

PHPG

The Pacific Health Policy Group



INTERIM PROGRAM EVALUATION

Global Commitment to Health

11-W-00194/1

On behalf of:

**State of Vermont
Agency of Human Services**

Prepared by:

**The Pacific Health Policy Group
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Introduction

Purpose of Evaluation

In compliance with the Special Terms and Conditions, the State of Vermont submits to the Centers for Medicare and Medicaid Services (CMS) this Interim Program Evaluation with its request to renew the Global Commitment to Health (GC) Section 1115 Demonstration waiver for the five year period from January 1, 2014 through December 31, 2018. This Evaluation reports the Demonstration's progress toward accomplishing its three goals: 1) increasing access, 2) improving quality, and 3) controlling costs.

This Evaluation includes a compilation of Vermont's quality assessment and improvement activities, as well as emerging results from Vermont's innovative programs for Chronic Care Management and its Patient Centered Medical Home Initiative, Blueprint for Health. As part of its renewal request the State is requesting that the 1115 Long Term Care Demonstration waiver, Choices for Care (CFC), be consolidated into the GC Demonstration. To-date, evaluation activities of the two waivers have been separate. This evaluation focuses on GC Demonstration activities while the CFC Demonstration information will be reported separately. Additionally, the Agency of Human Services (AHS) will be working closely with the Green Mountain Care Board (GMCB) to craft a revised evaluation plan that continues to align and complement any new health care reform initiatives.

Background on Health Care Reform in Vermont

The State of Vermont passed comprehensive health care reforms in 2006, augmented in 2007 and 2008, to expand access to coverage, improve the quality and performance of the health care system, and contain costs. The reforms encompass 11 bills with over 60 different initiatives including the availability of subsidized coverage options for low-income uninsured Vermonters, investments in health information technology, and the strategy to transform the health care delivery system through integration of prevention, chronic disease management, and provider payment reform.

In January 2011, Vermont Governor Shumlin announced his comprehensive plan for health reform, including implementing a single payer system of universal health coverage for Vermonters. In January of 2012, the Governor's Strategic Plan for Health Care Reform was released. Specific objectives of this Reform Plan are to: 1) reduce the growth of health care cost; 2) assure universal access to high quality health coverage; 3) improve the health of Vermonters; and 4) assure greater fairness in health care financing in Vermont. Core strategies of Governor Shumlin's Reform Plan include changing how care is delivered to Vermonters; moving from volume-based to value-based reimbursement; and moving from a fragmented and overly complex financing system to a unified system that supports integration of service delivery and payment reform.

Vermont Act 48 (2011) is the first step in this broader reform by providing legislative authority to create a health care system in which all Vermonters receive equitable coverage through universal health coverage. This included establishing Vermont's Health Benefit Exchange as per the Affordable Care Act (ACA) within the Department of Vermont Health Access (DVHA) as a unique integration of Medicaid and the Exchange in a single state department - the goal of which is to build on successes of the public programs, increase administrative efficiencies and begin the groundwork for a fully-integrated single payer system.

Act 48 also created the Green Mountain Care Board (GMCB) to oversee cost-containment and to approve the benefit design of Green Mountain Care, the comprehensive health care program that will provide coverage for the health care needs of Vermonters. GMCB members are responsible for controlling the rate of growth in health care costs and improving the health of Vermonters through a variety of regulatory and planning tools. Specifically, the GMCB is tasked with expanding health care payment and delivery system reforms by building on the Blueprint, and implementing policies that move away from a fee-for-service payment system to one that is based on quality and value, and reduces (or eliminates) cost-shifting between the public and private sectors.

Vermont's comprehensive package of health care reforms is based on the following design principles:

- It is the policy of the State of Vermont to ensure universal access to, and coverage for, essential health care services for all Vermonters.
- Health care coverage needs to be comprehensive and continuous.
- Vermont's health care delivery system must model continuous improvement of health care quality and safety.
- The financing of health care in Vermont must be sufficient, equitable, fair, and substantial.
- Built-in accountability for quality, cost, access, and participation must be the hallmark of Vermont's health care system.
- Vermonters must be engaged, to the best of their ability, to pursue healthy lifestyles, to focus on preventive care and wellness efforts, and to make informed use of all health care services throughout their lives.

Using these principles as a framework, Vermont's health care reforms are designed to simultaneously achieve the following three goals:

Increase access to affordable health insurance for all Vermonters;
Improve quality of care across the lifespan; and,
Contain health care costs.

The GC Demonstration has served as the foundation for Vermont's health reform model, providing the flexibility to improve access to health coverage and care based on individual and family needs. The GC

Demonstration enables Vermont to operate as if it were a (public) Medicaid Managed Care model for achieving the following reform objectives:

- Promoting universal access to affordable health coverage.
- Developing public health approaches for meeting the needs of individuals and families.
- Developing innovative, outcome- and quality-focused payment approaches.
- Enhancing coordination of care across providers and service delivery systems.
- Controlling program cost growth.

Similarly, the Choices for Care (CFC) Demonstration enables Vermont to promote early intervention and prevention, equal access to nursing home and community-based services, and person-centered services for beneficiaries in need of long-term services and supports. It is crucial to maintain these foundations of health care delivery for Vermont's most vulnerable and lower-income citizens while moving towards the broader goals of state and federal reform.

Background on Global Commitment

In October, 2005, Vermont entered into a new five-year comprehensive 1115 federal Medicaid Demonstration waiver, Global Commitment (GC) designed to, 1) provide the State with financial and programmatic flexibility to help Vermont maintain its broad public health care coverage and provide more effective services, 2) continue to lead the nation in exploring new ways to reduce the number of uninsured, and 3) foster innovation in health care by focusing on health care outcomes.

The GC Demonstration consolidates funding for all of the State's Medicaid programs, except for the Choices for Care (CFC) long-term care Demonstration, the Children's Health Insurance Program (CHIP) and Disproportionate Share Hospital (DSH) payments for hospitals. It also converts the operations of the state's Medicaid organization to a (public) Medicaid Managed Care Organization. Under the GC Demonstration, Vermont has the flexibility to implement creative programs and reimbursement mechanisms to help curb costs and improve quality of care: new payment mechanisms such as case rates, capitation, and combined funding streams to pay for services not traditionally reimbursable through Medicaid and investments in programmatic innovations. The managed care regulatory framework and program model also encourages interdepartmental collaboration and consistency across programs.

The Special Terms and Conditions require Vermont's (public) managed care model, DVHA, to comply with the Medicaid managed care requirements contained in federal law and regulations, including requirements that improve information available to beneficiaries, promote access to care, and enhance accountability. DVHA has transformed its operations to comply with these laws and regulations. In exchange for the additional flexibility granted under the GC Demonstration, the State of Vermont and Federal government have agreed to an aggregate cumulative 8.25 year spending limit.

A GC Demonstration amendment approved by CMS on October 31, 2007 allowed Vermont to implement the Catamount Health Premium Assistance Program with the corresponding commercial Catamount Health Plan (implemented by State statute October 1, 2007) to reduce the number of uninsured Vermonters. The Catamount Health Plan is offered in cooperation with Blue Cross Blue Shield of Vermont and until recently MVP Health Care. On December 23, 2009 a second amendment was approved to extend eligibility for Catamount Health and Employer Sponsored Insurance subsidies from 200% to 300% of the Federal Poverty Level (FPL), to extend pharmacy benefits for Medicare beneficiaries from 175% of FPL to 225% of FPL and to waive the 12-month waiting period. Following renewal effective January 1, 2011, another amendment, approved December 7, 2011, allows the state to provide both palliative and curative care at the same time for children with a terminal illness who are not expected to survive into adulthood. The last amendment, finalized on June 27, 2012, adjusted co-pay levels as directed by the Vermont Legislature.

Waiver Continuation

The State is in the final stage of submitting a letter of intent and draft request to CMS indicating its commitment to renew the GC Demonstration for the period January 1, 2014 to December 31, 2018.

Contents of Evaluation

In accordance with the Special Terms and Conditions of the GC Demonstration, AHS contracted with the Pacific Health Policy Group (PHPG) to prepare an evaluation of the GC Demonstration and its performance relative to the goals set forth at implementation. Specifically, PHPG has been directed to assess the following goals as specified in the Revised Evaluation Plan submitted to CMS in December 2008:

Goal 1: Increase Access to Care	<ul style="list-style-type: none">• Evaluation of Global Commitment’s ability to increase Medicaid beneficiary access to primary care
Goal 2: Enhance Quality of Care	<ul style="list-style-type: none">• Evaluation of the extent to which Global Commitment has enhanced the quality of care for Medicaid beneficiaries
Goal 3: Control Cost of Care	<ul style="list-style-type: none">• Evaluation of Global Commitment’s ability to contain (by maintaining or reducing) Medicaid spending in comparison to what would have been spent absent the waiver

This evaluation is organized according to the three goals specified previously. For each goal, a summary of goal accomplishments and a discussion of related data and initiatives is presented.

