals seeking coverage through VHC benefitted from some form of financial help.

In July 2014, the State became aware that a larger than expected number of members (approximately 14,000) did not renew their Medicaid/Dr. Dynasaur coverage during the months of April, May and June. These were members who were expected to transition into enrollment through VHC for the first time. The State gained federal permission to reinstate individuals whose cases were closed during those months. The State is currently delaying renewals for this population until an agreement is reached with CMS on a new renewal start date. Vermont has asked that Medicaid renewals be delayed into CY2015 to allow time for effective noticing and outreach subsequent to completion of all open enrollment activities. The State is exploring additional outreach and application strategies to increase the transition rate once Medicaid renewals resume. To date, the State has not received an official response from CMS regarding its proposed approach.

Throughout FFY14, the State continued to utilize federal resources to further the development of Vermont Health Connect, with the goal of creating one system to determine eligibility for Medicaid, CHIP, and QHPs. The State began this work in December 2012 when it signed a systems integration contract with CGI to purchase services for the implementation of core technology components necessary to create VHC.

CGI partnered with Exeter Consulting Group to implement the OneGate Exchange Product for the State. This pre-configured product greatly expedited Vermont's delivery and positioned Vermont Health Connect to meet its mission to provide Vermonters access to public and private health care benefits throughout open enrollment. OneGate leverages existing State software licenses (Oracle) and provided out-of-the-box Affordable Care Act (ACA) compliance rules for eligibility and the enrollment application. Additionally, OneGate had pre-designed the workflows for the Small Business Health Options Program (SHOP), plan selection, and the back-end case management process.

Throughout FY2014, the project suffered significant delays in the deployment of additional functionality, forcing the State to rely heavily on labor-intensive manual processes. After many months of working with CGI to advance deployment of needed functionality and improve performance and delivery, in August, the State announced its plan to transition this work to a new systems integration (SI) vendor, Optum Insight.

Project delays resulted in buildup of operational backlogs during the second half of FY2014. This includes change of circumstance requests, payment processing errors, and 834 enrollment transactions. The State contracted with Optum on a monthly basis beginning in June 2014 to provide staff augmentation services to support manual workarounds. Optum agents worked at contact center locations across the country to assist the State in processing change of circumstance requests, as well as QHP renewals. The State has moved from a high of 110 Optum agents in October, to a pool of 30 trained contact center representatives in December.

The State is currently negotiating a SI agreement with Optum to complete the work that was not delivered under the original contract. Optum successfully completed a limited deployment during the second week of November to update the VHC website and online application in preparation for open enrollment.

*Outreach & Education:*
Vermont continues to prioritize engagement and collaboration with key partners and stakeholders to ensure the successful design, development, and implementation of Vermont Health Connect. The State uses advisory meetings, public forums, media inquiries, and other interactions to educate Vermonters about the State's vision for health care reform and the role of the Exchange in that vision. The State also values the input of Vermonters in the process of building the Exchange, soliciting input through formal structures and information interactions.

An important priority for VHC is providing effective consumer assistance to individuals and small businesses. Vermont has developed goals for the consumer experience within the Marketplace for both individuals and small businesses. The mission of Vermont Health Connect is to provide all Vermonters with the knowledge and tools needed to easily compare and choose a quality, affordable, and comprehensive health plan. VHC has identified four functions that it feels are critical in providing the level of consumer support required by the ACA.

1. Having a call center with a toll-free hotline to assist all Vermonters seeking health insurance;
2. Developing a broad network of Navigators and in-person assister personnel;
3. Working closely with agents and brokers; and
4. Working closely with the Office of the Health Care Advocate.

The State continued to work with assisters throughout FY2014 to ensure adequate training and prepare this group to assist with 2015 open enrollment. The State's Outreach & Education Campaign for QE0914 focused on assisters and the help they can provide Vermonters during the application and renewal process. This is also a key focus for QE1214.

*Plan Management:*
In August 2012, DVHA provided recommendations on essential health benefits, pediatric vision and dental coverage, and plan design to the Green Mountain Care Board (GMCB). The GMCB approved a popular BCBS of Vermont package as the State's benchmark plan. The GMCB also accepted DVHA's recommendation on pediatric vision and dental coverage, making the Children's Health Insurance Program (CHIP) the benchmark plan for pediatric oral and Federal Employees Dental and Vision Program (FEDVIP) the benchmark plan for pediatric vision. Finally, the GMCB accepted DVHA's proposed approach to the development of Exchange plan designs through which each participating carrier would offer state-specific "standard" plan designs as well as the potential for additional "choice" plans through Vermont Health Connect. State-specific plans are offered at all metal tier levels – two bronze, two silver, one gold, and one platinum.

Early in CY2014, the State decided to keep the basic plan structure described above and utilize 2014 plan designs in 2015, with the carriers only making minor change to rates and forms based on updated federal guidance and the GMCB rate approval process. As a result, the plans sold on the Exchange for 2015 are nearly identical to those sold in 2014. In QE0914, the State signed contract amendments with the carriers to offer these plans for 2015 coverage.

Per STC#44, the total effectuated Vermont Premium Assistance (VPA) enrollees during FFY14, by month, were as follows:

**Table 1. VPA Enrollees by Month**

| | VPA Enrolled |
|---|---|
| January 2014 | 5,153 |
| February 2014 | 6,209 |
| March 2014 | 7,717 |
| April 2014 | 14,297 |
| May 2014 | 16,144 |
| June 2014 | 16,531 |
| July 2014 | 16,912 |
| August 2014 | 17,259 |
| September 2014 | 17,073 |
| **SUM FFY14** | **117,295** |

Total gross VPA claimed under the Global Commitment waiver during FFY14 was $3,352,234, against a budgeted figure of $8,580,309 for that period.

# IV. Findings

i. *External Quality Review*

**Key updates:**

- DVHA's Compliance score improved from 90% to 92% compliant since the last audit of these standards.
- All of DVHA's Compliance standards were "met" or "partially met."
- DVHA's Compliance Corrective Action Plan will be complete by the end of March 2015.
- The PIP validation review resulted in no corrective action requirements.
- The Performance Measure validation review resulted in no corrective action requirements.

As a Managed Care model, DVHA adheres to federal rules contained in 42 CFR 438. AHS contracts with the Health Services Advisory Group (HSAG) to conduct an external independent review of the quality outcomes and timeliness of—and access to—care furnished by DVHA to its Medicaid enrollees. These audits are known as External Quality Review Organization (EQRO) audits. The audits have three major areas of review:

- Performance Measures Validation
- Monitoring Compliance with Standards
- Performance Improvement Projects Validation

In preparation for this year's EQRO audits, the AHS Quality Improvement Manager (QIM) worked with auditors to prepare documents for the 2014 review activities and to develop and refine the specific standards that would be used in the audits. During this time, the Performance Improvement Project (PIP) summary form, compliance review tool, and performance measure review guides were developed by the EQRO with input from the AHS QIM. These are the tools that are used by the EQRO to gather data that assesses DVHA's performance relative to quality assessment and improvement requirements as well as their ability to comply with state and federal Medicaid managed care standards. In order to define the scope of the review, the AHS QIM finalized the performance measures subject to validation, identified the performance improvement expectations, and agreed upon the Medicaid managed care standards to be reviewed. Timelines were developed, which included the following information: key task, due date, responsible party, and any applicable comments. Once completed, these documents were shared with DVHA and its Intergovernmental Agreement (IGA) partners and made final ahead of the on-site and desk reviews.

In addition to preparing physical documents, the AHS QIM worked with DVHA staff to help them prepare for the upcoming EQRO review activities. This included participating in face-to-face meetings and conference calls between DVHA and the EQRO to determine how best to report PIP activities undertaken during the past year on the newly approved PIP Summary Form, clarifying requirements on the Information Systems Capabilities Assessment Tool (ISCAT) document, as well as clarifying the requirements associated with the measurement and improvement compliance standards. All tools and supporting documents were posted to the EQRO Secure File Transfer Protocol (SFTP) site by the due date.

As in previous years, the AHS QIM attended both on-site EQRO reviews (i.e., review of compliance with standards and performance measure validation) and participated in the desk review of the performance improvement project.

*a. Performance Measures Validation*

The EQRO conducted the validation of performance measures activities as outlined in the Centers for Medicare & Medicaid Services (CMS) publication, *EQR Protocol 2: Validation of Performance Measures Reported by the MCO: A Mandatory Protocol for External Quality Review (EQR), Version 2.0, September 1, 2012.* This year's performance measures were selected by AHS for 2014 reporting. The measurement period for each measure was identified by AHS as CY13. AHS required that the measures be calculated according to the National Committee for Quality Assurance's (NCQA's) *Healthcare Effectiveness Data Information Set (HEDIS) 2014, Volume 2, Technical Specifications for Health Plans*. Table 2 lists the performance measures that HSAG validated.

| Table 2—List of Measures for DVHA | |
|---|---|
| 1. | Adults' Access to Preventive/Ambulatory Health Services (AAP) |
| 2. | Adolescent Well-Care Visits (AWC) |
| 3. | Annual Dental Visit (ADV) |
| 4. | Antidepressant Medication Management (AMM) |
| 5. | Breast Cancer Screening (BCS) |
| 6. | Children and Adolescents' Access to Primary Care Practitioners (CAP) |
| 7. | Chlamydia Screening in Women (CHL) |
| 8. | Comprehensive Diabetes Care (CDC) |
| 9. | Follow-Up After Hospitalization for Mental Illness (FUH) |
| 10. | Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET) |
| 11. | Use of Appropriate Medications for People With Asthma (ASM) |
| 12. | Well-Child Visits in the First 15 Months of Life (W15) |
| 13. | Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34) |

The auditors identified several aspects in the calculation of performance measures as crucial to the validation process. These include data integration, data control, and documentation of performance measure calculations. DVHA received a passing score on all of these aspects. There was a recommendation that DVHA staff conduct additional root cause analysis on performance measures and incorporate national/regional benchmarks to manage rates.

HSAG evaluated eligibility system data and claims processing data and found no areas requiring corrective action.

*Performance Measure Specific Findings:*
DVHA contracted with a software vendor to assist in producing the performance measures. HSAG conducted primary source verification for each required performance measure and identified no errors. All member eligibility strings matched the Hewlett-Packard (HP) Medicaid Management Information System (MMIS) and the Verisk performance measure software vendor system's numerators.

The auditors identified a potential for underreporting of some lab-related measures due to case rates and minimal monitoring of data submitted by DVHA's Federally Qualified Health Centers (FQHCs). HSAG recommended that DVHA conduct further investigation on this data.

*b. Monitoring Compliance with Standards*

Also during this year, the EQRO reviewed DVHA's compliance with the Managed Care performance requirements described in 42 CFR §438, as well as state-specific requirements contained in the AHS/DVHA IGA. This year's performance audit focused on the following eight standards:

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

The EQRO performed an office-based desk review of DVHA's documents as well as an on-site review (in June 2014) that included reviewing additional documents, observing demonstrations of DVHA's processes, and conducting interviews with key DVHA staff members.

DVHA's overall compliance score for this set of standards improved from 90% three years ago (the last time these standards were measured) to 92% this year. While it is gratifying to see an improvement in this score, it is more important to focus on the content of the actual findings, summarized below. All programs either "met" or "partially met" the required compliance standards. No programs were graded as having "not met" a required standard.

This year's performance audit identified the following areas for improvement:

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

Several helpful recommendations were also presented. Most of these focused on helping to find better ways to communicate information to members and providers. Completing these recommendations is optional; however, DVHA has always made a practice of implementing all of HSAG's recommendations.

This audit helped DVHA to highlight (and be recognized for) new and existing programs and projects. The auditors have experience reviewing Managed Care Organizations (MCOs) across the United States,

so the annual EQRO audit is an excellent opportunity for to see how Vermont compares to other systems and to learn about "best practices" that DVHA can emulate. This audit has helped DVHA programs to improve incrementally over the years and this year's audit will certainly continue that trend. In their final report, the auditors noted that:

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

DVHA developed a corrective action plan to address audit findings above. Most of the findings require simple edits or additions to our Provider Manual and Member Handbook. DVHA has already corrected the appeals timeline issue. It is anticipated that all findings will be resolved by the end of QE0315.

### *c. Performance Improvement Validation*

This year's PIP validation audit evaluated the technical methods of the PIP (i.e., the study design and implementation/evaluation). Based on their technical review, the auditors determined the overall methodological validity of the PIP. HSAG reviewed one PIP for the 2013–2014 validation cycle. The PIP received an overall "met" validation status when submitted ("met" means DVHA was meeting all required standards and no corrective actions were required).

