PETER SHUMLIN
Governor

State of Vermont
OFFICE OF THE GOVERNOR

December 21, 2015

Victoria Wachino, Director
Center for Medicaid and CHIP Services 7500
Security Boulevard
Baltimore, MD 21244 Dear

Director Wachino:

Please find attached supporting materials for the renewal of Vermont's Global Commitment to Health Section 1115 Medicaid Demonstration.

As you are aware, the Centers for Medicare and Medicaid Services (CMS) and the State of Vermont have a long history of collaboration on a very innovative delivery and financing model. Since 2005, the Global Commitment Demonstration has provided Vermont with authority to operate its Medicaid program undera public managed care model. Since that time, Vermont has undertaken a major transformation of its Medicaid program to adhere to Medicaid managed care principles and rules. This transformation included the adoption of numerous operational and policy changes and the assumption of risk based on an actuarial rate setting process. In exchange, the public managed care model provides additional flexibilities regarding service delivery and payment. Vermont has used this flexibility to advance person-centered care, develop service delivery options to best meet individual needs, and to advance its reformgoals such as performance- based payment approaches. I am pleased to say that the Demonstration hasoperated with great success.

Looking toward the future, Vermont remains at the forefront of state-based health care reform. Futuregoals envision the creation of an All-Payer Model. All-Payer efforts include the continued alignment ofthe Global Commitment Demonstration and current State Innovation Model (SIM) work with the State's pursuit of related Medicare waivers. These efforts aim to increase value-based payments, accelerate payment reform, and put total health care spending on a more sustainable trajectory. Within the overallhealth reform framework, Vermont's Medicaid goal is to maintain the public managed care model toensure maximum ability to serve Vermont's most vulnerable and lower-income residents while moving towards broader state and federal health care reform goals.

Vermont has made significant investments to become a public managed care model and appreciates the opportunity the Demonstration has created to better serve program participants while making best use of public resources. Because of the investments in the current model, its proven successes and its alignment with future health care reform goals, the State is seeking a no-change extension of its current Special Terms and Conditions and looks forward to the continued success of its state-federal partnership.

Sincerely,

Peter Shumlin
Governor of Vermont

State of Vermont

Agency of Human Services

Global Commitment to Health
11-W-00194/1

Submitted 12/31/2015

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Vermont Application Certification Statement - Section 1115(e) Five Year Extension

This document, together with Appendices A through D, constitutes Vermont's application to the Centers for Medicare & Medicaid Services (CMS) to extend its demonstration entitled, Global Commitment to Health, Project Number 11-W-00194/1, without any programmatic changes pursuant to section 1115(e) of the Social Security Act. The state is requesting CMS' approval for a 5-year extension of the demonstration subject to the same approved Special Terms and Conditions (STCs), waivers, and expenditure authorities currently in effect for the period January 30, 2015, through December 31, 2016.

CMS' expedited review and assessment of the state's request to continue the demonstration without any substantive program changes is conditioned upon the state's submission and CMS' assessment of the below items that are necessary to ensure that the demonstration is operating in accordance with the objectives of title XIX and/or title XXI as originally approved. The state's application will only be considered complete for purposes of initiating federal review and federal-level public notice when the state provides the information as requested in the below appendices.

- **Appendix A:** A historical narrative summary of the demonstration project, which includes the objectives set forth at the time the demonstration was approved, evidence of how these objectives have or have not been met, and the future goals of the program.

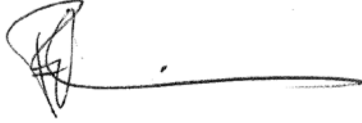
- **Appendix B:** Budget neutrality assessment, and projections for the projected 5-year extension period. The state will present an analysis of budget/allotment neutrality for the current demonstration approval period, including status of budget/allotment neutrality to date based on the most recent expenditure and member month data, and projected through the end of the current approval period. CMS will also review the state's Medicaid and Children's Health Insurance Program Budget and Expenditure System (MBES/CBES) expenditure reports to ensure that the demonstration has not exceeded the Federal expenditure limits established for the demonstration. The state's actual expenditures incurred over the period from initial approval through the current expiration date, together with the projected costs for the requested 5-year extension period, must comply with CMS budget/allotment neutrality requirements outlined in the STCs.

- **Appendix C:** Interim evaluation of the overall impact of the demonstration that includes evaluation activities and findings to date, in addition to plans for evaluation activities over the 5-year extension period. The interim evaluation should provide CMS with a clear analysis of the state's achievement in obtaining the outcomes expected as a direct effect of the demonstration program. The state's interim evaluation must meet all of the requirements outlined in the STCs.

- **Appendix D:** Summaries of External Quality Review Organization (EQRO) reports, managed care organization and state quality assurance monitoring, and any other documentation of the quality of and access to care provided under the demonstration.

- **Appendix E:** Documentation of the state's compliance with the public notice process set forth in 42 CFR 431.408 and 431.420.

The state attests that it has abided by all provisions of the approved STCs and will continuously operate the demonstration in accordance with the requirements outlined in the STCs.



Signature:________________________________ **Date:** December 22, 2015

Governor Peter Shumlin

Appendix A: Historical Summary of the Demonstration

Background

For more than two decades, the State of Vermont has been a national leader in making affordable health care coverage available to low-income children and adults, and providing innovative system reforms to support enrollee choice and improved outcomes. Vermont was among the first states to expand coverage for children and pregnant women, accomplished in 1989 through the implementation of the state-funded Dr. Dynasaur program, which later in 1992 became part of the state-federal Medicaid program. When the federal government introduced the Children's Health Insurance Program (CHIP) in 1997, Vermont extended coverage to uninsured and under-insured children living in households with incomes below 300% of the Federal Poverty Level (FPL). Effective January 1, 2014, Vermont incorporated the CHIP program into its Medicaid State Plan, with the upper income limit expanded to 312% FPL (the MAGI-converted income limit).

In 1995, Vermont implemented a Section 1115(a) Demonstration, the Vermont Health Access Plan (VHAP). The primary goal was to expand access to comprehensive health care coverage through enrollment in managed care for uninsured adults with household incomes below 150% (later raised to 185% of the FPL for parents and caretaker relatives with dependent children in the home). VHAP also included a prescription drug benefit for low-income Medicare beneficiaries who did not otherwise qualify for Medicaid. Both Demonstration populations paid a modest premium on a sliding scale based on household income. The VHAP Demonstration also included a provision recognizing a public managed care framework for the provision of services to persons who have a serious and persistent mental illness, through Vermont's Community Rehabilitation and Treatment program.

While making progress in addressing the coverage needs of the uninsured through Dr. Dynasaur and VHAP, by 2004 it became apparent that Vermont's achievements were being jeopardized by the ever-escalating cost and complexity of the Medicaid program. Recognizing that it could not spend its way out of projected deficits, Vermont worked in partnership with CMS to develop two new innovative 1115 Demonstration programs, Global Commitment to Health (GC) and Choices for Care (CFC). As explained in more detail below, the GC and CFC Demonstrations have enabled the state to preserve and expand the affordable coverage gains made in the prior decade, provide program flexibility to more effectively deliver and manage public resources, and improve the health care system for all Vermonters.

Effective January 30, 2015, Vermont received CMS approval to consolidate the Global Commitment and Choices for Care Demonstrations into one 1115(a) Demonstration, the current Global Commitment to Health.

According to the GC's Special Terms and Conditions (STCs), Vermont operates its managed care model in accordance with federal managed care regulations found at 42 CFR 438. The Agency of Human Services (AHS), as Vermont's Single State Medicaid Agency, is responsible for oversight of the managed care model. The Department of Vermont Health Access (DVHA) operates the Medicaid program as if it were a Managed Care Organization in accordance with federal managed care regulations. Program requirements and responsibilities are delineated in an inter-governmental agreement (IGA) between AHS and DVHA. CMS reviews the IGA annually to ensure compliance with the Medicaid managed care model and the Demonstration Special Terms and Conditions. DVHA also has sub-agreements with the other state entities that provide specialty care for GC enrollees (e.g., mental health services, developmental disability services, and specialized child and family services). As such, since the inception

of the GC Demonstration, DVHA and its IGA partners have modified operations to meet Medicaid managed care requirements, including requirements related to network adequacy, access to care, beneficiary information, grievances, quality assurance, and quality improvement. Per the External Quality Review Organization's findings (see Appendix D), DVHA and its IGA partners have achieved exemplary compliance rates in meeting Medicaid managed care requirements.