To measure the performance of the GC Demonstration, PHPG has compiled data from a variety of applicable projects and reports made available by AHS and nationally. The following resources were used:

- Global Commitment to Health Enrollment 2006-2012
- Vermont Department of Financial Regulation, formerly Department of Banking Insurance Securities and Health Care Administration (BISHCA), Vermont Health Insurance Coverage Survey (2001-2006, 2008, 2012)
- 2007-2012 External Quality Review Organization (EQRO) Technical Reports
- 2011-2012 HEDIS Measures
- 2011 and 2012 Consumer Assessment of Health Provider and Systems (CAHPS) Survey
- 2012 Blueprint for Health Annual Report
- 2012 Global Commitment to Health Demonstration Annual and Quarterly Reports to CMS
- NCQA, State of Health Care Quality 2012

Goal 1: Increase Access to Care

All Vermont Medicaid beneficiaries must have access to comprehensive care, including financial, geographic, physical, and communicative access. This means having health coverage, with appropriate providers, timely access to services, and culturally sensitive services.

Goal 1: Highlights:

The GC Demonstration has succeeded at increasing access to care for Vermont Medicaid beneficiaries over the first eight years of the waiver as measured in the following areas:

- *Average Enrollment:* average enrollment grew by 16.3% between 2009 and 2012, for an overall increase of 27.5% since 2006.
- *Number of Uninsured:* uninsured rate in Vermont decreased from 7.6% in 2009 to 6.8% in 2012, well below the national rate of 15.7% in 2011 (most recent U.S. Census data available).
- *HEDIS Measures:* improvement in standing relative to HEDIS access to care measures and as related to scores achieved by accredited Medicaid HMO's as reported in the NCQA 2012 *State of Health Care Quality Report*.
 - Significantly higher (10%) than the accredited Medicaid HMO average of 63% for Well Child Visits in the First 15 months of Life.
 - High performance for Child and Adolescent access to primary care physician (PCP) with scores ranging from 92% to 98% across the childhood years.
 - High scores related to Adult Access to Preventive and Ambulatory Care, 80% to 83.5% across the adult years.
- *Beneficiary Satisfaction:* According to the 2012 CAHPS, most respondents are satisfied with provider availability with 84.8% reporting they received the care needed and 84% reporting they received needed care quickly. Overall, respondents were satisfied with provider access.
- *Access to Buprenorphine:* DVHA, in cooperation with the Vermont Department of Health (VDH)/Division of Alcohol and Drug Abuse Programs (VDH/ADAP), the Department of Corrections (DOC), and the commercial insurers, is increasing access for patients to Buprenorphine services and increasing the number of physicians licensed to prescribe Buprenorphine. At the end of FFY 2012, the program successfully increased provider access for beneficiaries to receive treatment. In addition, providers who were enrolled in the program consistently increased their patient loads incrementally each month.

- *Blueprint for Health, Patient Centered Medical Home:* Starting in 2011 and continuing in 2012 there was accelerated growth in the number of primary care practices engaged in Vermont’s multi-payer patient centered medical home activities. Having moved from pilot to implementation, the Blueprint is now in all 14 Health Service Areas. As of December 31, 2012, 106 primary care practices serving approximately 422,000 Vermonters have successfully undergone the national recognition process, with several more scheduled for scoring in each month of 2013.

Goal 1: Data and Related Initiatives

Global Commitment Enrollment for 2006-2012

The GC Demonstration covers a significant portion of the total Vermont population, and its potential impact extends beyond those directly enrolled. As part of the Revised Evaluation Plan, the AHS must show that the GC Demonstration continues to enroll Medicaid beneficiaries. Data in Table 1-1 show the total lives (member months divided by 12) enrolled in the GC Demonstration from FFY 2006 through FFY 2012.

Table 1-1: Global Commitment Average Number of Enrollees

<i>Federal Fiscal Year (FFY):</i>	2006	2007	2008	2009	2010	2011	2012
Total Lives (Member Months / 12)	128,987	127,284	129,274	141,323	154,855	162,287	164,414
<i>Percent Change from Previous Year</i>		-1.3%	1.6%	9.3%	9.6%	4.8%	1.3%

Enrollments presented in Table 1-1 are summarized as follows:

- Enrollment was essentially flat during the first three years of the waiver.
- Average enrollment increased by over 9% in 2009 and 2010 before falling to more modest rates in 2011 and 2012.
- Average enrollment increased 27.5% from 2006 to 2012.

Department of Financial Regulation (formerly BISHCA) Health Insurance Coverage Survey (2001-2006; 2008, 2012)

According to the Health Insurance Group Profile of Vermont Residents, 2001-2006, and the 2008 and 2012 Vermont Household Health Insurance Survey, Table 1-2 summarizes the number of Vermonters insured under the private market, government, and uninsured from 2005 to 2012.

Table 1-2: Vermont Health Insurance Coverage 2000-2012

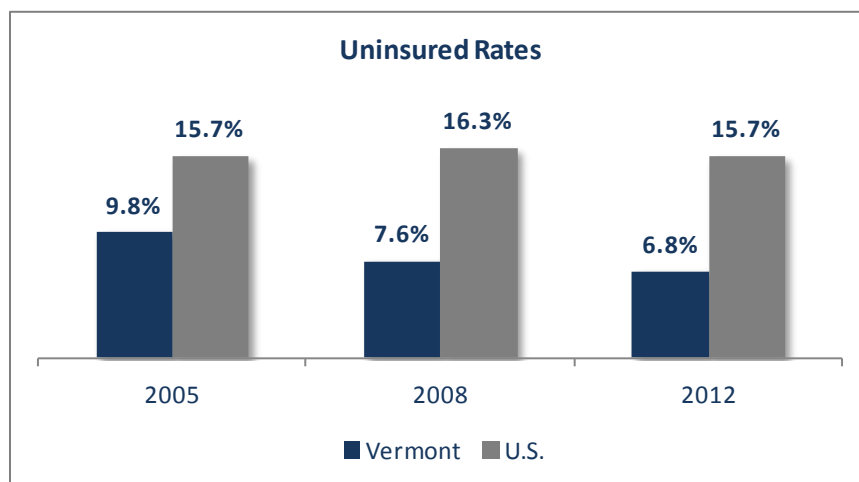
	2000	2005	2008	2009	2012	2000	2005	2008	2009	2012
	Rate					Count				
Private Insurance*	60.1%	59.4%	59.9%	57.2%	56.8%	366,213	369,348	370,981	355,358	355,857
Medicaid	16.1%	14.7%	16.0%	17.6%	17.9%	97,664	91,126	99,159	109,353	111,833
Medicare	14.4%	14.5%	14.3%	15.3%	16.0%	87,937	90,110	88,915	95,182	100,505
Military	0.9%	1.6%	2.4%	2.2%	2.5%	5,626	9,754	14,910	13,917	15,477
Uninsured	8.4%	9.8%	7.6%	7.6%	6.8%	51,390	61,057	47,286	47,460	42,760

Notes:

- Data sources: 2000, 2005, 2008, 2009, 2012 Vermont Household Health Insurance Survey, Dept. Financial Regulation
- Private Insurance includes Catamount Health Program
- Medicaid excludes enrollees dually eligible for Medicare, Catamount Health Program, and Employer-Sponsored Insurance (ESI) Programs, which are included in the enrollment figures in Table 1-1.

Table 1-2 can be summarized as follows:

- The number of Vermonters enrolled in Medicaid as their primary coverage increased by 2.3% between 2009 and 2012, for a total of 22.7% since before the GC Demonstration.
- The number of uninsured Vermonters has decreased by 10.5% as a percent of the population between 2009 and 2012, for a total decrease of 30.6% since before the GC Demonstration.
- The uninsured rate in Vermont has been consistently below the national rate throughout the life of the GC Demonstration, most recently in 2012, 6.8% compared to 15.7% (2011 for national rate, the most recent U.S. Census data available).



2012 HEDIS Measures

Table 1-3 shows four HEDIS measures used to evaluate access to primary care for 2011 and 2012. Where available, data are displayed with comparisons made to NCQA reported averages for accredited Medicaid HMO scores for 2012. GC Demonstration measures for children and adolescents include Annual Dental Visits, Well-Child Visits in the First 15 Months of Life (6 or more visits), Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life, and Adolescent Well-Care.