Overall, 100% of all applicable evaluation elements also received a score of "met."

*Design:*
According to the auditors, DVHA designed a scientifically sound study supported by the use of key research principles. The technical design of the PIP was sufficient to measure outcomes, and the PIP's solid design allowed for successful progression to the next stage of the PIP process.

*Implementation and Evaluation:*
DVHA met 100% of the requirements for data collection and analysis and interpretation of its reported data. These findings suggest that DVHA accurately documented and executed the implementation and evaluation phase of the study.

*Outcomes:*
Only baseline data were reported in this year's submission of DVHA's PIP; therefore, no assessment of real or sustained improvement could be completed.

*Analysis of Results:*
Table 2–3 displays outcomes data for DVHA's *Follow-up After Hospitalization for Mental Illness* PIP. DVHA reported baseline data for two study indicators.

**Table 2–3—Performance Improvement Project Outcomes for Department of Vermont Health Access**

| PIP #1—*Follow-up After Hospitalization for Mental Illness* | | |
|---|---|---|
| **Study Indicators** | **Baseline (1/1/13–12/31/13)** | **Sustained Improvement^** |
| Percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner within 7 days of discharge. | 62.49% | NA |
| Percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner within 30 days of discharge. | 79.26% | NA |
| ^ Sustained improvement is defined as statistically significant improvement in performance over baseline that is maintained or increased for at least one subsequent measurement period. Additionally, the most current measurement period's results must reflect statistically significant improvement when compared to the baseline results.<br>NA Statistically significant improvement over baseline and a subsequent measurement must occur before sustained improvement can be assessed. | | |

For the baseline measurement period, DVHA reported that 62.49% of members had follow-up after discharge within 7 days (Study Indicator 1). The baseline result for follow-up after discharge within 30 days was 79.26% (Study Indicator 2). DVHA set first remeasurement goals of a 9% increase for Study Indicator 1 and a 5% increase for Study Indicator 2.

*Barriers/Interventions:*
The identification of barriers through barrier analysis and the subsequent selection of appropriate interventions to address these barriers are necessary steps to improve outcomes. According to the auditors, DVHA's choice of interventions, the combination of intervention types, and the sequence of implementing the interventions are essential to the PIP's overall success.

DVHA completed a fishbone diagram for the initial barrier analysis for the PIP. The main categories identified were processes, people, mental health history, environment, and policies. The following are our top priority barriers in order of ranking:

1. Communication: Gaps in communication—between Vermont Medicaid and designated hospitals that provide psychiatric care—regarding discharge-planning policies and expectations.
2. Access: Lack of providers in some areas and possible relationship-building needed between hospital staff and area clinicians.
3. Skill/Training: Lack of skill and/or training on the part of discharge planners.
4. Community Supports: Lack of community supports for members and/or understanding of importance of the recovery plan.

In June 2014, to address the first barrier, DVHA implemented an education intervention with the five designated hospitals. The intervention included informing the hospitals about the PIP, follow-up rates, and updated material on the standard operating procedures manual. Starting in July 2014, follow-up appointment data will be collected quarterly and shared with the five hospitals receiving the education intervention. In January 2015, there will be a follow-up meeting with the hospitals. DVHA documented that intervention evaluation results will be reported in the next annual PIP submission.

*PIP Strengths:*
The *Follow-up After Hospitalization for Mental Illness* PIP received a "met" score for 100% of critical evaluation elements and 100% of overall evaluation elements in the Study Design, Implementation and Evaluation stages. The performance of this PIP suggests a thorough application of the PIP design. DVHA's documentation provided evidence that the Managed Care Entity (MCE) appropriately conducted the data collection activities of the Implementation stage. These activities ensured that the study properly defined and collected the necessary data to produce accurate study indicator rates. Additionally, DVHA documented appropriate improvement strategies targeted to overcome barriers identified by the MCE.

*Global Issues:*
No global issues were identified with DVHA's PIP for this validation cycle.

*Recommendations:*
There were two *Points of Clarification* identified in this year's validation. The *Points of Clarification* will be addressed in the PIP documentation when it is submitted for the next annual validation.

- Activity III: Numerator information and criteria should not be included in the study population definition. The study population should reflect the study indicator denominators. The MCE should remove the bulleted information referencing numerator positive hit criteria.
- Activity VI: Much of the documentation in Activity VI focused on accuracy of administrative data. The documentation should reflect only how complete data are when pulled and how the MCE obtains this percentage of completeness.

*ii. Quality Assurance and Performance Improvement Activities*

**Key updates:**
- 3 PIPs are underway with interventions in place.
- DVHA staff was trained on analyzing performance measures and implementing PIPs following CMS protocols.
- Results Based Accountability Scorecard software became available to DVHA during QE0914, which will allow for the development of a performance dashboard. DVHA Quality Improvement staff will attend software training in QE1214.

The DVHA Quality Improvement (QI) and Clinical Integrity Unit monitors, evaluates and improves the quality of care to our Vermont Medicaid beneficiaries by improving internal processes, identifying performance improvement projects and performing utilization management. Efforts are aligned across the Agency of Human Services as well as with community providers. The unit is responsible for instilling the principles of quality throughout DVHA; helping everyone in the organization to achieve excellence. Our Unit's goal is to develop a culture of continuous quality improvement throughout DVHA.

The MCE Quality Committee (formally the DVHA Quality Committee) was very active throughout FFY14. The new DVHA Medical Director arrived in December 2013 and became the co-chair of the committee. The committee focused on the CMS core performance measures for adults and children, evaluating DVHA's performance and receiving updates on performance improvement projects related to the measures. The committee agreed to structure its work around the triple aims of health care: improving the patient experience, improving the health of populations, and reducing the per capita of cost of health care.

Performance measures were established that each IGA partner will routinely report on for the Medicaid populations(s) they serve. The committee tasked a joint AHS-DVHA workgroup with an in-depth analysis

of the current Global Commitment for Health investment expenditures. The review is expected to determine whether the investment expenditures are realizing optimal outcomes as well as identify whether existing investments could become programmatic or administrative claims instead. The workgroup continued to make progress towards those goals by determining the analysis criteria and started interviewing appropriate subject matter experts in QE0914.

During QE1213, work began on the new performance improvement project focusing on improving follow-up care after psychiatric hospitalization. Throughout the year, the team cleaned up data, created an improvement strategy, and implemented one intervention with the designated psychiatric hospitals. Significant progress was also made on the two performance improvement projects funded by the Adult Quality Measures Grant. The two projects are focused on increasing breast cancer screenings and improving initiation and engagement in substance abuse treatment. All of the projects include representation from departments within AHS as well as community partners and stakeholders. In addition to the three formal performance improvement projects, DVHA continues to participate in the Agency Improvement Model (AIM) trainings and has implemented several process improvement projects.

During this year, DVHA continued to update the Quality Management Plan and provided technical assistance for the same to DVHA's IGA partners. Three of the four IGA partners completed their plans. The last one is currently in development.

The DVHA Quality Unit's QI Administrator coordinated the 2014 Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys. DVHA's contracted vendor, WBA Research, distributed and collated both the Adult and Children's Medicaid CAHPS 5.0H surveys. The QI Administrator registered Vermont Medicaid with the CAHPS data warehouse for the first time. This will allow DVHA access to national comparative reports in the future.

Throughout this year, DVHA worked on developing the internal capacity to complete hybrid Healthcare Effectiveness Data and Information Set (HEDIS) chart reviews for a limited number of measures. Building on the trainings, a chart review committee drafted a Chart Review Operating Principle and the internal process for the spring 2015 hybrid chart review. Training also began on the on-line web portal of DVHA's HEDIS vendor for medical record abstractions.

The DVHA Quality Unit continued to staff the CHIPRA (Child Health Improvement Program Reauthorization Act) grant. The DVHA QI Administrator, in concert with other team members from Vermont and Maine, began the task of setting the agenda and preparing for the last meeting of the CHIPRA Executive Committee in New Hampshire in November 2014. Preliminary discussions centered on the sustainability of the grant.

During this year, the AHS Performance Accountability Committee (PAC) recommended performance measures for the GC Waiver and for the Medicaid/Shard Savings Program (ACO). During the process, members of the committee reviewed/considered performance measures associated with the following AHS sponsored/supported initiatives: Blueprint for Health, Healthy Vermonters 2020, AHS Strategic Plan, and the CMS Adult/Child core measure sets. As the state moves forward with consolidating the Choices for Care waiver with the Global Commitment waiver, the group will need to make sure that long term services and supports (LTSS) measures are part of the Global Commitment measure set. The committee also supported the planning/design aspects of the AHS Results Scorecard. This is an electronic scorecard/dashboard that graphically displays AHS performance/accountability data relative to a number of population-based indicators of health and well-being. In addition to the tool – the group will continue their work to align measures associated with the Global Commitment waiver with those found in the AHS Strategic Plan/Results Scorecard.

During this year, the AHS Performance Accountability Committee (PAC) also met to review/discuss the following items: Global Commitment Quality Strategy, AHS Results Framework, Global Commitment Performance Measures, Vermont S.293, AHS Newsletter, Improvement Projects, and the AHS Scorecard. Members of the PAC also provided feedback re: the GC Quality Strategy. Also, the group reviewed a proposed quality management system (Results Framework) during this year. This framework will guide the quality assessment and improvement activities of the Medicaid program and be consistent with the GC Quality Strategy. During this year, the group also reviewed 3 quality improvement projects. Projects were conducted using the Agency Improvement Model, Results Based Accountability, or the CMS PIP methodology. In addition, the group began to strategize how the AHS Scorecard can be used to assist in monitoring the performance of the MCE as well as the Agency. Also, the group reviewed and provided feedback on the new AHS Newsletter. The group will continue to discuss how the newsletter can support their efforts.

Finally, during this year, the AHS Performance Accountability Committee (PAC) spent time reviewing its performance. According to the committee charter, the group is required to conduct such a review annually. Activities included a comparison of the PAC outputs with the requirements of the charter as well as identifying any improvements to the Committee Charter deemed necessary or desirable by the PAC. Feedback included the concern that the current structure and/or format of the group does not allow adequate time for each of the departments participating in the meeting to address their specific needs. During the next year, the group will continue to take feedback – and modify its structure/format to meet the needs of all participants.

*Quality Strategy:*
During this year, the AHS Quality Improvement Manager engaged members of the PAC in a review of the Quality Strategy. With the delivery of the final EQRO Annual Technical Report, the AHS PAC has begun to re-evaluate the strategy using its findings. In addition, the group has reviewed the CMS Quality Strategy resource documents. Using these documents as a guide, a tool was developed to collect feedback from each of the committee members. Specifically, the tool asked for feedback in the following areas: managed care goals, objectives, and overview; efforts or initiatives to reduce disparities in health care; targets for included CMS core performance measures; quality of care improvement efforts; delivery system reforms; best or promising practices; challenges or opportunities with data collection systems; and recommendations for on-going quality improvement.

Rather than seeking public comment–and finalizing an updated version–it was decided to modify the existing document to accommodate the quality assessment and improvement activities associated with the Choices for Care 1115 Waiver, which has been consolidated with the GC waiver effective January 30, 2015. An updated version of the strategy will be reviewed by the AHS Integrated Operations and Planning Team (IOPT) and AHS Executive Committee, and made available for public comment. After incorporating public comments, the final document will be forwarded to CMS for review/approval. In addition to including the aforementioned elements, the updated version of the strategy will follow the formatting requirements as set forth in Section 508 of the Rehabilitation Act (29 U.S.C. §794d). Going forward, the AHS Performance Accountability Committee will be responsible for conducting periodic reviews of the quality strategy to evaluate its effectiveness. In addition to modifying the document, the group will continue to consider how State quality strategy initiatives might align with separate yet related federal and state quality documents to ensure maximum results.

*iii. Evaluation Activities*

During this year, the AHS QIM continued to work with staff at the Pacific Health Policy Group (PHPG)

on the GC waiver evaluation. With the possibility of incorporating Long Term Care (LTC) in the GC waiver becoming more of a reality, attention is also being paid to how this change might impact the current evaluation plan. During this year, the AHS QIM continued to review evaluation documents associated with Long Term Care (LTC) program – specifically those linked to Vermont's Choices for Care program. The AHS QIM will continue to work with staff at PHPG to follow these developments and modify the plan as needed.