Under the current Demonstration structure, the State has agreed to an aggregate budget neutrality limit. In addition, total annual funding for medical assistance is limited based on an actuarially determined, per member per month limits. AHS uses prospectively derived actuarial rates for the Demonstration year to draw federal funds and pay DVHA a per member per month (PMPM). This capitation payment reflects the monthly need for federal funds based on estimated GC expenditures. On a quarterly basis, AHS reconciles the federal claims from the underlying GC expenditures on the CMS-64 filing. As such, Vermont's payment mechanisms function similarly to those used by state Medicaid agencies that contract with private managed care organizations to manage some or all of the Medicaid benefits.

Historical Summary

Global Commitment to Health

The Global Commitment (GC) to Health Section 1115(a) Demonstration, implemented on October 1, 2005, continued VHAP and provided flexibility with regard to the financing and delivery of health care to promote access, improve quality, and control program costs. The majority of Vermont's Medicaid program currently operates under the GC Demonstration, with the exception of Vermont's Disproportionate Share Hospital (DSH) program.

An amendment to the Global Commitment (GC) to Health Demonstration approved by CMS on October 31, 2007, allowed Vermont to implement the Catamount Health Premium Assistance Program for individuals with incomes up to 200% of the Federal Poverty Level (FPL) who enrolled in a corresponding Catamount Health Plan. Created by state statute and implemented in October 2007, the Catamount Health Plan was a commercial health insurance product, initially offered by both Blue Cross Blue Shield of Vermont and MVP Health Care, which provided comprehensive, quality health coverage for uninsured Vermonters at a reasonable cost, regardless of income. CMS approved a second amendment on December 23, 2009, that expanded federal participation for the Catamount Health Premium Assistance Program up to 300% of the FPL. Additionally, this amendment allowed for the inclusion of Vermont's supplemental pharmaceutical assistance programs in the GC Demonstration.

Renewed on January 1, 2011, the GC Demonstration was subsequently amended twice, once on December 13, 2011, to include authority for a children's palliative care program, and on June 27, 2012, to update co-pay obligations. On October 2, 2013, CMS approved the extension of the GC demonstration through December 31, 2016; the extension included sun-setting the authorities for most of the 1115 Expansion Populations since they would be eligible for Affordable Care Act Marketplace coverage beginning January 1, 2014. The renewal also added the New Adult Group to the demonstration effective January 1, 2014. Finally, the renewal included premium subsidies for individuals enrolled in a qualified health plan and whose income is at or below 300% of the FPL.

On January 30, 2015, Vermont received approval from CMS to consolidate its Global Commitment and Choices for Care 1115 Demonstrations.

Choices for Care

Vermont's Choices for Care Section 1115(a) Demonstration, implemented on October 1, 2005, and renewed through September 30, 2015, addressed consumer choice and funding equity for low-income seniors and people with disabilities by providing an entitlement to both home- and community-based services (HCBS) and nursing home care. Vermont was the first state to create such a program and the first state to commit to a global cap ($1.2 billion over five years) on federal financing for long-term care services.

Vermont's overarching goal for Choices for Care is to support individual choice, thus improving access to HCBS. In supporting more people in their own homes and communities, Vermont has sought to increase the range and capacity of HCBS.

As stated above, on January 30, 2015, Vermont received approval from CMS to consolidate its Global Commitment and Choices for Care 1115 Demonstrations.

Global Commitment to Health Demonstration Objectives

Vermont's goal in implementing the Demonstration is to improve the health status of all Vermonters by:

- Increasing access to affordable and high-quality health care;
- Improving access to primary care;
- Improving the health care delivery for individuals with chronic care needs;
- Containing health care costs; and
- Allowing beneficiaries a choice in long-term services and supports and providing an array of home- and community-based alternatives recognized to be more cost effective than institutional-based supports.

The state employs five major elements in achieving the above goals:

1. *Program Flexibility:* Vermont has the flexibility to invest in alternative services and programs designed to achieve the Demonstration's objectives (including the Marketplace subsidy program);
2. *Managed Care Delivery System:* Under the Demonstration AHS entered into an agreement with the Department of Vermont Health Access (DVHA), which operates using a managed care model;
3. *Removal of Institutional Bias:* Under the Demonstration, Vermont provides a choice of settings for delivery of services and supports to older adults, people with serious and persistent mental illness, people with physical disabilities, people with developmental disabilities, and people with traumatic brain injuries who meet program eligibility and level-of-care requirements.
4. *Aggregate Budget Neutrality Cap:* Vermont is at risk for the caseload and the per capita program expenditures, as well as certain administrative costs for all Demonstration populations. Effective January 1, 2014, the new adult group is not included in the total computable aggregate cap, but is subject to a separate per member per month (PMPM) budget neutrality limit; and
5. *Marketplace Subsidy Program:* To the extent it is consistent with Vermont's aggregate budget neutrality cap, effective January 1, 2014, Federal Financial Participation (FFP) is available for

state funds for a Designated State Health Program (DSHP) to provide a premium Marketplace subsidy program to individuals up to and including 300% of the FPL who purchase health care coverage in the Marketplace.

Each of the Demonstration goals has specific, measurable, achievable, realistic, and timed objectives that will assess and directly influence changes in access, cost, and quality during the life of the Demonstration.

Evidence of How the Goals Have Been Met

Vermont has proven the Demonstration to be a success. With the flexibility granted under the public managed care model, Vermont has achieved the Demonstration's goals and will continue to use innovative approaches to improve the health care delivery system and enhance positive health outcomes. A summary of Vermont's success in achieving the goals of the Demonstration is provided below.

Goal # 1: Increasing Access to Affordable and High-Quality Care, with an Emphasis on Increasing Access to Primary Care

The GC Demonstration has succeeded in increasing access to care for Vermont Medicaid beneficiaries as measured in the following areas:

- *Overall Enrollment:* Total enrollment grew by almost 36% between 2005 and 2014.
- *Number of Uninsured:* The 2014 Vermont Household Health Insurance Survey found that Vermont's uninsured rate was reduced by 46% from the 2012 uninsured rate. The 3.7% rate in 2014 put Vermont second in the nation in health insurance coverage. By November 1 of 2014, over 140,000 Vermonters had received coverage through Vermont Health Connect, including 32,237 enrolled in Qualified Health Plans.
- *HEDIS Measures:* Vermont demonstrated improvement in HEDIS access-to-care measures and in scores achieved by accredited Medicaid HMOs as reported in the NCQA 2014 *State of Health Care Quality Report.* Vermont achieved:
    - Significantly higher (14%) than the accredited Medicaid HMO average of 61.6% for the measure for Well Child Visits in the First 15 Months of Life;
    - High performance for the measure for Child and Adolescent Access to Primary Care Physician (PCP), with scores ranging from 93.9% to 98.6% across the childhood years; and
    - High scores related to the measure for Adult Access to Preventive and Ambulatory Care, 84.21% to 94.31% across the adult years.
- *Beneficiary Satisfaction:* According to the 2014 CAHPS, most respondents are getting needed care (86%), getting care quickly (83%), are satisfied with how doctors communicate (88%), and are satisfied with how care is coordinated (80%).
- *Access to Medicaid Assistance Treatment (MAT) for Opioid-Dependence:* AHS is collaborating with community partners to increase access to MAT for patients through the use of a Specialized Health Home program. CMS approved Specialized Health Home State Plan Amendments for

Vermont's Integrated Treatment for Opioid Dependence's "Hub and Spoke" Initiative in January and March of 2014. The initiative includes regional treatment centers (i.e., Hubs) along with community support (i.e., Spokes) integrated with the Blueprint for Health model and office-based practices statewide. The "Hubs," which began operations in late CY13, had caseloads of 2,542 statewide as of September 2014. Specialized statewide staff are also in more than 50 different practice settings, including OB-GYN, psychiatry, pain, and primary care specialties.

- *Access to Mental Health Treatment:* The abrupt closure of Vermont's only state-run psychiatric hospital, due to flooding from Tropical Storm Irene in 2011, resulted in significant legislative investments in the community mental health system. Vermont has continued to enhance the mental health system to reduce its reliance on institutional care. Small-scale psychiatric centers, enhanced mobile crisis teams, peer-run recovery options, and hospital diversion programs have been supported as the Department of Mental Health continues to promote a more person-centered, flexible, and community-based system of care.