Table 1-3: Global Commitment Access to Care Child/Adolescent HEDIS Measures

HEDIS Measure	VT EQRO Year		VT Average: 2011-2012	NCQA Accredited Medicaid HMO Average	VT vs. NCQA HMO Average
	2011	2012			
Well Child Visits 1 st 15 Months (6 or more)	72.18%	73.91%	73.05%	63.2%	9.85%
Well Child 3 rd , 4 th , 5 th , 6 th year	69.02%	69.70%	69.36%	72.8%	-3.44%
Adolescent Well Care	46.25%	46.17%	46.21%	50.8%	-4.59%
Annual Dental Combined <21 yo*	68.13%	68.10%	68.12%	n/a	
Child/Adolescent Access to PCP					
12-24months	98.18%	98.34%	98.26%	96.3%	1.96%
25months-6 yrs	91.56%	92.18%	91.87%	88.5%	3.37%
7-11 yrs	94.05%	94.54%	94.30%	90.1%	4.19%
12-19 yrs	93.52%	93.56%	93.54%	88.3%	5.24%

*n/a – not available

Well-Child Visits in the First 15 months of Life was significantly higher than the accredited Medicaid HMO scores for 2012 (10%). Well-Child Visits in the First 15 months of Life is defined as the percentage of enrolled members who turned 15 months during the measurement year, and who had 6 or more well-child visits with a primary care practitioner during their first 15 months of life.

Well-Child Visits (ages 3 -6 years) exceeded the accreditation Medicaid HMO scores by 3% in 2012. Well Child Visits represents the percentage of children (ages 3 – 6 years) who received one or more well-child visits with a primary care practitioner during the measurement year.

Child and Adolescent Access to a PCP scores were consistently higher than accredited Medicaid HMO scores for all age ranges.

Table 1-4 Adult Access Measures

Measure	VT EQRO Year		NCQA Accredited Medicaid HMO Average
	2011	2012	
Adult Access to Preventative/Ambulatory Care			
20-44 years	83.09%	81.39%	n/a
45-64 years	84.88%	83.59%	n/a
65 and over	82.09%	79.49%	n/a
Total	83.56%	81.92%	n/a
Anti-Depressant Medication Mgt			
Effective Acute phase Treatment	66.98%	68.42%	50.9%
Continuation Phase Treatment	51.38%	54.54%	34.5%

n/a: not available

For most adult access measures, NCQA comparison scores for accredited Medicaid HMOs were not available. However, the state’s contracted External Quality Review Organization (EQRO), Health Services Advisory Group (HSAG), notes that overall, Vermont showed strong performance (greater than the 75th percentile) across three measures related to access in 2012:

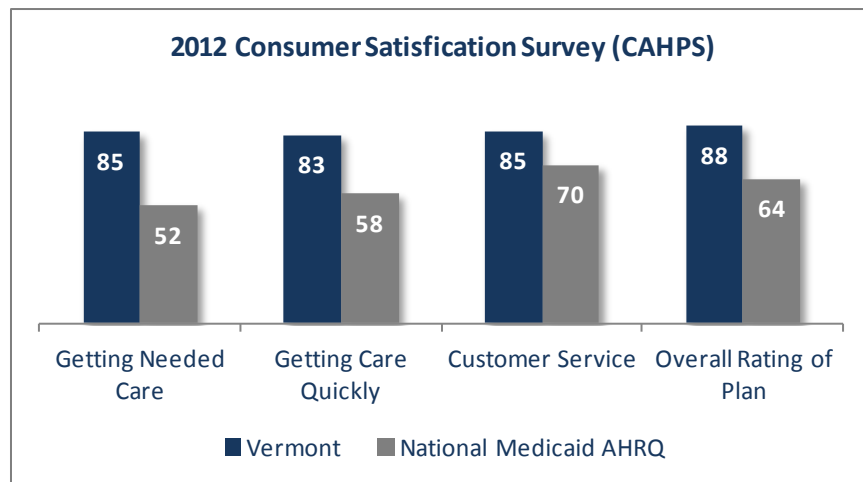
- Significantly exceeded the national average for Annual Dental Visits in 2011 (by 17.4%).
- Exceeded the national average for Children’s and Adolescents’ Access to Primary Care Practitioners in 2011 (by an average of 4.2%).
- Significantly higher than the national average for 2011 for Antidepressant Medication Management: Acute and Continuation Phase (by 18% and 20% respectively).

2012 Customer Assessment of Health Care Providers and Systems (CAHPS) Survey

The DVHA contracted with a private vendor, WB&A Market Research, who assisted in the administration and scoring of the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan 4.0 Adult Medicaid survey. The CAHPS Health Plan 4.0 Adult Medicaid survey includes 39 questions; DVHA added questions from the CAHPS Health Plan 4.0 Supplemental Items for a total of 55 questions. The survey was administered to 600 beneficiaries enrolled in the GC Demonstration in the six months prior to the fielding of the survey. A multi-modal (using both telephone and mail) approach was used to increase the response rate. Beneficiaries received an introductory mailing, a survey mailing, and a follow up reminder postcard after which beneficiaries are contacted by phone. The survey was administered in the spring of 2012. The 2012 overall response rate was 54.3% which was an increase over the 2009 response rate. 80% of beneficiaries responded by mail, while 20% responded by telephone. The mail response rate increased 3% over 2009.

According to the survey results, respondents overall were satisfied in their experiences with provider access, customer service and their plan.

- 84% of Vermont beneficiaries report satisfaction with access to care, as compared to 52% of Medicaid beneficiaries nationally.
- 83.4% of Vermont beneficiaries report satisfaction in getting needed care quickly as compared to 57.5% of Medicaid beneficiaries nationally.
- 85% of Vermont beneficiaries report satisfaction with customer service as compared to 70% of Medicaid beneficiaries nationally.
- 87.5% of Vermont beneficiaries report satisfaction with their health plan as compared to 64% of Medicaid beneficiaries nationally.



In addition, according to the 2012 CAHPS data, most respondents are satisfied with provider punctuality, availability (in both urgent and non-urgent situations), attentiveness, and coordination of care. Overall, Vermont’s Medicaid Managed Care model showed strong performance across two composite CAHPS measures related to access as compared to 2009 scores:

- Getting Needed Care - percentage of beneficiaries that responded they were “Always” or “Usually” able to get care when attempting to do so improved from 79.9% in 2009 to 84.8% in 2012.
- Getting Care Quickly – percentage of beneficiaries that responded that they were “Always” or “Usually” able to receive care or advice in a reasonable time, including office waiting room experiences, improved from 81.6% in 2009 to 83.4% in 2012.

AHS and DVHA must comply with the access to care standards as required by CMS. The Quality Assurance/Performance Improvement Committee (QAPI) produced the 2008 Medicaid Managed Care Quality Strategy (Quality Strategy) which implements a written strategy for assessing and improving all aspects of managed care services. The 2010 EQRO report shows an overall compliance score of 97%

with 42 CFR 438 standards related to enrollee and access. Specifically standards and associated scores contributing to the 97% overall score include:

- ✓ Availability of Services (100% or 13 of 13 elements met).
- ✓ Furnishing of Services (93% or 12 of 14 elements met and two partially met).
- ✓ Cultural Competence (100% or 4 of 4 elements met).
- ✓ Coordination and Continuity of Care (100% or 8 of 8 elements met).
- ✓ Coverage and Authorization of Services (95% or 19 of 21 elements met and 2 partially met).
- ✓ Emergency and Post Stabilization Services (100% or 13 of 13 elements met)
- ✓ Enrollment and Disenrollment (83% or 2 of 3 elements met and 1 partially met)

Catamount Health and Green Mountain Care

To increase access to care, the State made available in October of 2007 the Catamount Health Plan, a separate insurance pool for uninsured Vermonters. Since its launch in November 2007, the State has insured over 10,000 individuals under the plan. The success of the plan can be attributed to its lower premium costs versus comparable plans on the individual market – the State also offers premium assistance under the plan to those with incomes under 300% of the Federal Poverty Level (FPL).

With the launch of the Catamount Health Plan, all public health care programs were rebranded under the umbrella name “Green Mountain Care” with the tag line, “A Healthier State of Living.” Promotional materials, a web site, logo and an advertising campaign helped achieve 69% brand recognition for Green Mountain Care within three months of launching.

The legislature passed a provision providing amnesty for the pre-existing condition exclusion under the Catamount Health Plan. This created the need to educate the public about this time-limited offer to have all conditions covered without waiting periods if they applied before November 1, 2008. This was done through press releases, trainings, LISTSERVs, State government emails, a mailing in partnership with the Vermont Department of Labor to all 22,000 private sector employers in Vermont, and by updating the image of the web button link which existed on over 20 partnering websites.

Simultaneous with the Amnesty Campaign was a successful “Senior Campaign” to reach college graduates and their parents. Public and private colleges showed support by marketing directly to 6,250 college seniors and 3,600 faculty and staff.

The State also provides subsidies through its Employer-Sponsored Insurance (ESI) Premium Assistance Program to complement the Catamount Health Plan and limit the possibility of “crowd-out” from employer-based coverage. Finally, the State determines the cost-effectiveness of enrolling an individual in a certain program versus another, and makes the appropriate decision.

Enrollment in the Catamount Health premium assistance program grew steadily in the past few years but began to slow in 2012 with an average monthly enrollment of 10,716 individuals. Enrollment in the

Employer-Sponsored Insurance (ESI) program decreased for 2012 with only 1553 individuals enrolled (including those eligible for VHAP-ESI). On average 824 individuals enrolled in VHAP-ESI and on average 729 individuals enrolled in ESI. Most recent decreases in ESI enrollment is partially due to the fact that employers continue to increase the deductibles in their plans in an effort to control the cost of premiums. Vermont's ESI premium assistance program is not permitted, by law, to approve an ESI plan if the deductible is greater than \$500.