Also during this year, the AHS QIM reviewed a number of evaluation plans/frameworks associated with various health reform activities taking place in Vermont (e.g., Blueprint for Health, Choices for Care, Health Information Technology/Health Information Exchange, VHC, and State Innovation Model). As a member of the AHS Institutional Review Board (IRB), the AHS QIM participated in a review of Research Triangle Institute's (RTI) external State Innovation Model (SIM) evaluation plan. While Medicaid is only one of the participating payers, it was thought that there might be some efficiencies realized by leveraging the Global Commitment waiver evaluation efforts with those of the SIM grant. As the requirements and details of the SIM grant evaluation plan become clearer, so will the opportunities for coordination and integration.

Finally, during this year, the AHS QIM participated in the IMPAQ evaluation kick-off meeting. Unlike the aforementioned RTI evaluation, this work focuses on the review of state-specific activities. The agenda consisted of the following items: evaluation framework, evaluation design, intervention inventory and timeline, and performance measure set.

*iv. Provider and Member Relations*

**Key updates:**

- Quality audits of the Vermont Medicaid transportation brokers were implemented and executed.
- Project management and timelines for the remaining federal requirements regarding provider enrollment and screening are progressing toward total compliance by March 2016.
- Access to care and provider network issues for dental and vision/eyeglass services are a concern.

The Provider and Member Relations (PMR) Unit ensures members have access to appropriate health care for their medical, dental and mental health needs. The Unit monitors the adequacy of the Green Mountain Care (GMC) network of providers and is responsible for enrollment, screening and revalidation of providers. PMR is also responsible for outreach and communication, including Medicaid policy education, provider manuals and newsletters, member handbooks and newsletters, the Green Mountain Care member website, the Department of Vermont Health Access website, and other communications. Additionally, PMR serves as liaison to the Medicaid and Exchange Advisory Board (MEAB). The PMR Non-Emergency Medical Transportation (NEMT) program ensures that Medicaid members who do not have access to transportation are able to get rides to and from medical appointments and daily dosing for opioid addiction treatment. PMR handles contract management and quality review of the 8 transportation brokers who provide transportation services statewide.

In FFY2014, PMR initiated an ongoing audit plan to do onsite reviews of transportation providers relative to the terms of their contracts. Our NEMT Quality Chief visited and audited all 7 NEMT brokers in the second half of 2014, and will continue with two audits of each broker annually to ensure compliance.

*Federally required enrollment, re-enrollment and revalidation requirements:*
DVHA is on track to be in full compliance with the Program Integrity requirements of the Affordable Care Act (ACA)/42 CFR §455 Subpart E - Provider Screening and Enrollment. This has been a challenge for states and an additional challenge for Vermont with its 30 year old Medicaid Management Information System (MMIS). While many requirements have been met, the remaining challenges were rolled into a project plan with DVHA's fiscal agent with a timeline to meet all requirements by March 2016.

Access to care and provider network adequacy is a concern and could be more of a challenge in the future. Due to the Medicaid expansion, about 40,000 new members became eligible for Medicaid. In addition to increased enrollment, retiring dentists may put a strain on dental access along with dental practices adjusting their business models related to the added volume of members receiving dental services at the lower Medicaid rate. DVHA met with the Vermont Dental Society in December 2014 to discuss proposed requirements relating to billing practices and the required use of 2012 claim forms and diagnostic codes. The immediate outcome is to not require diagnostic codes at this time, and other issues are still being discussed and solutions considered.

Reimbursement rates are also a concern for other services and providers, including NEMT services, which is additionally strained by the volume of rides to opiate addiction treatment services. An additional topic at the top of the list is meeting the needs for services for children's eyeglasses in all areas of the State, as providers who do the vision exams neglect to also do the ordering and fitting of eyeglasses that are contracted with a sole source eyeglass provider. This has been a growing issue over a few years as some providers have quietly stopped doing the fittings. DVHA is in the process of reaching out to the Vermont Optometric Association and opticians to schedule a meeting to discuss issues and options, and internally may consider increasing the fitting and repair reimbursement rates.

# V. Cost Containment Initiatives

## *i. Vermont Chronic Care Initiative (VCCI)*

**Key updates:**

- In state fiscal year (SFY) 2013, the VCCI documented net savings of $23.5 million over anticipated expense among the top 5% of eligible Medicaid members (high utilizers).
- VCCI clinical leaders were key partners in the Enterprise MMIS/Care Management RFP development and review process.
- VCCI leadership engaged Medicaid ACO partners to assure collaboration and leveraging of existing resources for members, without duplication.
- The VCCI Pediatric Palliative Care Program transferred to Vermont Department of Health (VDH) to better align with other high risk programs for children.
- High Risk Pregnancy Case Management services were restructured to a decentralized versus centralized resource.

The goal of the VCCI is to improve health outcomes of Medicaid beneficiaries by addressing the increasing prevalence of chronic illness through various support and care management strategies. Specifically, the VCCI 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 by attempting to remove barriers, bridge gaps, and avoid duplication of services; and educate, encourage and empower members to eventually self-manage their chronic conditions. The VCCI is a component of DVHA's health care reform goals and its supporting strategic plan. The VCCI

employs 29 licensed and non-licensed professional staff, and contracts with an external vendor to provide supplemental services that include assistance with advanced data analytics and additional clinical and professional staff. In SFY14, the VCCI documented net savings of $23.5 million over anticipated expenses among the top 5% of the eligible population who account for roughly 39% of Medicaid expenditures.

The VCCI's strategy of embedding staff in high-volume hospitals and primary care sites continues to support population engagement at the point-of-need in areas of high service utilization. There are currently ten hospital and primary care physician (PCP) sites where VCCI staff is embedded and partnering with doctors and case managers. Further, starting in FFY15, the VCCI will assign staff to the role of 'hospital liaisons' where there is no capacity to embed staff on site. By targeting high volume locations and predicted high-cost members, resources can be allocated to areas representing the greatest opportunities for clinical improvement and cost savings. The advent of Accountable Care Organizations (ACOs) will further facilitate direct referral from participating providers and hospitals to support shared clinical and financial goals. A more robust relationship is anticipated in 2015 with these new partners.

The VCCI utilizes  a holistic approach to evaluate both medical and behavioral health conditions for its members, as well as the socioeconomic issues that often are barriers to sustained health improvement. The 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 for ambulatory care sensitive conditions (ACS). Eligible members account for the top 5% of utilization of these services; they are on a trajectory to become "super-utilizers".

There are roughly 32 chronic conditions that are generating high utilization patterns. The most recent data for the VCCI eligible cohort indicates that the top 5% accounts for 39% of Medicaid expenditures. This includes 20% of all ACS emergency department (ED) costs, about 60% of ACS inpatient costs, and 88% of hospital readmission costs. Our strategy of embedding staff in high volume hospital and primary care sites continues to support population engagement in these high utilization areas at the point of need and supports transitions between hospital and community care settings. Our SFY13 utilization change offers further evidence of this strategy with documented reduction of ACS inpatient admissions by 37%, 30-day hospital readmission rates by 34% and ED utilization decline of 15% for eligible VCCI members in the top 5%.

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. By 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 and engage in behavioral changes to improve their overall health by facilitating access to—and effective communication with—their PCP.

The VCCI is strategically aligned with other important State health care reform efforts, such as the Blueprint for Health, their NCQA certified advance practice medical homes and local Community Health Teams (CHTs) funded by a multi-payer demonstration. The VCCI staff function as members of the local CHT, supporting both patients and providers. This collaboration supports transition between levels of care and reduces redundancies, as VCCI supports the highest risk population and the CHT our less acute Medicaid members. As part of the Vermont Health Care Improvement Project (VHCIP), the VCCI is a member of the Care Management and Care Models workgroup (CMCM) and will be continue participation in the development of a joint learning collaborative with the Blueprint for Health, ACOs and other care management providers in 2015. Other FFY14 changes relative 'specialty care management' changes are outlined below:

*Pediatric Palliative Care:*
The Pediatric Palliative Care Program (PPCP) remains a statewide program funded by DVHA. However, based on needs of partners at VDH and a better fit for these services to be colocated with other programs servicing special needs children, the program and staff have been transitioned to VDH effective September 2014. VDH will provide DVHA with clinical and operational measures on program performance and clinical quality on a periodic basis to assure the program is operating according to the terms outlined in the 2013 Global Commitment to Health Waiver. An IGA with VDH was executed to ensure that these measures are attained.

*High Risk Pregnancy:*
The VCCI expansion to include High Risk Pregnancy Case Management services was initially delayed in FFY14 due to challenges in recruitment and retention of skilled nurses with this specialty training. Due to these difficulties, operational needs were reassessed, and one position was transferred to the field with one internal expert who will lead the VCCI field staff in the delivery of services for at risk/high risk pregnant women, in tandem with other local health partners. Data supports the opportunity to positively impact pregnancy outcomes for those with mental health and substance use/abuse diagnoses. The VCCI will facilitate operational alignment with partners, including the Department of Mental Health (DMH) and designated mental health providers in addition to the 'Hub and Spoke' providers.

*Nutrition/Obesity Specialty Supports:*
Based on Behavioral Risk Factor Surveillance System (BRFSS) data that indicates 60% of the Vermont population is either overweight or obese, the VCCI nutrition and obesity specialist, hired in 2014, supports and consults with field staff and members in developing strategies and action plans to reach and maintain healthy weight. It is well documented that obesity directly contributes to an increase in chronic conditions and associated costs to the health care system. The nutrition/obesity specialist also is supporting AHS goals for obesity reduction and will be the DVHA liaison to other state, academic and community programs to assure they are evidence-based and operationally aligned for synergistic benefit.

*APS Contract:*
Since 2007, DVHA has contracted with APS Healthcare for assistance in providing disease management assessment and intervention services to Vermont Medicaid beneficiaries with chronic health conditions. In SF12, the contract migrated to a focus on the top 5% of Medicaid utilizers. APS Healthcare provides several services to support the VCCI, including supplemental professional staffing and data analytics. APS Healthcare delivers enhanced information technology and decision-support tools to assist case management staff in outreaching the most costly and complex beneficiaries based on risk factors. Additionally, APS Healthcare provides supplemental population-based reports on gaps in care to PCPs, which supports ACO providers and case managers working with patients who are considered high utilizers and/or at risk to become so.

In 2011, the VCCI implemented a combination of individual- and population-based strategies for care management, with a primary focus on high utilizers. That same year, DVHA's contract with APS Healthcare was 100% risk-based with a guaranteed 2:1 return on investment (ROI). In SFY13, the VCCI delivered a net ROI of $23.5 million over anticipated costs, which included both APS and DVHA staff efforts. Utilization measures impacting these savings include a 17% reduction in ACS ED usage, a 37 % reduction in ACS hospitalizations, and a 34% reduction in 30-day readmission rates among the top 5% of members. Results for SFY14—our last year of a fully risk based contract with APS—are pending the 6 month claim run out and will be available early 2015.

The current contract with APS Healthcare is scheduled to terminate June 30, 2015 and includes supporting language to facilitate data transition to a new Enterprise MMIS/Care Management provider with anticipated go-live date for the new system scheduled for July 1, 2015.

*ii. Behavioral Health Services*

**Key updates:**

- Managed Substance Abuse Services and Mental Health Services have been consolidated into one unit to provide integrated Behavioral Health Services.
- The Behavioral Health Team adopted the McKesson/Interqual tool for authorizing mental health and substance abuse services.
- A new Autism Specialist was hired to manage Applied Behavioral Health (ABA) services.

In March 2014, Managed Substance Abuse Services and Mental Health Services consolidated into one unit to provide integrated Behavioral Health Services. This collaboration offers a more comprehensive approach for behavioral health care coordination and utilizes the combined staff's expertise in substance abuse, mental health and quality improvement. The consolidation of the two teams allows beneficiaries with co-occurring mental health and substance abuse conditions to receive coordinated services from DVHA as well as provide DVHA with resources from the efficiencies gained in consolidation to work on improving access to care.

The Mental Health Team is responsible for concurrent review and authorization of inpatient psychiatric and detox services for Medicaid primary beneficiaries. The team works closely with discharge planners at inpatient facilities to ensure timely and appropriate discharge plans. The Substance Abuse Team coordinates its Medication Assisted Treatment (MAT) efforts with the Care Alliance for Opioid Addiction (Hub and Spoke), the VCCI and the Pharmacy Unit to provide beneficiary oversight and outreach. All beneficiaries receiving MAT services and who are prescribed buprenorphine will continue to have a Pharmacy Home that dispenses all of their prescriptions. The team also manages the Team Care program (formally the lock-in program).