Goal #2: Enhance Quality of Care and improve Health Care Delivery for Individuals with Chronic Care Needs

The GC Demonstration has succeeded in enhancing the quality of care for Vermont Medicaid beneficiaries; examples include:

- *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 2014.
- *Performance Improvement Project (PIP):* In 2014 DVHA' s new PIP, *Follow-up after Hospitalization for Mental Illness,* received a score of 100% for all applicable evaluation elements scored as *Met*, a score of 100% for critical evaluation elements scored as *Met*, and an overall validation status of *Met.*
- *Vermont Chronic Care Initiative (VCCI):* The goal of the VCCI is to improve health outcomes for Medicaid beneficiaries by addressing the increasing prevalence of chronic illness. VCCI has made improvements in health outcomes for Vermont's highest-risk Medicaid beneficiaries. SFY13 utilization change offers further evidence of this strategy with documented reduction of Acute Ambulatory Care Sensitive Conditions inpatient admissions by 37%, 30-day hospital readmission rates by 34%, and an ED utilization decline of 15% for eligible VCCI members in the top 5% utilization category.

- *Blueprint for Health:* Medicaid is an active partner in Vermont's Blueprint for Health, 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).

  In 2014 Blueprint participants had lower hospitalization rates and lower expenditures on pharmacy and specialty care. In spite of lower expenditures, the results for measures of effective and preventive care for Blueprint participants were either better for participants or similar for both Blueprint and comparison groups (cervical cancer screening, breast cancer screening, imaging studies for low back pain, and five Special Medicaid Services (SMS), such as transportation, residential treatment, dental, and home and community based services).

- *Integrating Family Services Program (IFS):* Vermont has worked to integrate a variety of separate and discreet children and family services funded under the Medicaid program. Using a bundled payment approach to provider reimbursement, several disparate Medicaid programs were unified in a single payment model with clear provider expectations for treatment. In FFY14, the one AHS district with a fully implemented IFS program showed positive outcomes for clients and more efficient service delivery with the same level of funding providers received in previous years. In addition, there was a nearly 50% decrease in crisis interventions needed for children, since the community now has the flexibility to provide supports and services earlier than they were able to under the traditional fee-for-service model.

Goal #3: Contain Cost of Care

The GC Demonstration has contained spending relative to the absence of the Demonstration while adding significant quality and value to the health care system. The effectiveness of the GC cost containment efforts can be summarized as follows:

- *Decreased Expenditures:* The Demonstration generated a surplus associated with overall decreased expenditures relative to the aggregate budget neutrality limit (ABNL). Actual expenditures have been consistently below projected and the Demonstration surplus is projected to be $1.5 billion at the end 2016.
- *VCCI Savings:* In state fiscal year (SFY) 2013, the Vermont Chronic Care Initiative (VCCI) documented net savings of $23.5 million over anticipated expense among the top 5% of eligible Medicaid members (high utilizers).
- *Blueprint for Health Savings:* Year-to-year growth in health care expenditures was lower for Blueprint participants, particularly from 2011 forward as more of the 126 practices underwent preparation, scoring, and began working with community health teams.

Goal #4: Allowing Beneficiaries a Choice in Long-Term Services and Supports and Providing an Array of Home- and Community-Based Alternatives Recognized to be more Cost-Effective than Institutional-Based Supports

- *Participation:* SFY2014 participation in Choices for Care increased 6.5% from the previous year.

- *Balance of Settings:* As of October 2014, approximately 52% of people enrolled in Choices for Care's Highest/High Needs groups were served in a home- or community-based setting, while 48% were served in a nursing facility.

- *No Waiting List:* In September 2005, 241 people were on waiting lists for high- and highest-needs home- and community-based services; at the end of SFY2014, the number was 0.

- *Controlled Cost:* In recent years Choices for Care spending has been under State appropriations. This has provided program stability, as well as created opportunities for the State to support quality improvements as directive by the legislature. In SFY2014 Choices for Care expenditures were $5.6 million (3%) less than legislative appropriations.

The GC Demonstration has allowed Vermont to use any excess in the PMPM limit to support additional investments, provided that DVHA meets its contractual obligation to the populations covered under the Demonstration. These expenditures must meet one or more of the following four conditions:

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 beneficiaries in Vermont; or
4) Encourage the formation and maintenance of public-private partnerships in health care, including initiatives to support and improve the health care delivery system.

Examples of services supported through this mechanism include access to necessary substance abuse treatment services for uninsured and underinsured Vermonters; tuition support for health professionals in short supply in Vermont, such as nurses, primary care physicians, and dentists; support for Blueprint for Health provider practice transformation; healthy activity and prevention programs; and support for development of standards and training for medical emergency care.

Future Goals

Vermont remains at the forefront of state-based health care reform. Future goals envision the creation of an all-payer model of care. All-Payer efforts include the continued alignment of the Global Commitment (GC) to Health Section 1115 Demonstration and current State Innovation Model (SIM) work with the State's pursuit of related Medicare waivers. These efforts aim to increase value-based payments, accelerate payment reform, and put total health care spending on a more sustainable trajectory. Within the overall health reform framework, Vermont's Medicaid goal is to maintain the public managed care model to ensure maximum ability to serve Vermont's most vulnerable and lower-income residents while moving towards broader state and federal health care reform goals.

Act 48 of 2011, Vermont's landmark health care reform law, created the Green Mountain Care Board. The GMCB is an independent regulatory board charged with ensuring that changes in the health system improve quality while stabilizing costs. The Legislature assigned the GMCB three main health care responsibilities: regulation, innovation, and evaluation. The GMCB regulates health insurance rates, approves benefit plans for the Vermont Health Connect Benefit Marketplace, sets hospital budgets, and issues certificates of need for major hospital expenditures. The Board is the locus of payment and delivery system reform and a co-signatory of Vermont's SIM grant. Additionally, the GMCB acts as an important convener of the stakeholder community. Beyond these responsibilities, the Green Mountain Care Board is empowered by statute to:

- **Improve** the health of Vermonters;
- **Reduce** the rate of growth of Vermont's health care costs;
- **Enhance** the quality of care and experience of patients and providers;
- **Recruit** high-quality health care professionals to practice in Vermont; and
- **Simplify** and streamline administrative and claims processes to reduce overhead and enhance efficiency.

The GMCB is also charged with exploring the potential implementation of an All-Payer Model. Currently, the GMCB and the State are negotiating with CMMI regarding Medicare waivers to enable an All-Payer Model, including researching feasibility, developing analytics, and obtaining information to support APM negotiating team decision-making as needed to complete term sheet and Demonstration terms and conditions. SIM investments are contributing to analytics related to the all-payer model implementation design for the state, payers, and providers. These SIM investments are helping Vermont prepare for future success with both the GC Demonstration and the All-Payer Model.

Within an All-Payer Model, and through the GC Demonstration, Vermont's goals are to move away from volume-based payments toward a payment system that reinforces efforts to improve the health of Vermonters, improve quality of care, and contain the rate of growth in health care costs. Vermont is testing systems on a pilot basis with willing providers and across all payers, including Medicaid and Medicare. The pilots will be evaluated to judge their applicability to broader populations of health professionals and patients.

One such pilot includes the Vermont Shared Savings Programs. In this effort, participating insurers and Medicaid collaborate with Vermont's Patient Centered Medical Home Project, the Blueprint for Health and with Vermont's Health Care Improvement Project to support Vermont's three Accountable Care Organizations (ACOs). More than 150,000 Vermonters were attributed to Commercial, Medicaid, or Medicare Shared Savings Program participating providers in 2014. GC Demonstration enrollees represent approximately one quarter of the pilot's beneficiaries.

The implementation of Shared Savings Programs, the collaboration between the Blueprint and the ACOs, and findings of other GMCB studies all set the stage for an all-payer system of payments to providers. Additionally, many of these pilots strengthen primary care and better integrate mental health and substance abuse treatment into the health care system as a whole. These programs give Vermont confidence that the alignment of federal waivers and an All-Payer Model will succeed. As progress continues, Vermont will maintain its longstanding commitment to maintain an open, transparent, stakeholder-driven process of health care reform and constant evaluation of whether and how Vermont is meeting its goals.

The GC Demonstration has served as a foundational tool in Vermont's health reform model. The current GC construct provides the flexibility to improve access to health coverage and care based on individual and family needs. Specifically, the Section 1115 Demonstration efforts and the public managed care model have supported:

- Increasing access to affordable and high-quality health care;
- Improving access to primary care;
- Improving the health care delivery for individuals with chronic care needs;
- Containing health care costs through payment reform and other activities; and
- Allowing beneficiaries a choice in where they receive 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 aligning our shared federal and state priorities.