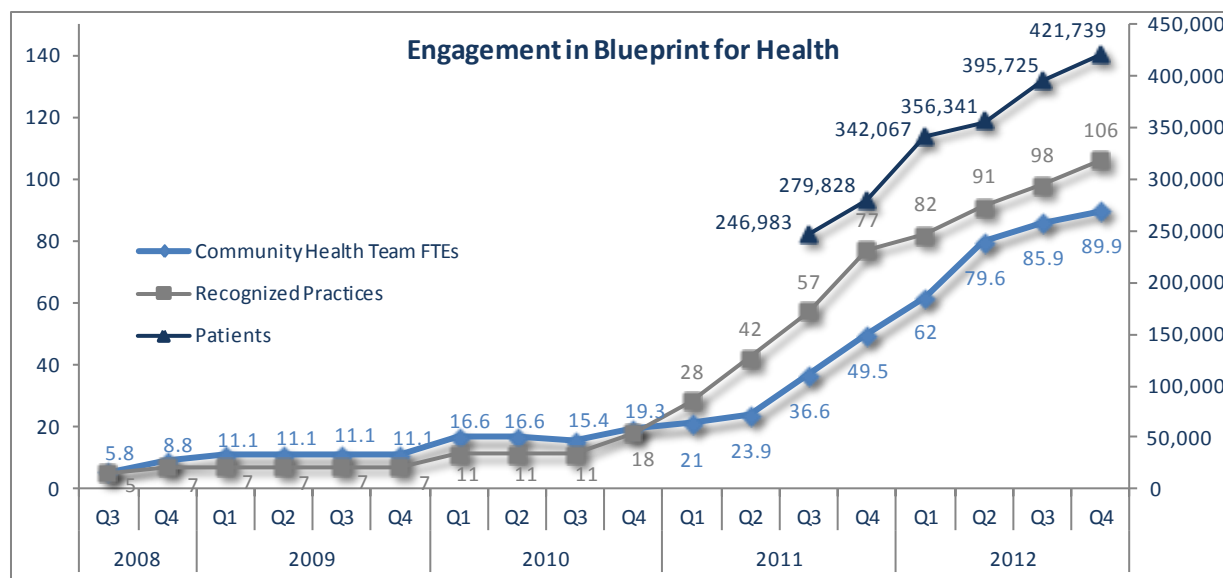
Green Mountain Care outreach has become an increasingly integral part of the Vermont Department of Labor's (DOL)'s response to layoffs. The DVHA and DOL have also developed a training curriculum for employers that explains everything an employer needs to know from paying the Catamount assessment to the health benefits available to uninsured Vermonters who qualify. As DVHA prepares for the transition to ACA in 2014, the Health Benefit Exchange team has begun aggressive work on the comprehensive outreach and education plan for Vermont's January 2014 transition.

Blueprint for Health

Vermont's Blueprint for Health (Blueprint) is a multi-payer patient centered medical home initiative that employs a multi-payer advanced primary care practice (APCP) model. Practices are supported by Community Health Teams (CHTs) comprised of nurse coordinators, clinician case managers, social workers and other professionals who extend the capacity of primary care practices to provide multidisciplinary care and support. This model has enabled Vermont to provide high quality primary care with embedded multidisciplinary support services, better coordination and transitions of care, and more seamless linkages among diverse community partners. The Blueprint includes the following components:

- Multi-insurer payment reforms that support APCPs and CHTs;
- Statewide health information architecture to support coordination across a wide range of providers of health and human services; and
- Evaluation and quality improvement infrastructure to support a Learning Health System which continuously refines and improves itself.

Starting in 2011 and continuing through 2012, there was extraordinary growth in the number of primary care practices engaged in patient centered medical home activities. Having moved from pilot to program phase, the Blueprint now has a solid presence in all 14 Health Service Areas.



Buprenorphine Program

DVHA in cooperation with the Vermont Department of Health - Alcohol & Drug Abuse Program (VDH-ADAP), the Department of Corrections (DOC), and commercial insurers, increased access for patients to Buprenorphine services, increased the number of physicians in Vermont licensed who prescribe Buprenorphine, and added support practices which care for the opiate-dependent population. In 2006, DVHA was appropriated funding by the legislature to implement the Buprenorphine Program.

Throughout FFY 2007 and FFY2008, DVHA in collaboration with VDH/ADAP, utilized the funding to establish and maintain the capitated payment program: reimbursement is tiered to increase reimbursement to physicians in a step-wise manner depending on the number of patients treated by the enrolled physician. Many physicians limit the number of opiate-dependent patients because of difficulties in caring for the population (i.e., missed appointments, diversion, time spent by office staff), and as a result, most physicians see fewer patients than they could.

In November 2007, despite a reduction in funding, DVHA and VDH-ADAP continued to collaborate to ensure that enrolled providers continued to receive support in the management of patients being treated with Buprenorphine for opioid dependence. At the end of FFY 2012, the program successfully increased provider access for beneficiaries to receive treatment. Enrolled providers consistently increased their patient loads incrementally each month. Additionally, Vermont’s Chronic Care Initiative (VCCI) staff provides direct care coordination in several pilot areas for beneficiaries in the Buprenorphine program.

As a result of this program DVHA, including the Blueprint for Health, VDH-ADAP and other AHS Departments have partnered on the creation of the “Hub and Spoke” model of medical home care for persons who are addicted to opioids (describe later in this report).

Goal 2: Enhance Quality of Care

The second goal of Global Commitment (GC) Demonstration is to enhance the quality of care to all Vermont Medicaid beneficiaries.

Goal 2: Highlights

The GC Demonstration has succeeded at enhancing the quality of care for Vermont Medicaid beneficiaries over the eight years of the waiver as measured in the following areas:

- Compliance with required Managed Care quality of care standards identified by AHS. DVHA has consistently improved its compliance, scoring 100% compliant with all CMS measurement and improvement standards in 2012.
- DVHA has engaged in two Performance Improvement Projects (PIP) related to clinical care and received a score of 100% for all evaluation and critical evaluation elements met and an overall final validation status of 'Met' for both.
- The Vermont Chronic Care Initiative (VCCI) has made improvements in health outcomes for Vermont's highest risk Medicaid beneficiaries. Data for SFY 2011 showed a 14% reduction in inpatient admissions and a 10% reduction for emergency room utilization over the baseline year of 2008 for enrolled beneficiaries.
- Beneficiaries enrolled in VCCI showed better adherence to evidenced-based treatments than those not enrolled.
- Medicaid is an active partner in Vermont's Patient Centered Medical Home initiative, the Blueprint for Health. Emerging data from this multi-payer effort is beginning to show decreased utilization of emergency rooms and inpatient stays, and increased statewide access to quality care. Additionally, the Blueprint has partnered with Seniors Aging Safely at Home (SASH) and Medicare to implement a statewide effort to provide care coordination, nursing and other services to seniors directly within their community housing.
- In SFY 2008, DVHA began distributing \$292,836 annually to recognize and reward dentists serving high volumes of Medicaid beneficiaries. For SFY 2009, a distribution of \$146,418 was made in October 2008 and another distribution of \$146,418 was made in the spring of 2009, for an annual total of \$292,836. The initiative has continued on the same cycle and same dollar amount. Typically, 35-40 dentists qualify for semiannual payouts each year.
- Following Tropical Storm Irene's abrupt closure of the only state psychiatric hospital in August of 2011, the Department of Mental Health (DMH) implemented significant enhancements to the home and community based service system. This includes several new community-based crisis

stabilization and rehabilitation treatment services, increased community based psychiatric inpatient services, partnerships with law enforcement and greater step-down and hospital diversion capacity.

- Global Commitment has allowed the AHS to look at one overarching regulatory structure (42 CFR 438) and one universal EPSDT screening, referral and treatment continuum for services that were once the purview of several separate and distinct 1915(c)waivers and Medicaid state plan options. The Integrated Family Services Initiative seeks to bring all agency children, youth and family services together in an integrated and consistent continuum of services for families, regardless of federal funding stream (Title V, Title XIX, IDEA part B and C, Title IV-E, etc.). This universal care coordination should reduce duplication and close gaps in the system, especially at pivotal transition times. The premise being that giving a family 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. Several pilot 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.

Goal 2: Data and Related Initiatives

2012 Medicaid Managed Care Quality Strategy

Since 2007, the Agency of Human Services (AHS) has contracted with Health Services Advisory Group, Inc. (HSAG), an External Quality Review Organization (EQRO), to review the performance of the Department of Vermont Health Access (DVHA) in the three CMS required areas (i.e., Compliance with Medicaid Managed Care Regulations, Validation of Performance Improvement Projects, and Validation of Performance Measures), and to prepare the EQR annual technical report which consolidates the results from the areas it conducted.