Throughout the year, the Behavioral Health Team was an active participant in the AHS Substance Abuse Treatment Coordination Workgroup. This workgroup is a coordinated effort to standardize substance abuse screening and referral processes throughout the Agency of Human Services. The workgroup is developing an AHS-wide training for substance abuse screening. Team members also participate in monthly meetings with the VDH's Alcohol and Drug Abuse Prevention Division to coordinate efforts between the two departments to provide substance abuse services to Vermont Medicaid beneficiaries.

Also during this year, the Behavioral Health Team adopted the McKesson/Interqual tool for authorizing mental health and substance abuse services. Significant research was done on the criteria as well as on the effectiveness of the tool. DVHA hosted a 2-day training on the McKesson/InterQual behavioral health care criteria tool for internal DVHA staff as well as VDH, DMH and the Department for Children and Families (DCF). DHVA hosted an informational webinar on the tool for providers. As part of the consolidation of the two teams, the Substance Abuse Team was able to implement an electronic record system utilizing Covisint. Covisint has been utilized by the Mental Health Team for the past year, and it allows for improved coordination of services.

During QE0914, DVHA hired an Autism Specialist who is a member of the Behavioral Health Team. This position was created in response to the additional funding appropriated by the State legislature for the provision of services for children diagnosed with autism spectrum disorders. The Autism Specialist will develop a system for managing and authorizing payment of these services. DVHA worked with other AHS departments to provide interim guidance to the Designated Agencies regarding the additional funding allocated to enhance the delivery of Applied Behavioral Analysis (ABA) services.

### *iii. Blueprint for Health*

The Blueprint for Health is described in Vermont statute as "*a program for integrating a system of health care for patients, improving the health of the overall population, and improving control over health care costs by promoting health maintenance, prevention, and care coordination and management"* (18 VSA Chapter 13).

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

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

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

Medical homes and CHT staff are intended to strengthen network interactions with a larger array of medical and non-medical providers in the community, and to help people link more seamlessly with the services they need. The implementation and expansion of the model has been supported with a locally organized transformation infrastructure, including program managers, CHT leaders, practice facilitators, multi-stakeholder workgroups, and shared learning forums.

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

*Practice Profiles:*
In FFY14, the Blueprint expanded Practice Profiles. These reports—derived from Vermont's all-payer claims database, the Vermont Healthcare Claims Uniform Reporting and Evaluation System (VHCURES)—allow individual practices to assess their utilization rates and quality of care delivered compared to local peers and to the State as a whole, giving them data to assist in honing their quality improvement efforts.

In 2014 two sets of profiles were released. Compared to previous versions of the Blueprint practice profiles, the version released in September 2014 contained two major enhancements:

- Data on the Medicare population.
- A new page displaying practice trends.

The inclusion of the Medicare population in the practice profiles marked the first time practices received *whole population* profiles with data from all payers combined into a single report. To clarify further, these profiles, completed in September 2014, included data for Vermont residents enrolled in commercial health plans, Medicaid enrollees for whom Medicaid was the primary payer (excluding Duals), and Medicare enrollees for whom Medicare was the primary payer (ages 18 years and older and including Duals).

The Blueprint distributes practice profiles directly to the primary contact on file with the Blueprint for each practice and to the project manager and practice facilitator representing the geographical hospital service area (as defined by VDH) in which the practice is located. Practices are encouraged to use the data in the profiles to fuel quality improvement initiatives.

*v. Hub and Spoke Initiative: Integrated Treatment for Opioid Dependence*

**Key updates:**

- CMS approved State Plan Amendments for the Hub and Spoke Initiative in January and March 2014.
- The new Hub program, which began operations in late CY13, has successfully implemented program operations and now has a caseload 399.
- The Hub and Spoke Initiative became statewide with Bennington, Rutland, Essex, Orleans, and Caledonia counties beginning operations.
- The Chittenden Hub resolved a zoning dispute and was able to open a second program site in late Spring 2014.
- Hub caseloads in general significantly expanded over the course of the year to 2,542 statewide.
- Spoke staff are now deployed statewide in more than 50 different practice settings, including OB-GYN, psychiatry, pain, and primary care specialties.

AHS is collaborating with community providers to create a coordinated, systemic response to the complex issues of opioid addictions in Vermont, referred to as the Care Alliance for Opioid Addiction (a Hub and Spoke model). The Hub and Spoke Initiative creates a framework for integrating treatment services for opioid addiction into Vermont's Blueprint for Health. This initiative is focused on beneficiaries receiving Medication Assisted Treatment (MAT) for opioid addiction. MAT is the use of medications, in combination with counseling and behavioral therapies, to provide a whole patient approach to the treatment of substance use disorders. Overall health care costs are approximately three times higher among MAT patients than within the general Medicaid population, not only from costs directly associated with MAT, but also due to high rates of co-occurring mental health and other health issues, and high use of emergency departments, pharmacy benefits, and other health care services.

The two primary medications used to treat opioid dependence are methadone and buprenorphine, with most MAT patients receiving office-based opioid treatment (OBOT) with buprenorphine prescribed by specially licensed physicians in a medical office setting. These physicians generally are not well-integrated with behavioral and social support resources. In contrast, methadone is a highly regulated treatment provided only in specialty opioid treatment programs (OTPs) that provide comprehensive addictions treatment but are not well integrated into the larger health and mental health care systems. The Hub and Spoke Model addresses this service fragmentation.

Vermont succeeded in getting two SPAs approved in January and March of 2014 for Health Home services to the MAT population under section 2703 of the Affordable Care Act. Health Home services include comprehensive care management, care coordination, health promotion, comprehensive

transitional care, individual and family support, and referral to community and social support services. State-supported nurses and licensed clinicians provide the Health Home services and ongoing support to both OTP and OBOT providers.

The comprehensive Hub and Spoke Initiative builds on the strengths of the specialty OTPs, the physicians who prescribe buprenorphine in OBOT settings, and the local Blueprint PCMH and CHT infrastructure. Each MAT patient has an established physician-led medical home, a single MAT prescriber, a pharmacy home, access to existing Blueprint CHTs, and access to Hub or Spoke nurses and clinicians for Health Home services.

There are five regional Hubs that build upon the existing methadone OTPs and provide buprenorphine treatment to a subset of clinically complex buprenorphine patients, as well as serve as the regional consultants and subject matter experts on opioid dependence and treatment. The goal is for Hubs to replace episodic care based exclusively on addictions illness with comprehensive health care and continuity of services.

Spokes include a physician prescribing buprenorphine in an OBOT and the collaborating health and addictions professionals who monitor adherence to treatment; coordinate access to recovery supports and community services; and provide counseling, contingency management, care coordination and case management services. Support is given to Spoke providers and their Medicaid MAT patients by nurses and licensed addictions/mental health clinicians, adding to the existing Blueprint CHTs. Similar to all CHT staff, Spoke staff are provided free of cost to MAT patients. Staff are embedded directly in the prescribing practices to allow more direct access to mental health and addiction services, promote continuity of care, and support the provision of multidisciplinary team care.

The below tables (Tables 3 and 4) present the patient counts for Hubs, Medicaid beneficiaries, individual Spoke providers, practice sites and staff.

**Table 3. Hub Caseload by Region as of December 30, 2014**

| Regional Hub Programs | Total Served | # Receiving Buprenorphine |
|---|---|---|
| Chittenden/Franklin/Grand Isle/Addison Counties | 945 | 287 |
| Windham/Windsor Counties | 455 | 145 |
| Washington/Lamoille/Orange Counties | 275 | 116 |
| Rutland/Bennington Counties | 399 | 157 |
| Essex/Orleans/Caledonia Counties | 468 | 118 |
| **Total** | **2,542** | **823** |

**Table 4. Buprenorphine Providers, Spoke Funding & Staff Recruitment, and Medicaid MAT Beneficiaries by Region**

| Region | Total MD Prescribing Buprenorphine | Staff FTE Funding | Staff FTE Hired | Medicaid Beneficiaries |
|---|---|---|---|---|
| **Bennington** | **9** | **4.5** | **2.4** | **207** |
| **St. Albans** | **11** | **6.5** | **4.8** | **307** |
| **Rutland** | **10** | **5.0** | **3.1** | **242** |
| **Chittenden** | **30** | **8.0** | **8.2** | **392** |
| **Brattleboro** | **15** | **4.5** | **4.5** | **217** |
| **Springfield** | **4** | **1.5** | **1.5** | **56** |

| | | | | |
|---|---|---|---|---|
| **Windsor** | **5** | **2.5** | **2.0** | **112** |
| **Randolph** | **7** | **2.0** | **1.8** | **100** |
| **Barre** | **19** | **5.5*** | **4.5** | **238** |
| **Lamoille** | **8** | **3.0** | **3.6** | **131** |
| **Newport & St Johnsbury** | **9** | **2.0** | **1.0** | **93** |
| **Addison** | **5** | **1.5*** | **1.5** | **30** |
| **Upper Valley** | **1** | **0** | **.5** | **7** |
| **Total** | **133** | **47** | **39** | **2,132** |

*iv. Pharmacy Program*

**Key updates:**

- The Pharmacy Unit successfully contracted with a new Pharmacy Benefit Management (PBM) contractor, Goold Health Systems, in May 2014. The new PBM's system is slated to go live January 2015.
- With the FDA approval of new drugs for Hepatitis C, there was and will continue to be a high demand for the new treatments among the DVHA's members.
- As a result of clinical analyses and review of drugs of abuse—particularly drugs used to control non-cancer pain and anxiety disorders—several new edits were put in place to better manage these classes.
- Work on improving the management of psychotherapeutic drugs in children continued and significant progress was made in inter-departmental workgroups and a technical assistance grant program.

The DVHA Pharmacy Unit is responsible for managing all aspects of Vermont's publicly funded pharmacy benefits program. Responsibilities include but are not limited to: processing pharmacy claims; making drug coverage determinations; administering drug reconsiderations and appeals; overseeing federal, state, and supplemental drug rebate programs; resolving drug-related pharmacy and medical provider issues; overseeing the contract with the PBM contractor; overseeing and managing the Drug Utilization Review (DUR) Board; managing of the Preferred Drug List (PDL); assuring compliance with state and federal pharmacy benefits regulations; managing an annual GC drug spend of over $140 million; and analyzing trends and seeking innovative cost and quality initiatives.

During FFY14, the DVHA Pharmacy Unit continued to focus on ensuring that members receive high quality, clinically appropriate, evidence-based medications in the most efficient and cost-effective manner. In addition, the Unit focused on health information exchange and administrative simplification. The key performance indicators for SFY14 include the following:

- Total GC Drug Spend: $143,672,030
- Total number of GC paid prescriptions: 1,513,930[1]
  - % Brand Dugs: 348,932[1]
  - % Generic Drugs: 1,164,998[1]

[1] These numbers do not include OTC's and CMS excluded drugs for Duals and VPharm members.

- Gross Medicaid pharmacy PMPM (per member per month spend): $91.83[1]; an increase of 8.11% compared to SFY13.
- Buprenorphine and buprenorphine/naloxone are drugs used to treat opiate addiction. In SFY14, utilization increased slightly by 1%, while there was a 3.79% decrease in cost compared to SFY13. Overall, DVHA spent $8,215,162 on buprenorphine products, and these drugs continue to be DVHA's most utilized and highest cost expenditure for drugs.

*Reducing Administrative Burden on Providers and Beneficiaries:*
DVHA is committed to reducing the administrative burden for providers and beneficiaries, in part by streamlining and improving the exchange of health information through electronic prescribing (e-prescribing) and electronic prior authorizations. Documented health benefits of e-prescribing include medication safety advantages, increased system efficiency and reduction in routine problem orders. E-prescribing also is a key aspect of Meaningful Use and is consistent with Vermont's Health Information Exchange (HIE) goals. Vermont's latest SureScripts report indicates that 82% of prescriptions are routed electronically by Vermont prescribers, as compared to only 8% in 2008. Vermont is ranked third in the nation by the SureScripts Safe-Rx ranking system, which is based on patient eligibility, medication history, and the percentage of prescriptions routed electronically.[2]

Effective November 1, 2012, DVHA expanded its e-prescribing capabilities to include the entire SureScripts network, which dramatically increased the rate of e-prescribing for Medicaid providers. DVHA continues to focus on increasing the percentage of Medicaid prescriptions sent electronically and improving the way Medicaid eligibility, medication history, and PDL information are displayed to providers.