Appendix B: Budget Neutrality Assessment and Projections

Vermont's actual and projected expenditures and enrollment under the Demonstration are presented in a series of tables, as follows:

Table 1: Projected Expenditures without Waiver, Years 1 – 5
Table 2: Actual Caseloads with Waiver, Years 1 – 5
Table 3: Actual Expenditures per Member per Month, Years 1 – 5
Table 4: Actual Expenditures, Years 1 - 5
Table 5: Summary of Program Expenditures with and without Waiver, Years 1 - 5
Table 6: Projected Expenditures without Waiver, Years 6 - 11
Table 7: Actual and Projected Caseloads with Waiver, Years 6 - 11
Table 8: Actual and Projected Expenditures per Member per Month, Years 6 - 11
Table 9: Actual and Projected Expenditures, Years 6 - 11
Table 10: Summary of Program Expenditures with and Without Waiver, Years 6 - 11
Table 11: Projected Expenditures without Waiver, Years 12 - 16
Table 12: Projected Caseloads with Waiver, Years 12 - 16
Table 13: Projected Expenditures per Member per Month, Years 12 - 16
Table 14: Projected Expenditures, Years 12 -16
Table 15: Summary of Program Expenditures with and without Waiver, Years 12 -16

Tables 1 through 5 provide a summary of the expenditures and enrollment for the initial Demonstration period, from October 2005 through September 2010. Table 1 provides the projected expenditures absent the Demonstration, which represents the aggregate budget neutrality limit for the first five years of the Demonstration. The annual budget neutrality limits are included in the approved Special Terms and Conditions for the Demonstration (STCs). Tables 2 through 4 provide a summary of Vermont's actual enrollment and expenditures under the Demonstration. Table 5 provides a summary comparison of the budget neutrality limit and actual program expenditures under the Demonstration.

Tables 6 through 10 provide a summary of actual and projected expenditures and enrollment for Years 6 through 11 (October 2010 through December 2016). Table 6 presents the projected expenditures absent the Demonstration and reflects the annual budget neutrality limits as approved in the STCs. Tables 7 through 9 provide actual and estimated expenditures and enrollment through end of the approved Demonstration period (December 2016). Table 10 provides a summary of Vermont's projected expenditures relative to the budget neutrality limit over the life of the Demonstration. Beginning in Calendar Year 2014, a separate budget neutrality limit was established for medical expenditures on behalf of the New Adult Group; these expenditures are tracked separately and are not included in the aggregate budget neutrality ceiling. Expenditure and caseload information related to the New Adult Group is included in the tables.

Tables 11 through 15 present the projected expenditures and enrollment absent the Demonstration and under the Demonstration for a five-year extension period from January 2017 through December 2021. The projected budget neutrality limit presented in Table 11 reflects the trend rates and methodology that were used to develop the budget neutrality limit under which the Demonstration currently operates.

State of Vermont

Global Commitment to Health

Table 1: Projected Expenditures Without Waiver, Years 1 - 5 (State and Federal)

	Waiver Year					Five-Year Total
	1 (Oct '05-Sept '06)	2 (Oct '06-Sept'07)	3 (Oct '07-Sept '08)	4 (Oct '08-Sept '09)	5 (Oct '09-Sept '10)	
Continuation of VHAP MEGs						
ANFC	$ 162,865,374	$ 180,391,545	$ 199,803,732	$ 221,304,891	$ 245,119,820	$ 1,009,485,362
ABD	$ 92,181,185	$ 98,000,805	$ 104,187,831	$ 110,765,458	$ 117,758,348	$ 522,893,626
Spend Down	$ 1,832,177	$ 1,947,847	$ 2,070,819	$ 2,201,555	$ 2,340,544	$ 10,392,943
Optional Expansion: Parent/Caretakers [1931(b) < 150% of FPL]	$ 32,343,864	$ 37,315,155	$ 43,050,539	$ 49,667,459	$ 57,301,407	$ 219,678,423
Optional Expansion: Parent/Caretakers [1931(b) 150 - 185% of FPL]	$ 7,779,307	$ 8,974,996	$ 10,354,463	$ 11,945,957	$ 13,782,065	$ 52,836,787
Optional Expansion: Children [1902(r)(2)]	$ 1,747,191	$ 1,938,773	$ 2,151,361	$ 2,387,261	$ 2,649,027	$ 10,873,612
Community Rehbabilitation and Treatment (CRT)	$ 29,345,283	$ 31,197,922	$ 33,167,521	$ 35,261,467	$ 37,487,608	$ 166,459,800
Community Rehbabilitation and Treatment (CRT) Duals	$ 138,411	$ 147,150	$ 156,440	$ 166,316	$ 176,816	$ 785,132
VHAP Surplus Carry-Forward	$ 66,605,297	$ -	$ -	$ -	$ -	$ 66,605,297
Subtotal	*$ 394,838,090*	*$ 359,914,191*	*$ 394,942,706*	*$ 433,700,363*	*$ 476,615,633*	*$ 2,060,010,982*
Additional Program Expenses Not Included Under VHAP	$ 372,800,747	$ 406,518,502	$ 443,439,549	$ 483,873,610	$ 528,160,809	$ 2,234,793,218
Program Administration	$ 73,627,826	$ 77,161,961	$ 80,865,735	$ 84,747,291	$ 88,815,161	$ 405,217,974
Total	**$ 841,266,663**	**$ 843,594,654**	**$ 919,247,991**	**$ 1,002,321,263**	**$ 1,093,591,603**	**$ 4,700,022,174**

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Table 2: Actual Caseloads with Waiver, Years 1 - 5 (Member Months)

	Waiver Year				
	1 (Oct '05-Sept '06)	2 (Oct '06-Sept'07)	3 (Oct '07-Sept '08)	4 (Oct '08-Sept '09)	5 (Oct '09-Sept '10)
ABD - Non-Medicare - Adult	180,954	182,711	143,469	153,096	161,974
ABD - Non-Medicare - Child	34,211	41,425	42,058	43,588	44,059
ABD - Dual	167,349	159,373	171,634	178,974	185,693
ANFC - Non-Medicare - Adult	125,441	111,976	112,489	120,450	126,544
ANFC - Non-Medicare - Child	612,860	609,295	611,127	634,843	655,412
Global Expansion (VHAP)	266,886	271,659	307,567	353,286	411,864
Global Rx	145,269	137,079	120,823	119,626	143,768
Optional Expansion (Underinsured)	14,875	13,886	14,005	14,253	14,348
VHAP ESI	-	-	5,365	10,659	11,270
ESIA	-	-	1,476	4,406	5,571
CHAP	-	-	21,278	62,457	82,765
ESIA Expansion - 200-300% of FPL	-	-	-	-	2,172
CHAP Expansion - 200-300% of FPL	-	-	-	-	23,541
Total	**1,547,845**	**1,527,404**	**1,551,291**	**1,695,638**	**1,868,981**

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Table 3: Actual Expenditures per Member per Month, Years 1 - 5 (State and Federal)

	Waiver Year				
	1 (Oct '05-Sept '06)	2 (Oct '06-Sept'07)	3 (Oct '07-Sept '08)	4 (Oct '08-Sept '09)	5 (Oct '09-Sept '10)
ABD - Non-Medicare - Adult	$ 1,125.37	$ 1,187.30	$ 1,324.11	$ 1,099.65	$ 1,106.66
ABD - Non-Medicare - Child	$ 1,780.10	$ 2,095.44	$ 2,343.40	$ 2,155.76	$ 2,152.63
ABD - Dual	$ 1,056.96	$ 851.74	$ 908.38	$ 1,270.88	$ 1,180.64
ANFC - Non-Medicare - Adult	$ 494.60	$ 501.49	$ 566.02	$ 502.58	$ 573.63
ANFC - Non-Medicare - Child	$ 301.09	$ 319.18	$ 354.39	$ 349.31	$ 364.72
Global Expansion (VHAP)	$ 343.40	$ 431.59	$ 488.96	$ 405.25	$ 413.76
Global Rx	$ 63.15	$ 3.74	$ 3.94	$ 15.97	$ 9.97
Optional Expansion (Underinsured)	$ 151.69	$ 190.84	$ 211.38	$ 177.70	$ 173.46
VHAP ESI	$ -	$ -	$ 234.15	$ 192.90	$ 224.80
ESIA	$ -	$ -	$ 178.38	$ 141.86	$ 177.43
CHAP	$ -	$ -	$ 407.94	$ 373.99	$ 427.96
ESIA Expansion - 200-300% of FPL	$ -	$ -	$ -	$ -	$ 176.87
CHAP Expansion - 200-300% of FPL	$ -	$ -	$ -	$ -	$ 432.52
Total	**$ 511.08**	**$ 530.65**	**$ 572.88**	**$ 557.74**	**$ 550.46**

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Table 4: Actual Expenditures, Years 1 - 5 (State and Federal)