Over the past five years, HSAG reports observing tremendous growth, maturity, and substantively improved performance results across all three activities. Vermont's (public) Medicaid Managed Care model has achieved the following scores relative to the three mandatory areas of EQR:

- Average Overall Percentage of Compliance Score of 93.8%;
- Average Performance Improvement Validation scores for Evaluation Elements Met of 98.4%, Critical Elements Met of 100%, and an Overall Validation Status of Met for each year - indicating high confidence in the reported results; and
- Performance Measures Validation finding of 100% Fully Compliant and a determination that the measures were valid and accurate for reporting for each year.

In addition, with each successive EQRO contract year, HSAG has found that DVHA has increasingly followed up on HSAG's prior year recommendations and has initiated numerous additional improvement initiatives. For example, HSAG found that DVHA regularly conducts self-assessments and, as applicable, makes changes to its internal organizational structure and key positions to more effectively align staff skills, competencies, and strengths with the work required and unique challenges associated with each operating unit within the organization.

HSAG also indicated that DVHA's continuous quality improvement focus and activities, and steady improvements over the five years have been substantive and have led to demonstrated performance improvements, notable strengths, and commendable and impressive outcomes across multiple areas and performance indicators.

Finally, HSAG concluded that DVHA has demonstrated incremental and substantive growth and maturity which has led to its current role and functioning as a strong, goal-oriented, innovative, continuously improving Medicaid Managed Care model.

This growth is also evidenced in evaluation efforts as reflected by the 2012 CAHPS survey data on "Overall Rating of Health Plan": the percentage of beneficiaries that rated the health plan 8 out of 10 or higher improved from 68.1% in 2009 to 81.3% in 2012.

Examples of DVHA's success in enhancing the quality of care for beneficiaries during the GC Demonstration period include the following data:

- Above-average performance (greater than the national HEDIS 75th percentile) in 2012 for the following HEDIS measures that also relate to quality of care:
 - ✓ Antidepressant Medication Management—Effective Acute Phase Treatment;
 - ✓ Antidepressant Medication Management—Effective Continuation Phase Treatment;
 - ✓ Well-Child Visits in the First 15 Months of Life—Six or More Visits; Children's and
 - ✓ Adolescents' Access to Primary Care Practitioners (all indicators); and
 - ✓ Annual Dental Visits measure, which involve distinct provider specialties.
- Most recent Performance Improvement Project (PIP), Increasing Adherence to Evidence-Based Pharmacy Guidelines for Members Diagnosed with Congestive Heart Failure, received a score of 96% for all applicable evaluation elements, a score of 100% for critical evaluation elements and an overall validation status of Met indicating a finding of high confidence in the reported baseline and re-measurement results.

Vermont Chronic Care Initiative

The goal of the Vermont Chronic Care Initiative (VCCI) is to improve health outcomes of Medicaid beneficiaries through addressing the increasing prevalence of chronic illness. 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 these beneficiaries to eventually self-manage their chronic conditions.

The VCCI uses a holistic approach of evaluating both the physical and behavioral conditions, as well as the socioeconomic issues, that often are barriers to health improvement. The VCCI emphasizes evidence-based, planned, integrated and collaborative care for beneficiaries who exhibit high-prevalence chronic disease states, high-expense utilization, high medication utilization, and/or high emergency room and inpatient utilization. Ultimately, the VCCI aims to improve health outcomes by supporting better self-care and lowering health care expenditures through appropriate utilization of health care services. 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; engage in changing their own behavior, and by facilitating effective communication with their primary care provider. The intention ultimately is to support the person in taking charge of his or her own health care.

The VCCI supports and aligns with other State health care reform efforts, including the Blueprint for Health APCPs and CHTs. The VCCI has now expanded its services to include all age groups and prioritize their outreach activities to target beneficiaries with the greatest need based on the highest acuity population (defined as the top 5%) with an ability to impact their conditions and/or utilization patterns. The VCCI is expanding both service scope as well as partnerships. A Pediatric Palliative Care Program was added in 2012 and in July 2010, the VCCI started embedding nursing and licensed social workers in primary care practices with high volume Medicaid populations and hospitals with high volume ambulatory sensitive emergency room and inpatient admissions.

Emerging data for VCCI is yielding positive results: data for State Fiscal Year 2011 showed a 14% reduction for inpatient admissions and a 10% reduction in emergency room utilization over the baseline year of 2008. Additionally, when compared to similar beneficiaries who were not enrolled in VCCI, those receiving VCCI service demonstrated better adherence to evidence based treatment.

Condition/Treatment Regime Measured	Percent adherence to treatment regime: <i>VCCI Participants</i>	Percent adherence to treatment regime: <i>Non-VCCI Participants</i>	VCCI vs. Non-VCCI Participants
Asthma (medication adherence)	53.2	33.8	19.4
COPD	75.8	58.9	16.9
Congestive Heart Failure (CHF) – ACE/ARB	65.3	42.4	22.9
CHF – Beta Blocker	70.5	45.7	24.8
CHF – Diuretic	65.3	41.2	24.1
Coronary Artery Disease (CAD) – Lipid test	67.0	56.6	10.4
CAD – Lipid lowering med	71.5	59.7	11.8
Depression – med 84 days	69.6	50.3	19.3
Depression – med 180 days	66.4	45.2	21.2
Diabetes – HbA1c test	86.3	67.4	18.9
Diabetes – Lipid test	69.6	55.7	13.9
Hyperlipidemia – 1 or more tests	67.8	56.8	11.0
Hypertension – 1 or more lipid tests	62.0	48.6	13.4
Kidney Disease – microalbuminuria screening	46.2	44.6	1.6
Kidney Disease – ACE/ARB	69.2	62.0	7.2

Blueprint for Health

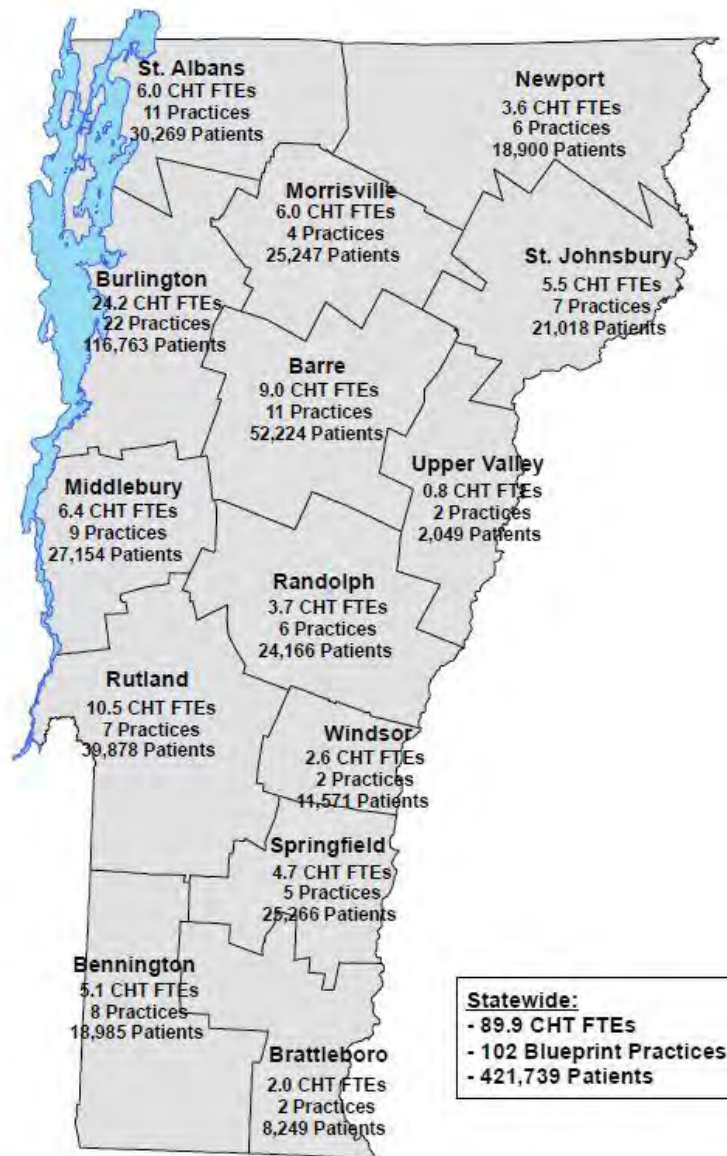
A critical component to the Blueprint for Health systems change strategy is financial incentives to reward quality. As part of the Blueprint, practices which undergo national accreditation through the NCQA and which are independently scored on their adherence to quality are given a PMPM incentive payment based on their quality scores. As of December 31, 2012, 106 primary care practices serving approximately 422,000 patients have successfully undergone the national recognition process (see previous chart on page 14), with several more scheduled for scoring in each month of 2013.