DVHA procured a new PBM contract in May 2014. Goold Health Systems (GHS), an Emdeon company, was chosen as the new PBM contractor effective January 1, 2015. GHS is a national leader in Medicaid health care management services with over 40 years of experience in developing Medicaid Pharmacy Benefit Management solutions and provides Medicaid services in 16 other states. Their expertise includes clinical management, account management, analytics, pharmacy cost management strategies, claims processing, formulary management, and rebate processing. A local Call Center/Helpdesk will be operated by GHS in their South Burlington office location servicing providers and staffed by Vermont pharmacists and pharmacy technicians. A new provider portal will give pharmacists and prescribers access to a secure, web-based application that offers features such as pharmacy and member queries, electronic submission of prior authorizations (PAs), uploading of clinical documentation into a document management system, and status updates for submitted PA requests. More information about this implementation can be found on the DVHA website, located at: http://dvha.vermont.gov/for-providers/pharmacy-programs-bulletins-alerts.

*Psychotherapeutic Drug Management in Children:*
DVHA's Pharmacy Unit participates in the *Psychiatric Medication for Children and Adolescents Trend Monitoring Group*, which includes members from DMH, DCF, and child psychiatrists from the community and the University of Vermont Medical School. The purpose of the work group is to assess and reduce the use of antipsychotics for children in Vermont. With support from the Vermont Child Health Improvement Program (VCHIP) at the University of Vermont, the group analyzed data obtained through a survey of all prescribers of antipsychotic medications for Medicaid children. The survey served a dual purpose of informing the work group of prescribing practices in Vermont and as a medical necessity review for each pediatric beneficiary being prescribed an antipsychotic. The work group now is

[2] References: http://healthit.gov/sites/default/files/oncdatabriefe-prescribingincreases2014.pdf; and http://surescripts.com/docs/default-source/national-progress reports/surescripts_2013_national_progress_report.pdf?sfvrsn=2

developing best practice recommendations for Vermont's prescribing medical providers who serve children and adolescents with mental health needs.

DVHA, with partners from DCF and DMH, continues to participate in the Center for Health Care Strategies Technical Assistance (TA) Grant, known as *Improving the Appropriate Use of Psychotropic Medication for Children in Foster Care (PMQIC),* which also includes Illinois, New Jersey, New York, Oregon and Rhode Island. The primary goal has been to ensure that use of anti-psychotic medications for children in foster care is appropriate. Vermont has developed an informed consent process for children in foster care and has developed capacity for the Vermont Center for Children, Youth and Families to provide independent consultation for DCF social workers. The PMQIC has developed a measure that all states will use to gather baseline and trend data over the three-year course of the grant and into the future.

*Retrospective Utilization Reviews:*
In addition to a continued focus on the appropriate use of mental health medications, DVHA and the DUR Board also perform retrospective drug utilization reviews of a variety of drugs with the potential for abuse. These reviews look at patterns of prescribing and utilization, and lead to development of recommendations for point-of-sale edits and educational initiatives to encourage evidence-based utilization. DVHA's DUR Board recommended the implementation of quantity limits and prior authorization criteria for several classes of controlled substances. As a result of these recommendations, the DVHA has implemented quantity limits and duration of therapy edits for skeletal muscle relaxants such as carisoprodol, methocarbamol, and cyclobenzaprine; quantity limits on benzodiazepines; daily quantity limits and a first fill days' supply limit for oxycodone and hydromorphone immediate release (IR); and applied prior authorization criteria and starting dose limits for methadone for pain treatment.

*Growth in Specialty Pharmacy Utilization:*
Specialty Pharmacy includes drugs that require difficult or unusual delivery processes or patient management before or after administration. Specialty drug utilization and spend have continued to increase. In Vermont, specialty drug costs were 18.7% of total paid pharmacy claims in SFY 2014, which represents an increase of 13% from the previous year. Manufacturers' prices for widely used specialty drugs increased approximately 20% from SFY 2010 to SFY 2012, and another 10% from 2012 to 2013. Since November 2008, the DVHA has achieved cumulative savings of $4,739,192 by contracting with Wilcox Pharmacy of Vermont and BriovaRx of Portland, Maine, for specialty pharmacy services.

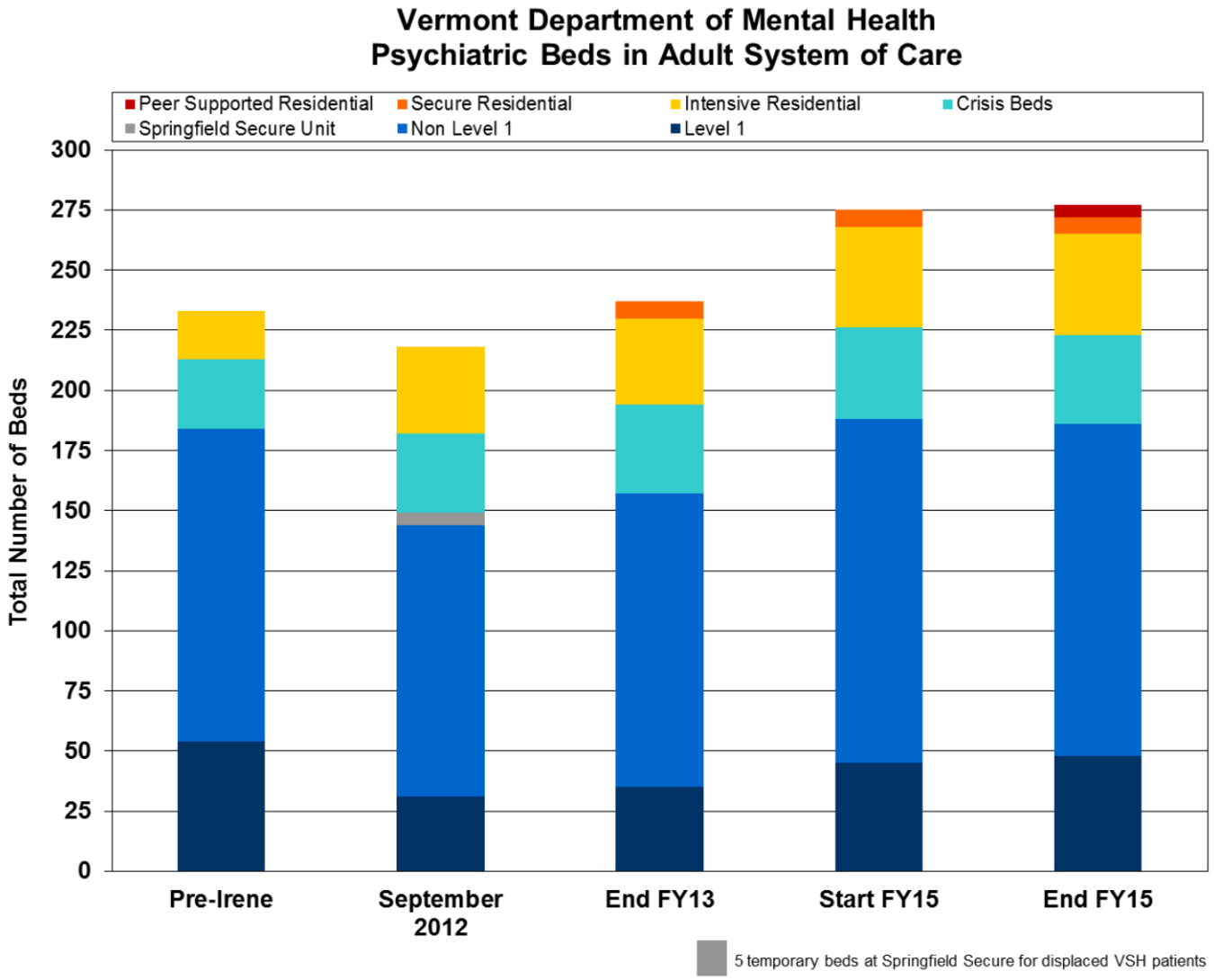
The FDA approved a new oral drug to treat Hepatitis C (called sofosbuvir (Sovaldi®) in December, 2013. Prior to this, all treatments were a combination of several injectable drugs. DVHA developed comprehensive criteria for sofosbuvir, which was approved by DVHA's DUR Board. During SFY'14, DVHA spent a total of $1,783,592 on all hepatitis drug treatments, of which $1,430,703 was spent on the new drug sofosbuvir, which was administered in combination with other injectable drugs. For the first six months of SFY'15, drug expenditures for Hepatitis C total $2,705,814.64 and is anticipated to exceed $8 million for SFY'15 as new "all oral" treatments have since become available, which have a high degree of tolerability and high response/cure rates. The average cost of a course of therapy for Sovaldi® is approximately $84,000, while one of the newer "all oral" regimens costs $95,000 per patient per course of therapy. Drug treatment of Hepatitis C is a rapidly evolving field. As new drugs enter the market and competition improves, it is expected that prices will moderate somewhat, but clearly this class will continue to put financial pressures on DVHA's drug budget.

*v. Mental Health System of Care*

Following the abrupt closure of Vermont's only state-run psychiatric hospital due to flooding from Tropical Storm Irene just before the start of FFY12, Vermont has continued to implement changes and enhancements to the adult mental health system of care in FFY14 to reduce its reliance on institutional

care and further build its community based system of care for persons with mental health conditions. The Department of Mental Health (DMH), consistent with the plan advanced by Governor Peter Shumlin and available Medicaid and Medicare funding resources, has continued to take significant steps forward in promoting a more person-centered, flexible and community based system with all the elements for a comprehensive and integrated system of care. Proposed major mental health reform legislation specific to this system reform was formally passed as Act 79 during the Vermont 2012 legislative session and continues to be the blueprint for system development and enhancement.

The enhancement of inpatient psychiatric, intensive residential and other hospital diversion beds in the system of care Pre-Irene and projected through the end of FFY15 is represented in the following table and described in the text below.




*Inpatient Care:*

Access to acute, psychiatric inpatient care remains a critical part of the overall mental health system reform efforts. Act 79 authorized up to 25 acute hospital beds to be developed at a new state-run hospital to be built in Berlin, Vermont, and the new facility (Vermont Psychiatric Care Hospital - VPCH) opened in July 2014. During this fiscal year, DMH also continued its contract with two general hospitals for 20 "Level I" inpatient beds for individuals who would otherwise have been treated at the former 54-bed state-run hospital. These beds are located at the Brattleboro Retreat (14 beds) and Rutland Regional Medical Center (6 beds). Long term agreements with the Brattleboro Retreat and Rutland Regional Medical Center (RRMC) include provisions for a "no-refusal" system, reimbursement based on acuity and

enhanced programming/staffing, and access to peer supports. These formal payment agreements assure that individuals needing inpatient mental health care are not waiting for excessive periods in emergency rooms awaiting a hospital admission. In addition, care in these settings can be covered in part by Medicare, and even more so by Medicaid.

With the opening of VPCH, DMH ended its contract with Fletcher Allen Health Care (FAHC) to provide Level I beds, and those FAHC inpatient beds returned to operating at their pre-Irene level of care. Other existing psychiatric inpatient service capacity provided by Central Vermont Medical Center and the Windham Center remains part of the ongoing continuum of inpatient care service options. This geographic distribution of acute inpatient services provides individuals with inpatient options closer to home which can be very important to their recovery and discharge planning needs.

During this period demand for inpatient care exceeded capacity with some frequency. DMH continued to operate an electronic bed board, which is updated daily to track capacity and facilitate placement of patients needing hospitalization or other crisis services in the system. Departmental leadership and its care management staff work to resolve issues as quickly as possible. Emergency departments across the state have had to hold individuals needing inpatient psychiatric care while waiting for an open bed. This is disruptive to the emergency care setting and not a standard that the department regards as adequate for individuals requiring inpatient care. During this year the number of inpatient beds was increased by 10, with the opening of the Vermont Psychiatric Care Hospital. In addition, a new Intensive Residential Recovery program in Rutland was opened, adding four beds for those needing to step down from hospital levels of care. With new services coming on line, the Department expects that pressure will be alleviated in the numbers of patients waiting for admission and the lengths of time they may spend in Emergency Departments or the Department of Corrections.

*Care Management:*
DMH's care management system, to support patient access and flow into acute care hospitalization or diversion when clinically appropriate and step-down transition from inpatient care, continues in earnest to triage and manage the inpatient needs and system movement. Staffed by department care management personnel, 24/7 admissions personnel of the former state hospital, and monitored by a web-based electronic bed board of inpatient and crisis bed census information that is available to service providers, components of the care management system have been operational with availability of staff and administrators weekdays and 24/7 on weekends throughout this period. Community and inpatient treatment providers have access to these centralized resources to assist with systemic issues or barriers that might arise as an individual moves through the continuum of care. The centralized department function supports timely access to the most acute levels of care and movement to lesser levels of care as quickly as clinically appropriate for individuals, consistent with the statutory directives outlined in Act 79.