	Waiver Year					Five-Year Total
	1 (Oct '05-Sept '06)	2 (Oct '06-Sept'07)	3 (Oct '07-Sept '08)	4 (Oct '08-Sept '09)	5 (Oct '09-Sept '10)	
Capitation Payments						
ABD - Non-Medicare - Adult	$ 203,640,203	$ 216,932,770	$ 189,968,738	$ 168,352,016	$ 179,249,891	$ 958,143,618
ABD - Non-Medicare - Child	$ 60,899,001	$ 86,803,602	$ 98,558,717	$ 93,965,267	$ 94,842,614	$ 435,069,201
ABD - Dual	$ 176,881,327	$ 135,744,359	$ 155,908,893	$ 227,454,477	$ 219,236,518	$ 915,225,575
ANFC - Non-Medicare - Adult	$ 62,043,119	$ 56,154,844	$ 63,671,024	$ 60,535,761	$ 72,589,220	$ 314,993,967
ANFC - Non-Medicare - Child	$ 184,526,017	$ 194,474,778	$ 216,577,298	$ 221,757,008	$ 239,043,470	$ 1,056,378,571
Global Expansion (VHAP)	$ 91,648,652	$ 117,245,308	$ 150,387,960	$ 143,169,152	$ 170,413,126	$ 672,864,198
Global Rx	$ 9,173,970	$ 512,594	$ 475,763	$ 1,911,020	$ 1,433,935	$ 13,507,282
Optional Expansion (Underinsured)	$ 2,256,389	$ 2,650,004	$ 2,960,377	$ 2,532,758	$ 2,488,843	$ 12,888,371
VHAP ESI	$ -	$ -	$ 1,256,215	$ 2,056,121	$ 2,533,498	$ 5,845,833
ESIA	$ -	$ -	$ 263,289	$ 625,035	$ 988,443	$ 1,876,767
CHAP	$ -	$ -	$ 8,680,147	$ 23,358,293	$ 35,420,469	$ 67,458,909
ESIA Expansion - 200-300% of FPL	$ -	$ -	$ -	$ -	$ 384,158	$ 384,158
CHAP Expansion - 200-300% of FPL	$ -	$ -	$ -	$ -	$ 10,181,948	$ 10,181,948
Subtotal Capitation Payments	*$ 791,068,678*	*$ 810,518,260*	*$ 888,708,420*	*$ 945,716,909*	*$ 1,028,806,133*	$ 4,464,818,400
Premium Offsets	$ (8,908,833)	$ (7,633,900)	$ (7,210,870)	$ (10,603,732)	$ (15,815,296)	$ (50,172,631)
Administrative Expenses Outside of Managed Care Model	$ 4,620,302	$ 6,464,439	$ 6,457,896	$ 5,495,618	$ 5,949,605	$ 28,987,860
Total	**$ 786,780,147**	**$ 809,348,799**	**$ 887,955,446**	**$ 940,608,795**	**$ 1,018,940,442**	**$ 4,443,633,629**

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Table 5: Summary of Program Expenditures With and Without Waiver, Years 1 - 5 (State and Federal)

	Waiver Year					Five-Year Total
	1 (Oct '05-Sept '06)	2 (Oct '06-Sept'07)	3 (Oct '07-Sept '08)	4 (Oct '08-Sept '09)	5 (Oct '09-Sept '10)	
Expenditures without Waiver (Aggregate Budget Neutrality Limit)	**$ 841,266,663**	**$ 843,594,654**	**$ 919,247,991**	**$ 1,002,321,263**	**$ 1,093,591,603**	**$ 4,700,022,174**
Expenditures with Waiver						
Capitation Payments	$ 791,068,678	$ 810,518,260	$ 888,708,420	$ 945,716,909	$ 1,028,806,133	$ 4,464,818,400
Premium Offsets	$ (8,908,833)	$ (7,633,900)	$ (7,210,870)	$ (10,603,732)	$ (15,815,296)	$ (50,172,631)
Admin. Expenses Outside Managed Care Model	$ 4,620,302	$ 6,464,439	$ 6,457,896	$ 5,495,618	$ 5,949,605	$ 28,987,860
Total	**$ 786,780,147**	**$ 809,348,799**	**$ 887,955,446**	**$ 940,608,795**	**$ 1,018,940,442**	**$ 4,443,633,629**
Annual Surplus (Deficit)	**$ 54,486,516**	**$ 34,245,856**	**$ 31,292,544**	**$ 61,712,468**	**$ 74,651,161**	**$ 256,388,545**
Cumulative Surplus (Deficit)	**$ 54,486,516**	**$ 88,732,372**	**$ 120,024,916**	**$ 181,737,384**	**$ 256,388,545**	**$ 256,388,545**

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Table 6: Projected Expenditures Without Waiver, Years 6 Through 11 (State and Federal)

	Waiver Year							Total
	6 (Oct '10-Sept '11)	7 (Oct '11-Sept'12)	8 (Oct '12-Sept '13)	9a (Oct '13-Dec '13)	9b (Jan '14-Dec '14)	10 (est.) (Jan '15-Dec '15)	11 (est.) (Jan '16-Dec '16)	Oct '10 - Dec '16
Continuation of VHAP MEGs								
ANFC	$ 263,358,696	$ 286,864,302	$ 312,467,859	$ 119,576,169	$ 341,704,747	$ 363,900,356	$ 387,537,692	$ 2,075,409,820
ABD	$ 126,696,206	$ 134,694,842	$ 143,198,450	$ 53,760,496	$ 155,072,171	$ 428,178,047	$ 456,405,036	$ 1,498,005,248
Spend Down	$ 2,534,821	$ 2,694,851	$ 2,864,983	$ 1,075,591	$ 3,102,542	$ 3,306,694	$ 3,524,281	$ 19,103,763
Optional Expansion: Parent/Caretakers [1931(b) < 150% of FPL]	$ 61,507,444	$ 69,848,352	$ 79,320,354	$ 31,268,586	$ -	$ -	$ -	$ 241,944,737
Optional Expansion: Parent/Caretakers [1931(b) 150 - 185% of FPL]	$ 14,793,696	$ 16,799,841	$ 19,078,035	$ 7,520,682	$ -	$ -	$ -	$ 58,192,253
Optional Expansion: Children [1902(r)(2)]	$ 2,848,800	$ 3,105,970	$ 3,386,356	$ 1,296,821	$ -	$ -	$ -	$ 10,637,947
Community Rehbabilitation and Treatment (CRT)	$ 40,332,917	$ 42,879,231	$ 45,586,300	$ 17,114,306	$ 49,366,222	$ 52,614,606	$ 56,076,741	$ 303,970,322
Community Rehbabilitation and Treatment (CRT) Duals	$ 190,236	$ 202,246	$ 215,015	$ 80,722	$ 232,843	$ 248,165	$ 264,494	$ 1,433,721
Subtotal	*$ 512,262,817*	*$ 557,089,634*	*$ 606,117,352*	*$ 231,693,373*	*$ 549,478,524*	*$ 848,247,868*	*$ 903,808,244*	*$1,907,163,176*
Additional Program Expenses Not Included Under VHAP	$ 559,850,458	$ 593,441,485	$ 629,047,974	$ 235,588,296	$ 676,575,239	$ 717,169,754	$ 760,199,939	$ 4,171,873,145
Program Administration	$ 93,078,288	$ 97,546,046	$ 102,228,256	$ 37,920,643	$ 108,398,321	$ 113,601,441	$ 119,054,310	$ 671,827,307
Waiver Surplus (Deficit) Carry-Forward	$ 256,388,545	$ -	$ -	$ -	$ -	$ -	$ -	$ 256,388,545
Budget Neutrality Limit	**$ 1,421,580,108**	**$ 1,248,077,166**	**$ 1,337,393,583**	**$ 505,202,312**	**$ 1,334,452,085**	**$ 1,679,019,063**	**$ 1,783,062,493**	**$ 9,308,786,808**

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Table 7: Actual and Projected Caseloads with Waiver, Years 6 Through 11 (Member Months)