Perhaps the most important innovation in the Blueprint is the Community Health Team (CHT) concept. Recognizing that, for many patients, support and coordination services have not been well integrated into the primary care setting, and have even not been readily available to the general population. These multi-disciplinary locally based teams, funded through targeted Blueprint payment reform, are designed and hired at the community level. Local leadership convenes a planning group to determine the most appropriate use of these positions, which can vary depending upon the demographics of the community and upon identified gaps in available services. This could include personnel from the following disciplines: nursing, social work, nutrition science, psychology, pharmacy, administrative support, and others. CHT job titles include but are not limited to Care Coordinator, Case Manager, Certified Diabetic Educator, Community Health Worker, Health Educator, Mental Health Clinician, Substance Abuse Treatment Clinician, Nutrition Specialist, Social Worker, CHT Manager and CHT Administrator.

The CHT effectively expands the capacity of the primary care practices by providing patients with direct access to an enhanced range of services, and with closer and more individualized follow up. Barriers to care are minimized since there is no charge (no co-payments, prior authorizations, or billing for CHT services) to patients or practices. Importantly, CHT services are available to all patients in the primary care practices they support, regardless of whether these patients have health insurance of any kind or are uninsured.

The dollar amount accessible to an individual community is proportional to the population served by the recognized and engaged primary care practices in the Health Service Area. Currently this is set at \$350,000 per year for a general population of 20,000 served by the practices (\$17,500 per year for every 1000 patients). Again, the way this money is spent, and specifically what types of staff are hired, is decided at the community level. This has resulted in enhanced ownership and pride in the local CHT as well as anecdotally improving working relationships locally. CHTs are now established in every health services area of the state.

Blueprint Engagement by Service Area



FTEs = Full Time Equivalents

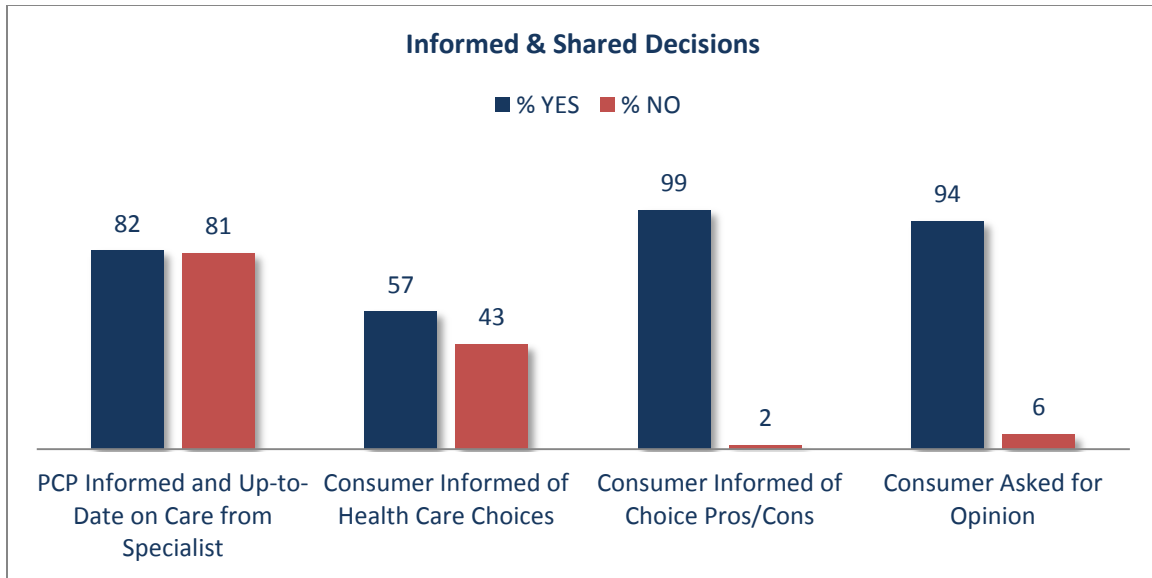
2012 HEDIS Measures

HEDIS measures for quality of care are summarized below. Comprehensive Diabetes Care scores have remained stable, although lower than NCQA accredited Medicaid HMO scores; this is an area noted for improvement in both the 2011 and 2012 EQRO report. Appropriate Medication for Asthma 5-11 years old and 12-18 years old as well as total scores remain at or above the NCQA average while improvement is needed in both the 19-50 and 51-64 age ranges. As noted earlier, scores related to Antidepressant Medication Management continue to be well above the national averages for both years.

HEDIS Measure	VT EQRO Year		VT Average: 2011-2012	NCQA Medicaid Accredited HMO's Average	VT vs. NCQA HMO Average
	2011	2012			
Comprehensive Diabetes Care					
HbA1c testing	62.02%	63.84%	62.93%	82.80%	-19.87%
Eye Exams	45.18%	45.69%	45.44%	54.10%	-8.67%
LDL-C Screens	47.24%	46.70%	46.97%	75.10%	-28.13%
Medical Attention for Nephropathy	59.21%	59.72%	59.47%	78.20%	-18.74%
Appropriate Medication for Asthma					
5-11 yrs	93.68%	92.72%	93.20%	90.90%	2.30%
12-18 yrs		87.57%	87.57%	87.30%	0.27%
19-50		79.10%	79.10%	73.70%	5.40%
51-64		81.62%	81.62%	71.50%	10.12%
Total	86.60%	85.34%	85.97%	85.50%	0.47%
Anti-Depressant Medication Management					
Effective Acute Phase Treatment	66.98%	68.42%	67.70%	50.90%	16.80%
Continuation Phase Treatment	51.38%	54.54%	52.96%	34.50%	18.46%

2009 Global Commitment to Health Beneficiary Survey

Informed and shared decision making is an underlying tenet of Vermont’s system of care. Person centered and self-directed care have been at the forefront of home and community based service planning for decades and are key elements in the medical home and chronic care initiatives. A review of CAHPS questions related to this key principle shows that Vermont scores remain high and indicate that actual practice embodies these values.



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

The Agency of Human Services (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 *Hub and Spoke* initiative. This initiative is focused on beneficiaries receiving Medication Assisted Therapy (MAT) for opioid addiction. MAT is the use of medications, in combination with counseling and behavioral therapies, to provide a holistic approach to the treatment of substance use disorders. Overall health care costs are approximately three times higher among MAT patients than 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 rooms, pharmacy benefits, and other health care services.

The *Hub and Spoke* initiative creates a framework for integrating treatment services for opioid addiction into the Blueprint for Health (Blueprint) model, which includes patient-centered medical homes, multi-disciplinary Community Health Teams (CHTs), and payment reforms. Initially focused on primary care, its goals include improving individual and overall population health, and controlling health care costs by promoting health maintenance, prevention, and care management and coordination.

The two primary medications used to treat opioid dependence are methadone and buprenorphine, with the majority of 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 addiction treatment but are not well integrated into the larger health and mental health care systems. To address this service fragmentation, AHS submitted a State Plan Amendment (SPA) to provide 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 will 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 office-based (OBOT) settings, and the local Blueprint patient-centered medical home and Community Health Team (CHT) infrastructure. Each MAT patient will have 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.

The five planned regional *Hubs* build upon the existing methadone OTPs and also will provide buprenorphine treatment to a subset of clinically complex patients. Working in partnership with primary care providers and Blueprint CHTs, *Hubs* will 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 addiction 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 will be provided by the nurses and licensed addiction/mental health clinicians, who will be added to the existing Blueprint CHTs. Accomplishments for 2012 include, but are not limited to:

- Planning Guidance was sent to all buprenorphine providers and the entities that manage the local Blueprint CHTs to assist with *Spoke* network development and staffing estimates.
- Two *Hub and Spoke* learning collaboratives with multidisciplinary provider teams were established; they are provided through a partnership of the Blueprint, the Vermont Department of Health, and the Dartmouth Psychiatric Research Center.
- Two western Vermont regional *Hubs* began developing their infrastructure for implementation in 2013, while proposals for remaining regional *Hubs* are under review.
- The Health Home SPA was submitted to CMS.

Mental Health System of Care

The abrupt closure of Vermont's single state psychiatric hospital due to Tropical Storm Irene resulted in an immediate shift of state funds. Funding previously spent on the physical plant and infrastructure of an antiquated hospital was used to enhance community-based support and mental health treatment services. Act 79, passed in the 2001-2012 legislative session, marked a historic investment of funds into the home and community based system of mental health care. Twenty-eight new community based inpatient beds were authorized while the legislature approved the development of a new replacement state psychiatric hospital no larger than 25 beds. Care management is being expanded to coordinate all

involuntary mental health inpatient services and facilitate coordination of treatment services between the community and inpatient provider. Designated Agencies (DA's) for mental health services throughout the state were provided resources to enhance emergency outreach and crisis support services at the local level. Mobile response capability and improved collaborations with local law enforcement are developing. GC Demonstration resources are targeting additional crisis bed capacity to divert unnecessary inpatient hospitalization where clinically appropriate and step-down individuals who are ready to transition from inpatient care back to community support services. Act 79 also supported the investment of GC Demonstration resources into intensive residential recovery support programs.