*Community System Development:*
Vermont was able to leverage Global Commitment funding to more flexibly support the under and uninsured needs for persons who would otherwise have been served at the state hospital. Services that had been paid for only with state general funds were able to be matched in large part with federal Medicaid and Medicare dollars when provided in alternative care settings and the community. Vermont's mental health care system has been working to provide evidence based and innovative practices to help people with recovery, to live independently, to work, and to fully participate in their communities. During FFY14, DMH made significant resource investments into community-based mental health services in the following ways:

*a. Expand and Improve Emergency, Crisis, and Residential Support*

There has been broad consensus that emergency services and supports need to be more consistent, flexible and mobile. Services need to be able to respond to people in supportive ways, where they are, and be available 24/7 every day. Services also need to integrate with local law enforcement, hospital emergency rooms and peer services where they exist. Given the anticipated and growing demand for mental health support services in a state experiencing a smaller capacity of acute psychiatric inpatient care, access to psychiatric evaluation has been an essential cornerstone of mental health service reform. As such, Designated Agencies (DAs) have continued to develop and enhance emergency outreach and crisis support services at the local level. Mobile response capability and improved collaborations with local law enforcement are emphasized to better meet the challenges of providing effective engagement in a rural state.

During this year, DMH continued to work with law enforcement, advocacy organizations, and mental health service providers to address county-wide needs, enhance service collaboration planning and develop alternative forms of transportation for individuals being hospitalized. The flexible application of Global Commitment resources has supported further development of both trauma sensitive and least restrictive modes of transportation consistent with increased safety needs. Collaboration with law enforcement and training in alternative transport options, when clinically appropriate, have already had a positive influence on reducing the use of hard restraints for acute emergency mental health transports as the norm.

DMH also continued to develop crisis bed stabilization and intensive residential capabilities, and now crisis beds are available at all 10 Designated Agencies. Crisis and intensive residential beds have increased from 49 (Pre-Irene) to 87 (Start FFY15), with an addition of 6 beds in the past year. This includes 4 new intensive residential recovery beds in Rutland County for people who no longer need acute inpatient care but are not yet ready for full independent living. Intensive residential recovery programs like this one assist individuals in their recovery by providing a safe and secure setting and therapeutic services aimed at returning persons served to their communities.

A number of these beds provide access to peer support services, and the number of peer-supported residential beds included the projected opening of Soteria-Vermont during the next FFY. This program was delayed in its opening due to funding and is planning to open early in 2015. This five-bed facility in Chittenden County will serve individuals experiencing psychosis that seeking to avoid or reduce reliance on psychotropic medication. Residents will be encouraged to follow recommended treatment plans, and will have the option of choosing to work on recovery using alternatives to medication.

DMH continues to operate the Middlesex Therapeutic Community Residence (MTCR), which is a state-run, secure 7-bed residential facility targeted for individuals who are ready for step down from acute inpatient care, but still require a secure program as a point of transition into the community. Individuals admitted to the facility are placed on orders of non-hospitalization with conditions that include a requirement to reside at this secure program. Residents considered for this residential facility must be reasonably stable in their recovery process as the facility does not routinely employ involuntary emergency procedures in response to behavioral dysregulation. The physical environment maximizes indoor space with quiet areas and ample outside space within secure perimeters.

*b. Flexible Outpatient Services*

Developing a stronger outpatient service in the DAs, with a strong emphasis on identifying and responding to people at risk, was also a key component of the mental health system reform efforts. Services must be flexible and person-centered to respond to the real needs and choices of the individuals. Having available case management to meet the needs of people who do not meet other eligibility criteria was often identified as a "gap" service. Inroads for the outpatient services population were made via the expansion of "service planning and coordination supports" or case management services that extended beyond the severe and persistently mentally ill population. More responsive, hands-on case management support services to stabilize individuals who might otherwise further decompensate from mental health stressors or exhaust existing coping mechanisms were supported through Act 79. What has been called "non-categorical" case management is an expanded service capacity that is no longer reserved for the most incapacitated individuals served in community-based programs. Earlier supportive intervention available to individuals struggling with mental health issues will further reduce potential need for limited acute inpatient resources. A population targeted for these support services, which are at risk for higher cost public and health care resource utilization, are individuals transitioning between periods of incarceration and re-entry to the community. Individuals at risk for recidivism, law enforcement involvement and incarceration, are a continuing priority group for expanded mental health and community support services. DMH expects that this service capacity will meet the needs of an expanded group of persons served and will continue to grow in the upcoming year.

c. *Housing Subsidies*

Act 79 also provided for new investment in housing supports and coordinated treatment supports to provide greater stabilization in the community for individual at higher risk for homelessness. The pairing of both treatment and stable housing resources increases the likelihood of individuals with mental health needs remaining more engaged with services and less likely to destabilize requiring acute inpatient treatment. Stable housing is one of the most important elements in preventing crisis and in supporting recovery. Yet, persons with mental health conditions often find themselves struggling to maintain stable housing and even worse, are at high risk for homelessness. DMH allocated funds during this FFY to establish housing subsidies to ensure stable housing.

Housing assistance is being provided as much as possible in the "housing first" model, in which housing is provided without pre-qualification or agreements to accept certain services in order to receive assistance. However, when desired, DMH though its DA network is employing support services from minimal case management to full wrap-around plans to keep the individual successfully housed. Augmenting formal support services with peer support services is also being promoted to further support stability and linkages in the community.

d. *Peer Services*

Act 79 also supported investments in alternative services provided by individuals with the lived experience of mental illness (peers) to broaden the array and options for recovery supports to individuals with mental illness. Over the past year, the Department has focused primarily on improving and refining Vermont's expanded array of peer services, many of which were developed or enhanced following the passage of Act 79. This expanded array of services includes community outreach, support groups, local peer-run initiatives, education, advocacy, transition support between hospital and community treatment settings, hospital diversion and step-down, crisis respite, and pre-crisis telephone-based support, referral and emotional support. A full listing

of peer programming supported by the Department of Mental Health is listed below.

**Table 5.**

| **Vermont Peer Services Organizations** | |
|---|---|
| **Organization** | **Services Provided** |
| Alyssum | Operates two-bed program providing crisis respite and hospital diversion and step-down. |
| Another Way | Provides community center offering outreach, development/enhancement of natural supports networks, support groups, service linkages, crisis prevention, and employment and housing supports. Specializes in serving individuals who are not eligible or choose not to access Designated Agency Community Rehabilitation and Treatment services. |
| NAMI-VT | Statewide family and peer organization providing support groups, educational and advocacy groups for individuals with mental health conditions and their families. |
| Northeast Kingdom Human Services Peer Cadre | Provides respite and peer support for individuals waiting in hospital emergency departments for inpatient psychiatric care. |
| Northeast Kingdom Youth Services | Community Outreach, support groups and crisis intervention for young adults at risk of hospitalization. |
| Pathways – Peer Support Line | Statewide telephone peer support to prevent crisis and provide wellness coaching. |
| Vermont Psychiatric Survivors | Statewide organization providing community outreach, support groups, local peer-run micro-initiatives, telephone support, referral and emotional support, education, advocacy, and transition support between hospital and community treatment settings. |
| Vermont Vet-to-Vet | Community outreach, support groups and crisis intervention for veterans at risk of hospitalization due to mental health and substance use challenges. |
| Wellness Cooperative | Provides community center offering outreach, development/enhancement of natural supports networks, support groups, service linkages, crisis prevention, and employment and housing supports. Specializes in serving young adults who are not eligible or choose not to access Designated Agency Community Rehabilitation and Treatment services. |
| Wellness Workforce Coalition | Provides infrastructure and workforce development for organizations that provide peer support. Activities include:<br>o Coordinating core training (e.g Intentional Peer Support)<br>o Workforce development (e.g. recruitment, retention, career development)<br>o Mentoring<br>o Quality improvement<br>o Coordination of peer services<br>o Communication and networking<br>o Systems advocacy. |

During FFY14, each of the programs have worked closely with the Wellness Workforce Coalition (WWC) to participate in core training and mentoring for staff using the Intentional Peer Support curriculum, which is used nation-wide for peer support providers. These peer organizations have also worked with the WWC to improve their infrastructure (e.g. financial management, board development) and expand their capacity for collecting and reporting service outcomes.

The Vermont Support Line is one of the programs developed subsequent to the implementation of Act 79. It provides statewide telephone peer support to prevent crisis and provide wellness coaching; currently operating 365 days a year. The line is operated by full time and part time peer staff who have been trained using the Intentional Peer Support model which uses a specialized curriculum developed expressly for support line workers. The Vermont Support Line took its first call on March 18, 2013 and has provided 8,030 individual instances of completed support through mid-December 2014, with almost a 2,000 call increase in 2014. Through mid-December 2014, the Vermont Support Line has diverted 245 callers from emergency level services (crisis, emergency room, hospital, 911, etc.). Due to the increasing number of calls, in 2014 the support line has been able to answer only 8.42% of the total incoming calls. 80% of support line connections are made by returning messages left, but only 50% of missed callers leave a message.

*vi. Integrated Family Services (IFS) Initiative*

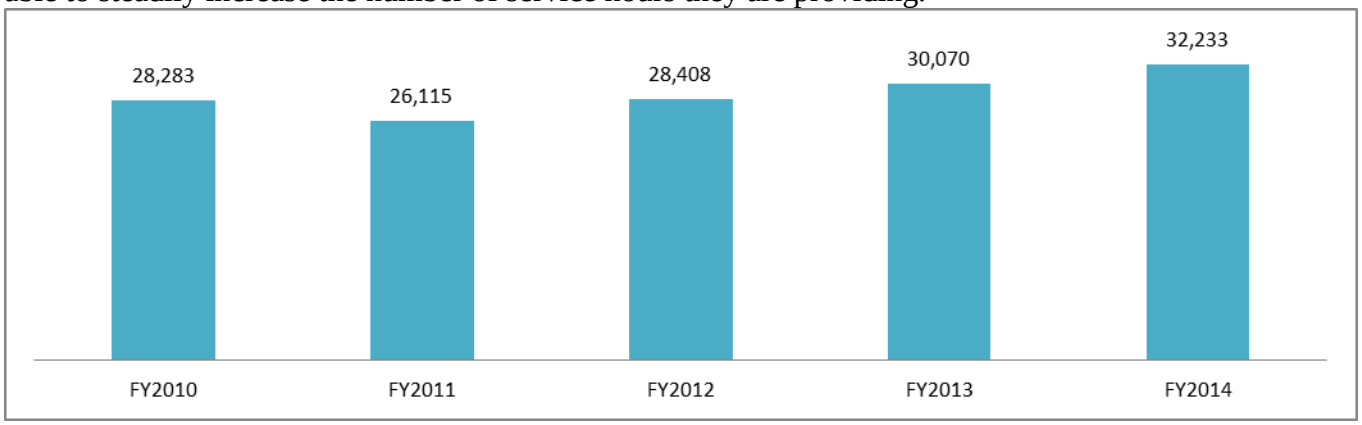
AHS continues to act on opportunities to improve quality and access to care, within existing budgets, using managed care flexibilities and payment reforms available under 42 CFR § 438 and the GC waiver. This includes such items as: integration of administrative structures for programs serving the same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

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

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

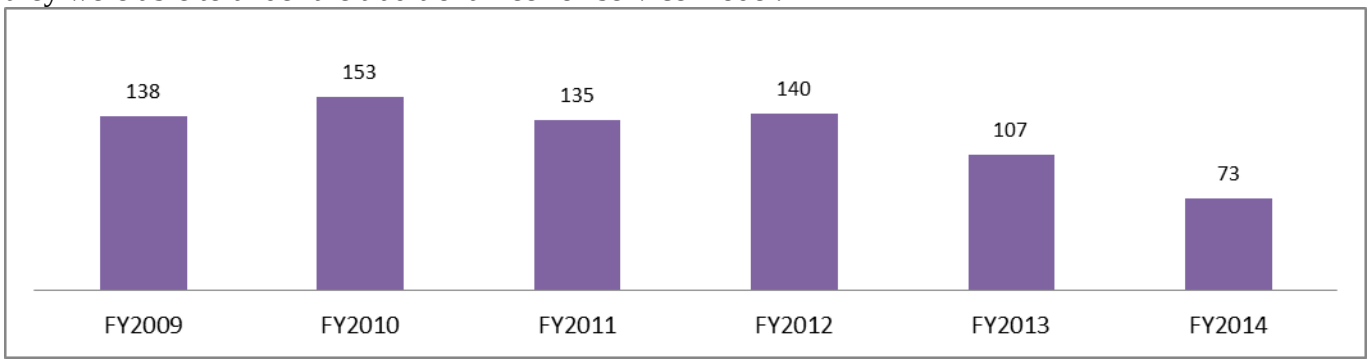
In FFY14, one AHS district was fully implementing an integrated grant. Data from that community indicate positive outcomes for clients and more efficient service delivery with the same level of funding the providers had in previous years. Below are two charts that indicate the success of the IFS model.