	Waiver Year							Annual Growth Oct '10 - Dec '15
	6 (Oct '10-Sept '11)	7 (Oct '11-Sept'12)	8 (Oct '12-Sept '13)	9a (Oct '13-Dec '13)	9b (Jan '14-Dec '14)	10 (Jan '15-Dec '15)	11 (est.) (Jan '16-Dec '16)	
ABD - Non-Medicare - Adult	166,049	168,306	171,716	43,359	193,529	202,175	211,759	4.74%
ABD - Non-Medicare - Child	44,349	44,619	44,203	10,815	44,778	40,498	39,642	-2.11%
ABD - Dual	193,983	202,000	205,960	52,041	212,732	267,143	288,035	7.82%
Moderate Needs Group						2,853	2,953	
ANFC - Non-Medicare - Adult	131,746	136,075	135,532	33,133	187,670	230,823	263,380	14.10%
ANFC - Non-Medicare - Child	661,211	664,341	663,820	165,296	706,727	760,663	786,159	3.35%
Global Expansion (VHAP)	444,056	444,652	449,364	109,808	10,150	-	-	
Global Rx	151,971	151,240	151,759	38,096	148,291	140,343	137,739	-1.86%
Optional Expansion (Underinsured)	13,360	12,606	11,397	2,615	11,759	-	-	
VHAP ESI	10,554	9,870	9,318	2,171	940	-	-	
ESIA	5,952	5,609	5,961	1,381	1,831	-	-	
CHAP	86,965	92,725	101,961	28,516	22,553	-	-	
ESIA Expansion - 200-300% of FPL	3,171	2,898	2,991	765	-	-	-	
CHAP Expansion - 200-300% of FPL	34,078	38,467	40,104	11,450	-	-	-	
Total	**1,947,445**	**1,973,408**	**1,994,086**	**499,446**	**1,540,960**	**1,644,498**	**1,729,667**	**1.14%**
Supplemental Test: New Adult					*561,524*	*691,550*	*760,705*	

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Table 8: Actual and Projected Expenditures per Member per Month with Waiver, Years 6 Through 11 (State and Federal)

	Waiver Year							Annual Growth Oct '10 - Dec '14
	6 (Oct '10-Sept '11)	7 (Oct '11-Sept'12)	8 (Oct '12-Sept '13)	9a (Oct '13-Dec '13)	9b (Jan '14-Dec '14)	10 (est.) (Jan '15-Dec '15)	11 (est.) (Jan '16-Dec '16)	
ABD - Non-Medicare - Adult	$ 1,063.14	$ 1,166.93	$ 1,234.99	$ 1,253.93	$ 1,179.41	$ 1,321.94	$ 1,364.84	3.24%
ABD - Non-Medicare - Child	$ 2,218.64	$ 2,329.20	$ 2,278.63	$ 2,526.56	$ 2,371.94	$ 2,421.21	$ 2,471.50	2.08%
ABD - Dual	$ 1,151.67	$ 1,164.31	$ 1,225.19	$ 1,288.25	$ 1,278.90	$ 1,799.07	$ 1,858.02	3.28%
Moderate Needs Group						$ 1,862.44	$ 1,922.88	3.24%
ANFC - Non-Medicare - Adult	$ 580.55	$ 632.97	$ 686.74	$ 739.50	$ 598.61	$ 604.27	$ 609.99	0.95%
ANFC - Non-Medicare - Child	$ 357.34	$ 388.23	$ 400.18	$ 424.72	$ 431.64	$ 457.48	$ 484.86	5.99%
Global Expansion (VHAP)	$ 406.08	$ 441.14	$ 461.89	$ 491.47	$ 1,561.76	$ -	$ -	
Global Rx	$ 51.33	$ 64.78	$ 70.00	$ 69.67	$ 69.28	$ 75.97	$ 83.31	9.66%
Optional Expansion (Underinsured)	$ 176.14	$ 240.41	$ 315.12	$ 414.88	$ 427.52	$ -	$ -	
VHAP ESI	$ 181.73	$ 168.13	$ 127.49	$ 179.02	$ 188.26	$ -	$ -	
ESIA	$ 144.81	$ 150.43	$ 131.63	$ 135.49		$ -	$ -	
CHAP	$ 462.38	$ 441.42	$ 450.30	$ 529.89		$ -	$ -	
ESIA Expansion - 200-300% of FPL	$ 94.27	$ 80.93	$ 40.01	$ 85.79	$ -	$ -	$ -	
CHAP Expansion - 200-300% of FPL	$ 536.32	$ 527.18	$ 643.81	$ 647.17	$ -	$ -	$ -	
Total	**$ 539.89**	**$ 577.82**	**$ 604.86**	**$ 642.99**	**$ 719.79**	**$ 848.67**	**$ 888.68**	**9.25%**
Supplemental Test: New Adult					*$ 360.49*	*$ 393.84*	*$ 430.28*	

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Table 9: Actual and Projected Expenditures with Waiver, Years 6 Through11 (State and Federal)

	Waiver Year							Total
	6 (Oct '10-Sept '11)	7 (Oct '11-Sept'12)	8 (Oct '12-Sept '13)	9a (Oct '13-Dec '13)	9b (Jan '14-Dec '14)	10 (est.) (Jan '15-Dec '15)	11 (est.) (Jan '16-Dec '16)	Oct '10 - Dec '16
Capitation Payments								
ABD - Non-Medicare - Adult	$ 176,533,340	$ 196,401,943	$ 212,067,557	$ 54,369,179	$ 228,249,483	$ 267,263,025	$ 289,016,679	$ 1,423,901,206
ABD - Non-Medicare - Child	$ 98,394,380	$ 103,926,653	$ 100,722,261	$ 27,324,784	$ 106,210,781	$ 98,054,129	$ 97,974,233	$ 632,607,221
ABD - Dual	$ 223,405,044	$ 235,190,575	$ 252,340,195	$ 67,041,601	$ 272,062,944	$ 480,610,231	$ 535,175,918	$ 2,065,826,508
Moderate Needs Group						$ 5,313,547	$ 5,677,976	$ 10,991,524
ANFC - Non-Medicare - Adult	$ 76,485,531	$ 86,130,995	$ 93,075,905	$ 24,501,934	$ 112,340,347	$ 139,480,008	$ 160,660,033	$ 692,674,755
ANFC - Non-Medicare - Child	$ 236,275,482	$ 257,918,575	$ 265,649,659	$ 70,204,550	$ 305,053,753	$ 347,986,095	$ 381,175,493	$ 1,864,263,607
Global Expansion (VHAP)	$ 180,323,101	$ 196,154,448	$ 207,557,724	$ 53,967,312	$ 15,851,843	$ -	$ -	$ 653,854,427
Global Rx	$ 7,800,691	$ 9,797,150	$ 10,622,700	$ 2,653,995	$ 10,272,954	$ 10,661,918	$ 11,475,331	$ 63,284,740
New Adult Investment and Admin Allocation					$ 35,989,900	$ 48,483,816	$ 58,337,845	$ 142,811,561
Marketplace Subsidy					$ 4,418,351	$ 4,860,186	$ 5,346,205	$ 14,624,742
Optional Expansion (Underinsured)	$ 2,353,178	$ 3,030,604	$ 3,591,401	$ 1,084,911	$ 5,027,163	$ -	$ -	$ 15,087,257
VHAP ESI	$ 1,917,976	$ 1,659,423	$ 1,187,965	$ 388,655	$ 177,959	$ -	$ -	$ 5,331,978
ESIA	$ 861,905	$ 843,777	$ 784,675	$ 187,114	$ 176,961	$ -	$ -	$ 2,854,431
CHAP	$ 40,210,567	$ 40,930,244	$ 45,913,483	$ 15,110,438	$ 10,247,481	$ -	$ -	$ 152,412,213
ESIA Expansion - 200-300% of FPL	$ 298,915	$ 234,532	$ 119,679	$ 65,631	$ 35,214	$ -	$ -	$ 753,971
CHAP Expansion - 200-300% of FPL	$ 18,276,722	$ 20,278,846	$ 25,819,475	$ 7,410,120	$ 4,463,893	$ -	$ -	$ 76,249,056
Subtotal Capitation Payments	*$ 1,063,136,831*	*$ 1,152,497,766*	*$ 1,219,452,678*	*$ 324,310,224*	*$ 1,110,579,028*	*$ 1,402,712,956*	*$ 1,544,839,714*	*$ 7,817,529,197*
Premium Offsets	$ (17,794,216)	$ (17,971,216)	$ (19,565,123)	$ (4,388,444)	$ (2,081,327)	$ (2,151,090)	$ (2,223,191)	$ (66,174,607)
Administrative Expenses Outside of Managed Care Model	$ 6,071,553	$ 5,751,066	$ 6,260,794	$ 1,214,631	$ 5,086,126	$ -	$ -	$ 24,384,170
Total	**$ 1,051,414,168**	**$ 1,140,277,616**	**$ 1,206,148,349**	**$ 321,136,411**	**$ 1,113,583,826**	**$ 1,400,561,866**	**$ 1,542,616,523**	**$ 7,775,738,760**
Supplemental Test: New Adult					*$ 202,422,277*	*$ 272,693,300*	*$ 328,116,487*	