The realities of a rural state, with remote or geographic distance between points of service, require that transportation also be a consideration for access of any crisis stabilization, residential, or inpatient treatment capacities established. Trauma sensitive and the least restrictive transportation options, consistent with safety, are being enhanced. 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.

Act 79 also provided for new investment in housing and coordinated treatment supports to provide greater stabilization in the community for individuals 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. Augmenting these formal support services with peer support services is also being promoted. Investments in peer services to broaden the array and options for recovery supports to individuals with mental illness are being made and a statewide peer "warmline" is in development as an alternative for individuals needing active listening and problem-solving support from peers.

Dental Dozen

The Dental Dozen are 12 targeted initiatives that DVHA (in partnership with VDH-Office of Oral Health) is undertaking to improve oral health, and to remedy existing delivery system issues. Key highlights include: A collaboration between the VDH, DVHA, and the Department of Education to reinforce school outreach efforts and encourage preventive care; reimbursement of Primary Care Physicians for Oral Health Risk Assessments; selection/assignment of a dental home for children; loan repayment incentives to dentists in return for a commitment to practice in Vermont and serve low income populations; scholarships, administered through the Vermont Student Assistance Corporation, have been awarded to encourage new dentists to practice in Vermont; and supplemental payment incentives to recognize and reward dentists serving high volumes of Medicaid beneficiaries.

Goal 3: Contain Cost of Care

Cost effectiveness takes into consideration the costs associated with providing services and interventions to the Vermont Medicaid population. For the GC Demonstration, this is measured at the eligibility group and aggregate program levels. The final goal of GC Demonstration is to contain Medicaid spending in comparison to what would have been spent absent the Demonstration. AHS assumes that the impact of the Demonstration will be “cost neutral.”

Goal 3: Summary

The GC Demonstration has contained spending relative to the absence of the Demonstration over the eight years of the waiver and the reallocation of resources generated greater “value” for program expenditures. The cost-effectiveness of the GC Demonstration can be summarized as follows:

- Generated a significant surplus associated with overall decreased expenditures relative to the aggregate budget neutrality limit (ABNL).
- Overall, since the inception of the GC Demonstration in October 2005 through FFY 2012, a surplus has accrued for each year at an average of 9.6% of ABNL.
- Total cumulative surplus at time of renewal (January 1, 2014) is projected to be \$980 million.

Goal 3: Data

The following measures were used to illustrate the cost-effectiveness of the GC Demonstration in containing spending relative to the absence of the Demonstration:

- Total Capitated Revenue Spending per MEG.
- Summary of Global Commitment Expenditures: With and Without Demonstration (relative to the ABNL).

Total Capitated Revenue Spending per MEG

Table 3-1 shows total capitated revenue spending for Global Commitment per MEG from 2006-2012. Also included in Table 3-1 is the average annual percent change during the previous (2006 to 2008) and current (2009 to 2012) interim evaluation periods.

Table 3-1: Global Commitment Capitated Revenue Spending per MEG from 2006-2012

MEG	Federal Fiscal Year					Average Annual Percent Change:	
	2006	2009	2010	2011	2012	2006-2009	2009-2012
ABD - Non-Medicare - Adult	\$203,640,203	\$168,352,016	\$179,249,891	\$176,533,399	\$190,519,365	-6.1%	4.2%
ABD - Non-Medicare - Child	\$60,899,001	\$93,965,267	\$94,842,614	\$98,394,413	\$101,488,090	15.6%	2.6%
ABD – Dual	\$176,881,327	\$227,454,477	\$219,236,518	\$223,405,119	\$227,781,883	8.7%	0.0%
ANFC - Non-Medicare - Adult	\$62,043,119	\$60,535,761	\$72,589,220	\$76,485,557	\$83,964,229	-0.8%	11.5%
ANFC - Non-Medicare - Child	\$184,526,017	\$221,757,008	\$239,043,470	\$236,275,561	\$254,203,807	6.3%	4.7%
Global Expansion (VHAP)	\$91,648,652	\$143,169,152	\$170,413,126	\$180,323,161	\$189,841,022	16.0%	9.9%
Global Rx	\$9,173,970	\$1,911,020	\$1,433,935	\$7,800,694	\$9,482,604	-40.7%	70.6%
Optional Expansion (Underinsured)	\$2,256,389	\$2,532,758	\$2,488,843	\$2,353,179	\$2,473,802	3.9%	-0.8%
VHAP ESI	n/a	\$2,056,121	\$2,533,498	\$1,917,977	\$1,607,347	n/a	-7.9%
ESIA	n/a	\$625,035	\$988,443	\$861,905	\$817,498	n/a	9.4%
CHAP	n/a	\$23,358,293	\$35,420,469	\$40,210,581	\$39,644,962	n/a	19.3%
ESIA Expansion - 200-300% of FPL	n/a	n/a	\$384,158	\$298,915	\$227,184	n/a	-23.1%
CHAP Expansion - 200-300% of FPL	n/a	n/a	\$10,181,948	\$18,276,728	\$19,640,320	n/a	38.9%
Total Capitated Spending	\$791,068,678	\$945,716,909	\$1,028,806,133	\$1,063,137,188	\$1,121,692,114	6.1%	5.9%

n/a: not available

The capitated amounts presented in Table 3-1 are summarized as follows:

- ✓ Overall, capitated spending has grown consistently at an average annual rate of approximately 6% from 2006 to 2012, on par with national Medicaid spending over the same period. (Source: The Henry J. Kaiser Family Foundation)
- ✓ ABD Adult capitated spending decreased about 6% per year from 2006 to 2009 (due to decreasing enrollment), while increasing 4% annually from 2009 to 2012.
- ✓ Capitated spending for ABD Children grew more modestly per year between 2009 to 2012 (2.6%) compared to 2006 to 2009 (15.6%)
- ✓ While growing nearly 9% per year between 2006 and 2009, ABD Dual capitated spending has remained essentially flat since 2009.
- ✓ ANFC Adults capitated spending remained level in the first few years before growing over 11% annually between 2009 and 2012
- ✓ Capitated spending for ANFC Children has consistently grown on average between 4% and 6% each year since 2006.
- ✓ Global Expansion (VHAP) capitated spending grew 16% annually from 2006 to 2009, slowing down modestly to 10% between 2009 and 2012.
- ✓ After implementation of Medicare Part D, capitated spending for Global Pharmacy (Duals, Non-Duals, and Expansion) has grown from \$513,000 in 2007 to \$9.5 million in 2012, due mostly to the Duals Expansion population created in 2010.
- ✓ After growing approximately 4% per year between 2006 and 2009, capitated spending for Optional Expansion (Underinsured) has remained essentially level as of 2012.

Note: The following MEGs will be eliminated as of January 1, 2014 because of the Affordable Care Act (ACA).

- ✓ Since inception in 2008, Vermont has made an average of \$3.1 million in capitated expenditures each year from 2009 to 2012 for Employer-Sponsored Insurance (ESI) programs (VHAP ESI, ESIA, and ESIA Expansion).
- ✓ Capitated spending for Catamount Health with Premium Assistance (CHAP) ramped up to \$59 million in the first four years after implementation (2008 to 2011) before leveling off in 2012.

Global Commitment Expenditures: With and Without Demonstration Relative to ABNL

CMS guidelines state that Section 1115 waivers are required to be budget neutral, i.e., do not increase federal funding over what would have been spent without the waiver. To evaluate budget neutrality, actual expenditures are measured against projections on what otherwise would have spent, based on the State's historical experience for the years prior to implementation of the waiver (e.g., enrollment, benefits, utilization, and cost of care). The cumulative spending projections are referred to as the aggregate budget neutrality limit, or ABNL. Table 3-2 on the following page summarizes actual ("with Demonstration") and projected ("without Demonstration") expenditures through December 2013, including the federal share of any surpluses or deficits.

Table 3-2: Total Global Commitment Expenditures including Premium Offsets and Administrative Costs, with and without Demonstration 2006-2012

	Federal Fiscal Year						
	Subtotal: 2006-2008	2009	2010	2011	2012	Estimated: Oct '12-Dec '13	TOTAL: 2006-Dec '13
Total Capitated Spending	\$2,490,295,359	\$945,716,909	\$1,028,806,133	\$1,063,137,188	\$1,121,692,114	\$1,469,171,414	\$8,118,819,116
Premium Offsets	(\$23,753,603)	(\$10,603,732)	(\$15,815,296)	(\$17,794,216)	(\$17,971,216)	(\$22,732,605)	(\$108,670,668)
Administrative Costs	<u>\$17,542,637</u>	<u>\$5,495,618</u>	<u>\$5,949,605</u>	<u>\$6,071,553</u>	<u>\$5,751,066</u>	<u>\$7,511,394</u>	<u>\$48,321,873</u>
Total GC Expenditures	\$2,484,084,392	\$940,608,795	\$1,018,940,442	\$1,051,414,525	\$1,109,471,964	\$1,453,950,203	\$8,058,470,320
ABNL	\$2,604,109,308	\$1,002,321,263	\$1,093,591,603	\$1,165,191,563	\$1,248,077,166	\$1,842,595,895	\$8,955,886,798
Surplus (Deficit)	\$120,024,916	\$61,712,468	\$74,651,161	\$113,777,038	\$138,605,202	\$388,645,692	\$897,416,477
Surplus (Deficit), % of ABNL	4.6%	6.2%	6.8%	9.8%	11.1%	21.1%	10.0%
Federal Share of Surplus (Deficit)	\$70,522,235	\$43,174,043	\$52,225,952	\$66,798,499	\$79,808,875	\$217,797,046	\$530,326,650

Actual expenditures for Oct '12 – Dec '13 are estimated.