**Figure 1.** The first year of IFS in Addison was FFY12. With the same level of funding, they have been able to steadily increase the number of service hours they are providing.




With the same level funding, not only have they provided more services, the community has reduced the number of crisis service calls they have received.

**Figure 2.** Since IFS implementation, there has been a nearly 50% decrease in crisis interventions needed for children because the community now has the flexibility to provide supports and services earlier than they were able to under the traditional fee-for-service model.




In FFY14, a second community received an IFS grant. The Franklin/Grand Isle region in northwest Vermont started working under the IFS grant in April 2014. The services offered under the grant ranged from developmental services to intensive family services for families at risk of abusing their children. We expect to report on progress in that region in FFY15.

# VI. Utilization Management

Utilization Management is a systematic evaluation of the necessity, appropriateness, and efficiency of managed care model services. These activities are designed to influence providers' resource utilization and clinical practice decisions in a manner consistent with established criteria or guidelines to maximize appropriate care and minimize or eliminate inappropriate care. The DVHA must have a mechanism to detect both under/over-utilization of services and to assess the quality and appropriateness of care furnished to enrollees with special health care needs.

## *i. Clinical Utilization Review Board*

The Clinical Utilization Review Board (CURB) was established by Act 146 Sec. C34, 33 V.S.A. Chapter 19, Subchapter 6 during the 2010 legislative session. DVHA was tasked to create the CURB to examine existing medical services, emerging technologies, and relevant evidence-based clinical practice guidelines

and make recommendations to DVHA regarding coverage, unit limitations, place of service, and appropriate medical necessity of services in the state's Medicaid programs.

The CURB is comprised of 10 members with diverse medical experience, appointed by the Governor upon recommendation of the DVHA Commissioner. The CURB solicits additional input as needed from individuals with expertise in areas of relevance to the CURB's deliberations. The Medical Director of DVHA serves as the State's liaison to the CURB.

The CURB has the following duties and responsibilities:

1) Identify and recommend to the Commissioner opportunities to improve quality, efficiencies, and adherence to relevant evidence-based clinical practice guidelines in the Department's medical programs by:
   a) Examining high-cost and high-use services identified through the programs' current medical claims data;
   b) Reviewing existing utilization controls to identify areas in which improved utilization review might be indicated, including use of elective, nonemergency, out-of-state outpatient and hospital services;
   c) Reviewing medical literature on current best practices and areas in which services lack sufficient evidence to support their effectiveness;
   d) Conferring with commissioners, directors, and councils within the Agency of Human Services and the Department of Financial Regulation, as appropriate, to identify specific opportunities for exploration and to solicit recommendations;
   e) Identifying appropriate but underutilized services and recommending new services for addition to Medicaid coverage;
   f) Determining whether it would be clinically and fiscally appropriate for the DVHA to contract with facilities that specialize in certain treatments and have been recognized by the medical community as having good clinical outcomes and low morbidity and mortality rates, such as transplant centers and pediatric oncology centers; and
   g) Considering the possible administrative burdens or benefits of potential recommendations on providers, including examining the feasibility of exempting from prior authorization requirements those health care professionals whose prior authorization requests are routinely granted.

2) Recommend to the Commissioner the most appropriate mechanisms to implement the recommended evidence-based clinical practice guidelines. Such mechanisms may include prior authorization, prepayment, post service claim review, and frequency limits.

*ii. Drug Utilization Review Board*

The DUR Board was authorized by Congress under Section 4401, 1927(g) of the Omnibus Reconciliation Act of 1990. This act mandated that the Vermont AHS develop a drug use review program for covered outpatient drugs, effective January 1, 1993. The Act required the establishment of a DUR Board to:

1) Review and approve drug use criteria and standards for both retrospective and prospective drug use reviews (DURs)
2) Apply these criteria and standards in the application of DUR activities
3) Review and report the results of DURs, and
4) Recommend and evaluate educational intervention programs.

Additionally, the Vermont Legislature enacted the Pharmacy Best Practices and Cost Control Program from the 2002 Appropriations Act, H. 485, which mandated that:

*"The commissioner of prevention, assistance, transition, and health access [now the Department of Vermont Health Access] shall establish a pharmacy best practices and cost control program designed to reduce the cost of providing prescription drugs, while maintaining high quality in prescription drug therapies. The program shall include a preferred list of covered prescription drugs that identifies preferred choices within therapeutic classes for particular diseases and conditions, including generic alternatives, utilization review procedures, including a prior authorization review process, and any other cost containment activity adopted by rule by the commissioner, designed to reduce the cost of providing prescription drugs while maintaining high quality in prescription drug therapies."*

Implementation of this pharmaceutical initiative required that either the DUR Board or a Pharmacy and Therapeutics Committee be established that would provide guidance on the development of a Preferred Drug List for Medicaid patients. The DVHA elected to utilize the already established DUR Board to obtain current clinical advice on the use of pharmaceuticals. Meetings of the DUR Board occur monthly or bimonthly depending upon the numbers of drugs and issues to be reviewed.

The DUR Board typically includes 10-12 members who are appointed to two-year terms. At least one-third, but not more than half, of the Board's members are licensed and actively practicing physicians, and at least one-third of its members are licensed and actively practicing pharmacists. Other interested and qualified people also may be appointed. Board members are recommended by the DVHA Commissioner and approved by the Governor.

*iii. Appropriateness of Services*

DVHA delegates to its IGA partners who provide care to the four identified special health care needs populations, the responsibility to develop mechanisms to assess the quality and appropriateness of care furnished to enrollees with special health care needs. DMH monitors the quality and appropriateness of care for enrollees in the Community, Rehabilitation and Treatment (CRT) Program through the biennial Minimum Standards Review and for children identified with severe emotional disturbance through Program Reviews. The Department of Disability, Aging and Independent Living (DAIL) monitors the quality and appropriateness of care to enrollees in the Developmental Services Program and the Traumatic Brain Injury Program through Quality Service Reviews. (For further descriptions of the delegated activities see the individual departments' quality plans.)

*iv. Program Integrity Unit*

The Agency of Human Services has delegated responsibility for program integrity to DVHA's Program Integrity (PI) Unit. The PI Unit strives to ensure that Medicaid funds are utilized appropriately by identifying and ultimately reducing fraud, waste and abuse.

The PI Unit works with providers, beneficiaries, the Medicaid Fraud and Residential Abuse Unit (MFRAU) of the Office of the Attorney General, State fiscal agents, other DVHA units, AHS Departments, and the Medicaid Integrity Contractors (MIC) to insure the integrity of services provided and that actual, medically necessary healthcare services for beneficiaries are provided, coded, billed and paid in accordance with federal and state Medicaid rules, regulations, provider agreements and relevant statutes. Cases of suspected provider fraud are referred to the Medicaid Fraud and Residential Abuse Unit (MFRAU). Beneficiary eligibility fraud is referred to the DCF. Identified quality or process improvement needs are brought to the Managed Care Medical Committee (MCMC) at DVHA.

The PI Unit employs several methods to identify fraud, waste and abuse. Examples include:

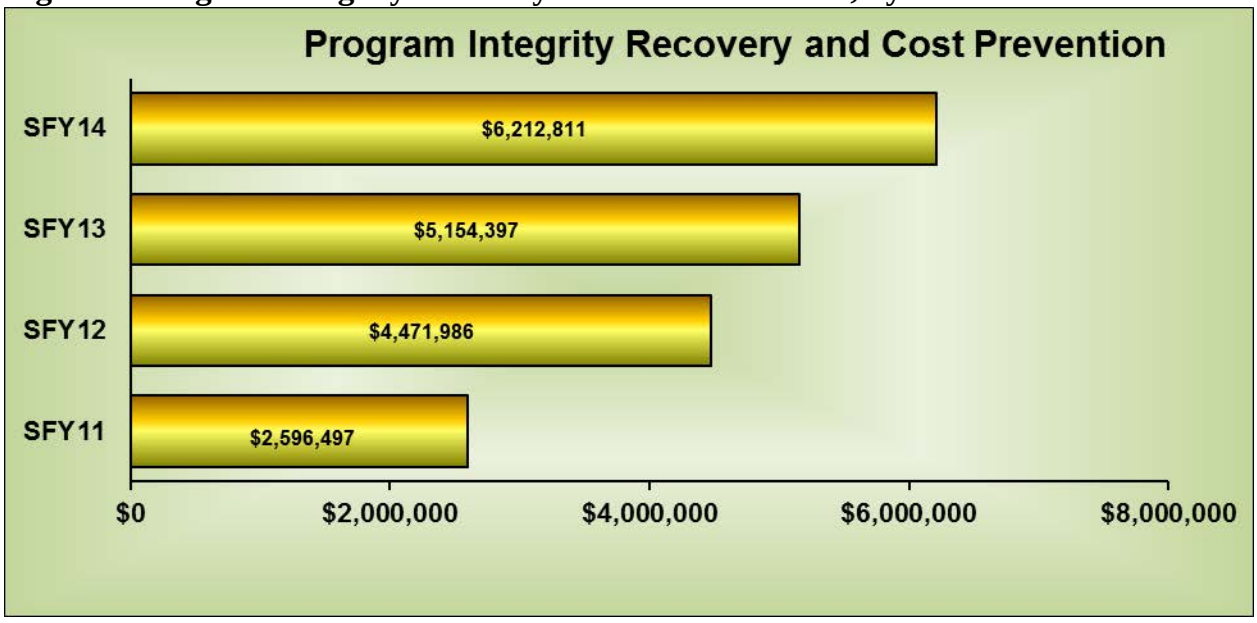
- Referrals from providers, pharmacies, national alerts, general public, etc.
- Pre-Payment reviews
- Post-Payment reviews
- Data mining activities

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 various investigative approaches. Some examples of more extensive reviews help to determine if the findings are:

- Suspected provider fraud, which may result 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.

*Outcomes:*
The Program Integrity Unit in DVHA has made significant strides in finding, investigating, and preventing fraud, waste and abuse in the Vermont Medicaid program. The annual savings to the State of Vermont was a total of $2.6 million (gross) from recoupment and cost avoidance for SFY11. The total recovery in recoupment and cost avoidance for SFY12 was $4.47 million, $5.15 million in SFY13, and $6.21 in SFY14. In addition, five members of the PI Unit staff have successfully completed all required training and earned their certification as Certified Program Integrity Professionals from the Medicaid Integrity Institute.

**Figure 3. Program Integrity Recovery and Cost Prevention, by State Fiscal Year**




*Medicaid Management Information System:*
The Medicaid Management Information System (MMIS) is an integral component of the PI Unit's utilization review activities. The MMIS maintains Medicaid claims data which allows for additional review and scrutiny of claims data.

*Claims Data Analysis and Post Payment Review:*
The PI Unit staff includes one Medicaid Healthcare Data & Statistical Analyst and one Fiscal Analyst who examine claims data and perform post payment review. Analysts utilize data mining techniques and have developed a variety of algorithms to detect aberrant utilization. They used Medicaid policies, guidelines and claims data in the development of these algorithms. Reports generated from these reviews identify aberrant claims 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 the PI Unit to mine data and create varied and comprehensive ad hoc reports from the MMIS. EVAH is an invaluable tool employed by the PI Unit Medical Health care Data & Statistical Analyst, Fiscal Analyst and Programs and Operations Auditors to advance investigations that enables them 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 reported and analyzed using any of the claim details to allow the PI unit to compare individuals, evaluate adherence to policy, etc. This is a valuable tool in detecting under/over-utilization on a global scale.

*v. Inpatient, Outpatient, and Emergency Department Utilization*

*Methods:*
Utilization statistics for inpatient, outpatient, and emergency department services provided under Global Commitment during FFY14 were compiled by the DVHA's Data & Reimbursement Unit in December 2014 using paid claims data. The scope of analysis included institutional services provided under the Medicaid program between 10/1/2013 and 9/30/2014, excluding crossover claims.[3] 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 (Table 6) presents discharge counts and average length-of-stay by age for inpatient services provided in FFY 2014.