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Table 10: Summary of Program Expenditures With and Without Waiver, Years 6 -11 (State and Federal)

	Waiver Year							Total
	6 (Oct '10-Sept '11)	7 (Oct '11-Sept'12)	8 (Oct '12-Sept '13)	9a (Oct '13-Dec '13)	9b (Jan '14-Dec '14)	10 (est.) (Jan '15-Dec '15)	11 (est.) (Jan '16-Dec '16)	Oct '10 - Dec '16
Expenditures without Waiver (Aggregate Budget Neutrality Limit)	**$ 1,421,580,108**	**$ 1,248,077,166**	**$ 1,337,393,583**	**$ 505,202,312**	**$ 1,334,452,085**	**$ 1,679,019,063**	**$ 1,783,062,493**	**$ 9,308,786,808**
Expenditures with Waiver								
Capitation Payments	$ 1,063,136,831	$ 1,152,497,766	$ 1,219,452,678	$ 324,310,224	$ 1,110,579,028	$ 1,402,712,956	$ 1,544,839,714	$ 7,817,529,197
Premium Offsets	$ (17,794,216)	$ (17,971,216)	$ (19,565,123)	$ (4,388,444)	$ (2,081,327)	$ (2,151,090)	$ (2,223,191)	$ (66,174,607)
Admin. Expenses Outside Managed Care Model	$ 6,071,553	$ 5,751,066	$ 6,260,794	$ 1,214,631	$ 5,086,126	$ -	$ -	$ 24,384,170
Total	**$ 1,051,414,168**	**$ 1,140,277,616**	**$ 1,206,148,349**	**$ 321,136,411**	**$ 1,113,583,826**	**$ 1,400,561,866**	**$ 1,542,616,523**	**$ 7,775,738,760**
Annual Surplus (Deficit)	$ 370,165,940	$ 107,799,549	$ 131,245,234	$ 184,065,901	$ 220,868,258	$ 278,457,196	$ 240,445,969	$ 1,533,048,049
Cumulative Surplus (Deficit)	**$ 370,165,940**	**$ 477,965,489**	**$ 609,210,723**	**$ 793,276,624**	**$ 1,014,144,883**	**$ 1,292,602,079**	**$ 1,533,048,049**	**$ 1,533,048,049**
Supplemental Test: New Adult								
Limit					*$ 254,774,669*	*$ 328,513,912*	*$ 378,351,846*	*$ 961,640,427*
Actual					*$ 202,422,277*	*$ 272,693,300*	*$ 328,116,487*	*$ 803,232,064*
Annual Surplus (Deficit)					*$ 52,352,393*	*$ 55,820,612*	*$ 50,235,359*	*$ 158,408,363*

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Table 11: Projected Expenditures Without Waiver, Years 12 Through 16 (State and Federal)

	Waiver Year					Total
	12 (Jan '17-Dec '17)	13 (Oct '18-Sept'18)	14 (Oct '19-Sept '19)	15 (Oct '20-Dec '20)	16 (Jan '21-Dec '21)	Jan '17 - Dec '21
Continuation of VHAP MEGs						
ANFC	$ 412,710,404	$ 439,518,222	$ 468,067,356	$ 498,470,913	$ 530,849,350	$ 2,349,616,245
ABD	$ 486,437,296	$ 518,445,733	$ 552,560,381	$ 588,919,834	$ 627,671,804	$ 2,774,035,049
Spend Down	$ 3,756,185	$ 4,003,348	$ 4,266,776	$ 4,547,537	$ 4,846,773	$ 21,420,619
Community Rehbabilitation and Treatment (CRT)	$ 59,766,690	$ 63,699,444	$ 67,890,980	$ 72,358,327	$ 77,119,633	$ 340,835,075
Community Rehbabilitation and Treatment (CRT) Duals	$ 281,898	$ 300,448	$ 320,218	$ 341,289	$ 363,746	$ 1,607,599
Subtotal	*$ 962,952,473*	*$ 1,025,967,195*	*$ 1,093,105,711*	*$ 1,164,637,901*	*$ 1,240,851,306*	*$ 4,246,663,280*
Additional Program Expenses Not Included Under VHAP	$ 805,811,935	$ 854,160,651	$ 905,410,290	$ 959,734,908	$ 1,017,319,002	$ 4,542,436,787
Program Administration	$ 124,768,917	$ 130,757,825	$ 137,034,201	$ 143,611,842	$ 150,505,211	$ 686,677,995
Waiver Surplus (Deficit) Carry-Forward	$ 1,533,048,049	$ -	$ -	$ -	$ -	$ 1,533,048,049
Total	**$ 3,426,581,374**	**$ 2,010,885,671**	**$ 2,135,550,202**	**$ 2,267,984,651**	**$ 2,408,675,519**	**$ 9,733,502,635**
Supplemental Test: NewAdult	$ 414,913,829	$ 455,008,975	$ 498,978,710	$ 547,197,455	$ 600,075,813	$ 2,516,174,782

State of Vermont

Global Commitment to Health

Table 12: Projected Caseloads with Waiver, Years 12 Through 16 (Member Months)

	Waiver Year					Trend Rate
	12 (Jan '17-Dec '17)	13 (Oct '18-Sept'18)	14 (Oct '19-Sept '19)	15 (Oct '20-Dec '20)	16 (Jan '21-Dec '21)	
ABD - Non-Medicare - Adult	221,798	232,313	243,326	254,861	266,943	4.74%
ABD - Non-Medicare - Child	40,038	40,438	40,843	41,251	41,664	1.00%
ABD - Dual	310,561	334,849	361,035	389,270	419,713	7.82%
Moderate Needs Group	2,982	3,012	3,042	3,073	3,103	1.00%
ANFC - Non-Medicare - Adult	266,014	268,674	271,361	274,074	276,815	1.00%
ANFC - Non-Medicare - Child	794,021	801,961	809,981	818,080	826,261	1.00%
Global Rx	135,183	132,675	130,213	127,797	125,426	-1.86%
Total	**1,770,597**	**1,813,922**	**1,859,801**	**1,908,407**	**1,959,925**	**2.57%**
Supplemental Test: New Adult	*796,768*	*834,540*	*874,103*	*915,541*	*958,944*	4.74%

State of Vermont

Global Commitment to Health

Table 13: Projected Expenditures per Member per Month with Waiver, Years 12 Through 16 (State and Federal)

	Waiver Year					PMPM Trend
	12 (Jan '17-Dec '17)	13 (Oct '18-Sept'18)	14 (Oct '19-Sept '19)	15 (Oct '20-Dec '20)	16 (Jan '21-Dec '21)	
ABD - Non-Medicare - Adult	$ 1,409.13	$ 1,454.85	$ 1,502.06	$ 1,550.80	$ 1,601.12	3.24%
ABD - Non-Medicare - Child	$ 2,522.84	$ 2,575.24	$ 2,628.73	$ 2,683.33	$ 2,739.07	2.08%
ABD - Dual	$ 1,918.90	$ 1,981.78	$ 2,046.71	$ 2,113.78	$ 2,183.04	3.28%
Moderate Needs Group	$ 1,985.27	$ 2,049.69	$ 2,116.20	$ 2,184.87	$ 2,255.77	3.24%
ANFC - Non-Medicare - Adult	$ 615.77	$ 621.60	$ 627.48	$ 633.42	$ 639.42	0.95%
ANFC - Non-Medicare - Child	$ 513.88	$ 544.63	$ 577.23	$ 611.78	$ 648.39	5.99%
Global Rx	$ 91.36	$ 100.19	$ 109.88	$ 120.49	$ 132.14	9.66%
Total	**$ 941.49**	**$ 993.92**	**$ 1,049.28**	**$ 1,107.68**	**$ 1,169.25**	**7.49%**
Supplemental Test: New Adult	*$ 451.60*	*$ 472.83*	*$ 495.05*	*$ 518.32*	*$ 542.68*	*4.70%*

State of Vermont

Global Commitment to Health

Table 14: Projected Expenditures with Waiver, Years 12 Through16 (State and Federal)