Federal Share of Surplus/(Deficit) based on predominant FMAP.

The totals presented in Table 3-2 are summarized as follows:

- ✓ During the first three years of the waiver surpluses averaged 4.6%, for a total of \$120 million.
- ✓ Between 2009 and 2012, surpluses increased to an average of 8.6%, for a four-year aggregate of \$389 million.
- ✓ An additional surplus of \$389 million is estimated for the period October 2012 to December 2013, or 21.1% of the ABNL.
- ✓ Annual surpluses have been steadily increasing; most recently in 2012 with a surplus of \$139 million, of over 11% of the ABNL.
- ✓ By the end of December 2013, GC is estimated to have achieved aggregate surplus through 2012 of \$897 million, or 10% of the ABNL.
- ✓ The aggregate federal share of the surplus through December 2013 is estimated at \$530 million.

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Legal Notices

NOTICE OF DISSOLUTION OF NORTHGROUP SPONSORED CAPTIVE INSURANCE, INC.

Pursuant to Title 11A, Section 14.07 of the laws of the State of Vermont, notice is hereby given that the Articles of Dissolution of Northgroup Sponsored Captive Insurance, Inc. (the "Company") have been filed with the office of the Secretary of State for the State of Vermont. Notice is hereby given that all unknown creditors of and claimants against the Company are required to present their claims within five (5) years of publication of this notice. The claim will be barred unless a proceeding to enforce the claim is commenced within five (5) years of publication of this notice. Notice is further given that all claimants with contingent claims or claims contingent upon the occurrence or nonoccurrence of a future event or otherwise conditional or un-matured, against the Company are required to present their respective claims in writing to the address below within five (5) years of this notice. Any such claim will be barred unless a proceeding to enforce the claim is commenced within five (5) years of this notice.

Notice is further given that all claims must be in writing and sent to the dissolved Company's principal office:
Northgroup Sponsored Captive Insurance, Inc.
c/o Downs Rachin Martin PLLC
199 Main Street, 6th Floor
P.O. Box 130
Burlington, VT 05402-0130

Published February 14, 2013
STATE OF VERMONT

SUPERIOR COURT CIVIL DIVISION
CHITENDEN UNITDOCKET NO: 50329-12 Cnc

BANK OF AMERICA, N.A., AS SUCCESSOR BY MERGER TO BAC HOME LOAN SERVICING, LP
F/K/A COUNTRYWIDE HOME LOANS SERVICING, LP
Plaintiff

ORRIN W. LONGBOTHUM; MILLYARD CONDOMINIUM ASSOCIATION;

Defendants
NOTICE OF SALE

By virtue and in execution of the Power of Sale contained in a certain mortgage given by Orrin W. Longbothum to Mortgage Electronic Registration Systems, Inc., as nominee for Countrywide Home Loans, Inc. dated May 25, 2006 and recorded in Book 174 at Page 187 of the City/Town of Winoski Land Records, of which mortgage the undersigned is the present holder by Assignment of Mortgage recorded on July 30, 2009 in Book 201 at Page 136, for breach of the conditions of said mortgage and for the purpose of foreclosing the same will be sold at Public Auction at 10:00 a.m. on March 5, 2013 at 100 West Canal Street, designated as Apt. 2H of the Millyard Condominium, Winoski, VT 05404 and all singular the premises described in said mortgage,

To Wit:

Being Apartment No. 2H of the Millyard Condominium as numbered and further described and depicted in the Declaration dated September 1, 1984, recorded in Volume 58, Pages 368-379, together with an undivided interest in the Common Areas and Facilities as set forth in the Declaration.

Being the same premises conveyed to the herein named mortgage(s) by deed recorded with the Winoski, Town Office-Land Records in Book 168, Page 126.

Plaintiff may adjourn this Public Auction one or more times for a total time not exceeding 30 days, without further court order, and without publication or service of a new notice of sale, by announcement of the new sale date to those present at each adjournment. **Terms of Sale:** \$10,000.00 to be paid in cash or by certified check by the purchaser at the time of sale, with the balance due at closing. Proof of financing for the balance of the purchase to be provided at the time of sale. The sale is subject to taxes due and owing to the Town of Winoski.

The Mortgagor is entitled to redeem the premises at any time prior to the sale by paying the full amount due under the mortgage, including the costs and expenses of the sale.

Other terms to be announced at the sale.

Bank of America, N.A., as successor by merger to BAC Home Loan Servicing, LP f/k/a Countrywide Home Loans Servicing, LP, Richard J. Volpe, Esq., Shechtman, Halperin, Savage, LLP, 1080 Main Street, Pawcatuck, RI 02860, 877-575-1400, Attorney for Plaintiff

(5502844)(Longbothum)(02-07-13, 02-14-13, 02-21-13)(295746)

February 7th, 14th & 21st, 2013.

The State of Vermont, Agency of Human Services (AHS), plans to submit an extension request for the period from 1/1/2014 to 12/31/2018, to the Centers for Medicare and Medicaid Services (CMS) for its Section 1115(a) Demonstration Waiver: Global Commit-

ment (GC) to Health. The GC Demonstration was designed to test the hypothesis that greater program flexibility in the use of Medicaid resources and the lessening of federal restrictions on Medicaid services would permit the State to better meet the needs of Vermont's uninsured, underinsured and Medicaid beneficiaries for the same or lower cost. Specifically, the GC Demonstration aims to: 1) promote access to affordable health coverage, 2) develop public health approaches for meeting the needs of individuals and families, 3) develop innovative, outcome- and quality-focused payment approaches, 4) enhance coordination of care across health care providers and service delivery systems, and 5) control program cost growth.

Summary of Extension Proposal for effective date of January 1, 2014

- Continuation of the current public Medicaid managed care model and all current payment and service system flexibilities;
- Consolidation of the Choices for Care and GC waivers and the Children's Health Insurance Program (CHIP) (a) authorized under Title XXI of the Social Security Act into one 1115 Demonstration Waiver;
- Inclusion of any necessary authorities for the Dual Eligible integrated Medicaid and Medicaid model, once approved;
- Revisions to eligibility groups due to the Affordable Care Act;
- Use of Modified Adjusted Gross Income methodologies for income determination;
- Premium subsidies for individuals with incomes up to and including 300% of FPL who purchase insurance through the Health Benefit Exchange;
- Continued coverage of existing home and community-based programs;
- Continued coverage of specialized mental health services through continuation and expansion of the Community Rehabilitation and Treatment Program benefit;
- Expand service options for persons in the moderate needs group;
- Add an enhanced hospice benefit for persons with terminal illness; and
- Continue authorities and preserve choice for Long Term Support and Service beneficiaries.

The complete description of changes and draft extension request, including financial data (preliminary budget neutrality data from 2014 through 2018 and potential Medicaid impacts as they align with the Governor's single payer financial plan), can be found at: <http://doha.vermont.gov/administratio/n/2013-global-commitment>.

Public Hearings will be held on 2/19/13 from 3:30pm-5:30pm at Vermont Interactive Television (VIT) sites in Bennington, Brattleboro, Johnson, Lyndonville, Middlebury, Newport, Randolph Center, Rutland, Springfield, St. Albans, White River Junction, Montpelier, originating in Williston, and on 3/11/13 from 11:00am-1:00pm at the VSAC Building, 1st floor Community Conference Room, 10 East Allen Street, Winoski (call in number: 213-289-0155, Conference room #4238242). Written comments on the draft are due 3/22/13 by 4:30pm. Written comments should be sent via email to ashley.berliner@state.vt.us or mailed to Ashley Berliner, DVHA, 289 Hurricane Lane, Williston, VT 05495. Comments received will be posted to the DVHA website for viewing by 4:30pm on 3/27/13. Copies of the draft extension request are available at: <http://doha.vermont.gov/administratio/n/2013-global-commitment>, or can be requested from local Department for

Children and Families (DCF) offices or from DVHA at (802) 879-5603.

If you need special accommodations to participate in the public hearing, please notify Ashley Berliner at (802) 879-5603.

February 14th, 2013.

Personals

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May the Sacred Heart of Jesus be adored, glorified loved and preserved throughout the world now and forever. Sacred heart of Jesus pray for us. St. Jude worker of miracles pray for us. St. Jude help for the hopeless pray for us.

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