[3] 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 6. Inpatient Utilization**

| Utilization | Age | Discharges | Sum LOS Days | Avg. LOS Days |
|---|---|---|---|---|
| TOTAL INPATIENT (IP) | <1 | 3,331 | 12,768 | 3.83 |
| TOTAL INPATIENT (IP) | 1-9 | 544 | 2,223 | 4.09 |
| TOTAL INPATIENT (IP) | 10-19 | 1,275 | 8,501 | 6.67 |
| TOTAL INPATIENT (IP) | 20-44 | 6,168 | 25,375 | 4.11 |
| TOTAL INPATIENT (IP) | 45-64 | 3,291 | 19,127 | 5.81 |
| TOTAL INPATIENT (IP) | 65-74 | 75 | 434 | 5.79 |
| TOTAL INPATIENT (IP) | 75-84 | 31 | 253 | 8.16 |
| TOTAL INPATIENT (IP) | 85+ | 22 | 156 | 7.09 |
| TOTAL INPATIENT (IP) | Total | 14,737 | 68,837 | 4.67 |
| IP MEDICINE | <1 | 3,303 | 12,597 | 3.81 |
| IP MEDICINE | 1-9 | 448 | 1,861 | 4.15 |
| IP MEDICINE | 10-19 | 1,058 | 7,481 | 7.07 |
| IP MEDICINE | 20-44 | 4,773 | 19,217 | 4.03 |
| IP MEDICINE | 45-64 | 2,391 | 13,428 | 5.62 |
| IP MEDICINE | 65-74 | 61 | 305 | 5.00 |
| IP MEDICINE | 75-84 | 25 | 212 | 8.48 |
| IP MEDICINE | 85+ | 20 | 148 | 7.40 |
| IP MEDICINE | Total | 12,079 | 55,249 | 4.57 |
| IP MED ALCOH/SUBST | <1 | 0 | 0 | 0.00 |
| IP MED ALCOH/SUBST | 1-9 | 0 | 0 | 0.00 |
| IP MED ALCOH/SUBST | 10-19 | 17 | 51 | 3.00 |
| IP MED ALCOH/SUBST | 20-44 | 641 | 2,813 | 4.39 |
| IP MED ALCOH/SUBST | 45-64 | 247 | 1,080 | 4.37 |
| IP MED ALCOH/SUBST | 65-74 | 0 | 0 | 0.00 |
| IP MED ALCOH/SUBST | 75-84 | 0 | 0 | 0.00 |
| IP MED ALCOH/SUBST | 85+ | 0 | 0 | 0.00 |
| IP MED ALCOH/SUBST | Total | 905 | 3,944 | 4.36 |
| IP MED PSYCHIATRIC | <1 | 0 | 0 | 0.00 |
| IP MED PSYCHIATRIC | 1-9 | 57 | 684 | 12.00 |
| IP MED PSYCHIATRIC | 10-19 | 419 | 5,367 | 12.81 |
| IP MED PSYCHIATRIC | 20-44 | 757 | 6,257 | 8.27 |
| IP MED PSYCHIATRIC | 45-64 | 313 | 3,239 | 10.35 |
| IP MED PSYCHIATRIC | 65-74 | 2 | 31 | 15.50 |
| IP MED PSYCHIATRIC | 75-84 | 1 | 106 | 106.00 |
| IP MED PSYCHIATRIC | 85+ | 1 | 70 | 70.00 |
| IP MED PSYCHIATRIC | Total | 1,550 | 15,754 | 10.16 |
| IP MED OTHER | <1 | 3,303 | 12,597 | 3.81 |
| IP MED OTHER | 1-9 | 391 | 1,177 | 3.01 |
| IP MED OTHER | 10-19 | 622 | 2,063 | 3.32 |
| IP MED OTHER | 20-44 | 3,375 | 10,147 | 3.01 |
| IP MED OTHER | 45-64 | 1,831 | 9,109 | 4.97 |
| IP MED OTHER | 65-74 | 59 | 274 | 4.64 |
| IP MED OTHER | 75-84 | 24 | 106 | 4.42 |
| IP MED OTHER | 85+ | 19 | 78 | 4.11 |
| IP MED OTHER | Total | 9,624 | 35,551 | 3.69 |
| IP SURGERY | <1 | 28 | 171 | 6.11 |
| IP SURGERY | 1-9 | 96 | 362 | 3.77 |
| IP SURGERY | 10-19 | 217 | 1,020 | 4.70 |
| IP SURGERY | 20-44 | 1,395 | 6,158 | 4.41 |

| | | | | |
|---|---|---|---|---|
| IP SURGERY | 45-64 | 900 | 5,699 | 6.33 |
| IP SURGERY | 65-74 | 14 | 129 | 9.21 |
| IP SURGERY | 75-84 | 6 | 41 | 6.83 |
| IP SURGERY | 85+ | 2 | 8 | 4.00 |
| IP SURGERY | Total | 2,658 | 13,588 | 5.11 |

The following table (Table 7) presents visit counts by age for outpatient services provided in FFY 2014, first for all outpatient services, and then for emergency department services.

**Table 7. Outpatient Utilization**

| Age | TOTAL OUTPATIENT (OP) Visits | OP EMERG DEPT Visits |
|---|---|---|
| <1 | 6,467 | 3,075 |
| 1-9 | 33,979 | 15,165 |
| 10-19 | 43,249 | 14,804 |
| 20-44 | 143,506 | 40,117 |
| 45-64 | 94,643 | 12,847 |
| 65-74 | 1,004 | 123 |
| 75-84 | 429 | 30 |
| 85+ | 266 | 26 |
| Total | 323,543 | 86,187 |

*Discussion:*
In FFY14, Global Commitment, Medicaid, paid for 14,737 inpatient stays and 323,543 outpatient visits for Vermonters. Of the inpatient stays, 82% were for medicine, and 18% were for surgery. Psychiatric services constituted 13% of the inpatient medicine stays, and treatment for alcohol and substance abuse services constituted 7.5% 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 27%.

## VII. Policy and Administrative Difficulties

*Fiscal & Operational Management:*
On October 2, 2013, the Global Commitment to Health waiver renewal was approved with a new set of Special Terms and Conditions (STCs). The STCs brought about new reporting requirements for the CMS-64. Most of these reporting changes became effective January 1, 2014 with the implementation of the Affordable Care Act (ACA). AHS has worked with DVHA and CMS throughout the FFY to ensure all the new reporting requirements per the STCs are met.

The State's eligibility system has faced some difficulty with accurate beneficiary coding post-ACA implementation; AHS and DVHA continue to work through issues with the Eligibility Services unit to ensure enrollees are properly bucketed in the proper MEGs. We are working to institute a permanent automated solution. Additionally, due to technical difficulties with Vermont's Health Care Exchange website, certain populations previously slated to transition on December 31, 2013 were extended through March 31, 2014 after the ACA became effective on January 1, 2014. Impacted eligibility groups include segments of the VHAP, Catamount, ESI, and Pharmacy Only populations.

AHS paid DVHA a prospective PMPM capitation payment on the first business day of every month during FFY14. The PMPM payments included retroactive changes in enrollment with a 12-month runout

period, per our PMPM payment process. This PMPM payment served as the proxy by which to draw down Federal funds for Global Commitment. The State prepared the CMS-64 based upon actual allowable Medicaid expenditures (administrative, program, and MCE Investments) for the given quarter. After each quarterly submission, we reconciled what was claimed on the CMS-64 versus what we made for Capitation payments to DVHA.

AHS extended and amended the contract in February 2014 to allow Milliman to prepare rates for FFY15. The AHSCO Financial Director position was filled by Tracy O'Connell in June 2014. Monica Light replaced Stephanie Beck as the AHS Director of Health Care Operations, Compliance and Improvement in April 2014.

## VIII. Capitated Revenue Spending

The PMPM rates as set for FFY14 are listed below.

**Table 8.**

| | Oct-Dec 2013 | | | Jan-Sep 2014 |
|---|---|---|---|---|
| **Medicaid Eligibility Group** | **Monthly Premium PMPM** | | **Medicaid Eligibility Group** | **Monthly Premium PMPM** |
| ABD - Non-Medicare - Adult | **$ 1,312.30** | | ABD Adult | **$ 1,383.20** |
| ABD - Non-Medicare - Child | **$ 2,560.41** | | ABD Child | **$ 2,685.75** |
| ABD - Dual | **$ 1,304.73** | | ABD - Dual | **$ 1,364.05** |
| ANFC - Non-Medicare - Adult | **$ 732.92** | | non-ABD Adult | **$ 600.97** |
| ANFC - Non-Medicare - Child | **$ 434.83** | | non-ABD Child | **$ 453.62** |
| GlobalExp (VHAP) | **$ 464.20** | | GlobalRx | **$ 67.71** |
| GlobalRx - Dual | **$ 66.70** | | Premium Subsidy | **$ 31.48** |
| GlobalRx - Non-Medicare | **$ 66.70** | | | |
| OptionalExp | **$ 216.42** | | | |
| VHAP ESI | **$ 188.19** | | | |
| ESI Premium Assistance | **$ 140.16** | | | |
| Catamount Premium Assistance | **$ 533.54** | | | |

Investments made by the MCE for SFY14 totaled $127,103,459. Areas of capitated spending and the associated categories are outlined in Attachment 1.

# Attachments

# Attachment 1: SFY14 Final MCO Investments

| 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 and other innovative programs to improve the health outcomes, health status and quality of life for uninsured, underinsured, and Medicaid-eligible individuals in Vermont |
| 4 | Encourage the formation and maintenance of public-private partnerships in health care, including initiatives to support and improve the health care delivery system. |

## MCO Investment Expenditures

| Criteria | Department | Investment Description |
|---|---|---|
| 2 | DOE | School Health Services |
| 4 | GMCB | Green Mountain Care Board |
| 2 | BISHCA | Health Care Administration |
| 2 | VVH | Vermont Veterans Home |
| 2 | VSC | Health Professional Training |
| 2 | UVM | Vermont Physician Training |
| 3 | VAAFM | Agriculture Public Health Initiatives |
| 2 | AHSCO | Designated Agency Underinsured Services |
| 4 | AHSCO | 2-1-1 Grant |
| 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 |
| 2 | 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 | Coalition of Health Activity Movement Prevention Program (CHAMPPS) |
| 2 | VDH | Substance Abuse Treatment |
| 4 | VDH | Recovery Centers |
| 2 | VDH | Immunization |
| 4 | VDH | Poison Control |
| 4 | VDH | Challenges for Change: VDH |
| 3 | VDH | Fluoride Treatment |
| 4 | VDH | CHIP Vaccines |
| 4 | VDH | Healthy Homes and Lead Poisoning Prevention Program |
| 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 |
| 2 | DMH | Recovery Housing |
| 2 | DMH | Seriously Functionally Impaired: DMH |

## MCO Investment Expenditures

| Criteria | Department | Investment Description |
|---|---|---|
| 2 | DMH | Acute Psychiatric Inpatient Services |
| 2 | DMH | Institution for Mental Disease Services: DMH |
| 4 | DVHA | Vermont Information Technology Leaders/HIT/HIE/HCR |
| 4 | DVHA | Vermont Blueprint for Health |
| 1 | DVHA | Buy-In |
| 1 | DVHA | HIV Drug Coverage |
| 1 | DVHA | Civil Union |
| 2 | DVHA | Patient Safety Net Services |
| 2 | DVHA | Institution for Mental Disease Services: DVHA |
| 2 | DVHA | Family Supports |
| 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 | Therapeutic Child Care |
| 2 | DCF | Lund Home |
| 2 | DCF | GA Community Action |
| 3 | DCF | Prevent Child Abuse Vermont: Shaken Baby |
| 3 | DCF | Prevent Child Abuse Vermont: Nurturing Parent |
| 4 | DCF | Challenges for Change: DCF |
| 2 | DCF | Strengthening Families |
| 2 | DCF | Lamoille Valley Community Justice Project |
| 3 | DCF | Building Bright Futures |
| 2 | DCF | Children's Integrated Services Early Intervention |
| 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 |
| 4 | DDAIL | Support and Services at Home (SASH) |
| 4 | DDAIL | HomeSharing |
| 4 | DDAIL | Self-Neglect Initiative |
| 2 | DDAIL | Seriously Functionally Impaired: DAIL |
| 2 | DOC | Intensive Substance Abuse Program (ISAP) |
| 2 | DOC | Intensive Sexual Abuse Program |
| 2 | DOC | Intensive Domestic Violence Program |
| 2 | DOC | Community Rehabilitative Care |
| 2 | DOC | Return House |
| 2 | DOC | Northern Lights |
| 4 | DOC | Challenges for Change: DOC |
| 4 | DOC | Northeast Kingdom Community Action |
| 2 | DOC | Pathways to Housing |