	Waiver Year					Total
	12 (Jan '17-Dec '17)	13 (Oct '18-Sept'18)	14 (Oct '19-Sept '19)	15 (Oct '20-Dec '20)	16 (Jan '21-Dec '21)	Jan '17 - Dec '21
Capitation Payments						
ABD - Non-Medicare - Adult	$ 312,540,954	$ 337,979,967	$ 365,489,569	$ 395,238,291	$ 427,408,387	$ 1,838,657,168
ABD - Non-Medicare - Child	$ 101,009,367	$ 104,138,525	$ 107,364,621	$ 110,690,659	$ 114,119,733	$ 537,322,905
ABD - Dual	$ 595,936,675	$ 663,595,855	$ 738,936,664	$ 822,831,230	$ 916,250,696	$ 3,737,551,120
Moderate Needs Group	$ 5,920,844	$ 6,174,100	$ 6,438,188	$ 6,713,573	$ 7,000,736	$ 32,247,440
ANFC - Non-Medicare - Adult	$ 163,802,754	$ 167,006,951	$ 170,273,826	$ 173,604,606	$ 177,000,539	$ 851,688,677
ANFC - Non-Medicare - Child	$ 408,029,209	$ 436,774,763	$ 467,545,434	$ 500,483,891	$ 535,742,854	$ 2,348,576,152
Global Rx	$ 12,350,802	$ 13,293,062	$ 14,307,210	$ 15,398,728	$ 16,573,520	$ 71,923,322
New Adult Investment and Admin Allocation	$ 63,975,316	$ 70,157,562	$ 76,937,229	$ 84,372,049	$ 92,525,331	$ 387,967,487
Marketplace Subsidy	$ 5,880,825	$ 6,468,908	$ 7,115,798	$ 7,827,378	$ 8,610,116	$ 35,903,026
Subtotal Capitation Payments	*$ 1,669,446,745*	*$ 1,805,589,694*	*$ 1,954,408,540*	*$ 2,117,160,404*	*$ 2,295,231,913*	*$ 9,841,837,296*
Premium Offsets	$ (2,445,510)	$ (2,690,061)	$ (2,959,067)	$ (3,254,974)	$ (3,580,471)	$ (14,930,082)
Total	**$ 1,667,001,235**	**$ 1,802,899,633**	**$ 1,951,449,473**	**$ 2,113,905,431**	**$ 2,291,651,442**	**$ 9,826,907,214**
Supplemental Test: New Adult	*$ 359,823,983*	*$ 394,595,528*	*$ 432,727,217*	*$ 474,543,758*	*$ 520,401,234*	*$ 2,182,091,720*

Table 15: Summary of Program Expenditures With and Without Waiver, Years 12 -16 (State and Federal)

	Waiver Year					Total
	12 (Jan '17-Dec '17)	13 (Oct '18-Sept'18)	14 (Oct '19-Sept '19)	15 (Oct '20-Dec '20)	16 (Jan '21-Dec '21)	Jan '17 - Dec '21
Expenditures without Waiver (Aggregate Budget Neutrality Limit)	**$ 3,426,581,374**	**$ 2,010,885,671**	**$ 2,135,550,202**	**$ 2,267,984,651**	**$ 2,408,675,519**	**$ 12,249,677,417**
Expenditures with Waiver						
Capitation Payments	$ 1,669,446,745	$ 1,805,589,694	$ 1,954,408,540	$ 2,117,160,404	$ 2,295,231,913	$ 9,841,837,296
Premium Offsets	$ (2,445,510)	$ (2,690,061)	$ (2,959,067)	$ (3,254,974)	$ (3,580,471)	$ (14,930,082)
Total	**$ 1,667,001,235**	**$ 1,802,899,633**	**$ 1,951,449,473**	**$ 2,113,905,431**	**$ 2,291,651,442**	**$ 9,826,907,214**
Annual Surplus (Deficit)	**$ 1,759,580,138**	**$ 207,986,038**	**$ 184,100,729**	**$ 154,079,220**	**$ 117,024,077**	**$ 2,422,770,203**
Cumulative Surplus (Deficit)	**$ 1,759,580,138**	**$ 1,967,566,177**	**$ 2,151,666,905**	**$ 2,305,746,125**	**$ 2,422,770,203**	**$ 2,422,770,203**
Supplemental Test: New Adult						
Limit	*$ 414,913,829*	*$ 455,008,975*	*$ 498,978,710*	*$ 547,197,455*	*$ 600,075,813*	*$ 2,516,174,782*
Projected	*$ 359,823,983*	*$ 394,595,528*	*$ 432,727,217*	*$ 474,543,758*	*$ 520,401,234*	*$ 2,182,091,720*
Annual Surplus (Deficit)	*$ 55,089,847*	*$ 60,413,447*	*$ 66,251,493*	*$ 72,653,698*	*$ 79,674,578*	*$ 334,083,062*

Appendix C: Interim Evaluation of the Overall Impact of the Demonstration

Background

In April 2013 Vermont submitted to CMS its Interim Program Evaluation with its request to renew the Global Commitment to Health (GC) Section 1115 Demonstration. The evaluation reported the Demonstration's progress toward accomplishing its three goals: 1) increasing access, 2) improving quality, and 3) controlling costs.

The evaluation included 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 Blueprint for Health initiative. As part of the 2013 and 2014 CMS discussions, the state requested and ultimately received approval to incorporate the 1115 Long-Term Care Demonstration waiver, Choices for Care (CFC), into the GC Demonstration. Prior to January 30, 2015, evaluation activities of the two waivers had been separate. An updated evaluation plan for the consolidated waiver is currently under review with CMS.

2015 Interim Program Evaluation Report

In accordance with the Special Terms and Conditions of the GC Demonstration, AHS contracted with the Pacific Health Policy Group (PHPG) to prepare an interim evaluation of the GC Demonstration and its performance relative its goals. Specifically, PHPG was directed to compile findings related to:

- Increasing access to affordable and high-quality health care, with an emphasis on primary care;
- Improving the health care delivery for individuals with chronic care needs;
- Containing health care costs; and
- Allowing beneficiaries a choice in long-term services and supports and providing an array of home- and community-based alternatives recognized to be more cost-effective than institutional-based supports.

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

- Global Commitment to Health Enrollment 2008-2014
- 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, and 2014)
- 2012-2015 External Quality Review Organization (EQRO) Technical Reports
- 2013-2014 HEDIS Measures
- 2012 and 2014 Consumer Assessment of Health Provider and Systems (CAHPS) Survey
- 2014 Blueprint for Health Annual Report
- 2014 Global Commitment to Health Demonstration Annual and Quarterly Reports to CMS
- NCQA, State of Health Care Quality 2014.

Based on current evaluation efforts, the GC Demonstration has succeeded at achieving all four goals as demonstrated by multiple measures detailed in the report. Please see Attachment 1 for the full report.

Vermont Premium Assistance Program Evaluation

As Vermont prepared for the transition to the Affordable Care Act (ACA) in 2013, a preliminary comparison of cost-sharing obligations between existing Vermont Medicaid coverage groups and the ACA found that in some instances ACA cost sharing would be substantially higher than the state's existing Medicaid waiver programs, such as Vermont Health Access Plan (VHAP) and Catamount Health.

Concerned that the ACA could result in a financial challenge for those currently with health care coverage through VHAP and Catamount Health, Vermont sought CMS guidance on supplementing the federal subsidies under the ACA for premiums and out-of-pocket expenses. In October of 2013, Vermont received approval effective January 1, 2014, to further subsidize monthly premiums to ensure greater affordability for low- and middle-income Vermonters.

Specifically, the state may claim Marketplace premium subsidies as allowable expenditures under the GC Section 1115 Demonstration waiver for individuals with incomes up to and including 300% of the Federal Poverty Level (FPL). Vermont provides subsidies on behalf of individuals who are not Medicaid eligible, are eligible for the advance premium tax credit (APTC), and who have household income up to and including 300% of FPL.

CMS has set annual limits for gross expenditures for which federal financial participation is available. During the transition to ACA, Vermont estimated that approximately 19,222 individuals would move from Medicaid waiver expansion programs into the Marketplace. An interim study of the marketplace subsidy program was conducted in 2014. Based on Vermont Health Connect (VHC) data at the time of the evaluation report, approximately 90%, or 17,377 covered persons who may have otherwise been part of this former group were benefiting from the VPA program.

Preliminary VHC data suggest that the program is attracting persons in income categories above 133% who may have otherwise applied for VHAP, Catamount, or Employer-Sponsored Premium Assistance pre-January 1, 2014. As of the fourth quarter of 2015, enrollment in VPA was 16,906.

Draft Demonstration Evaluation Design

Following the consolidation of Choices for Care under the Global Commitment to Health Demonstration, Vermont submitted a revised Draft Demonstration Evaluation Design to CMS. This revised evaluation plan includes:

- Background information on the Demonstration and its principles, goals, and objectives;
- Detailed evaluation design; and
- Information on the evaluation reports to be provided to CMS during the lifetime of the Demonstration and at its conclusion.

Vermont will select an independent contractor to conduct the evaluation. The contractor's work will be overseen by the Quality Improvement team within the Agency of Human Services (AHS), Vermont's Single State Agency for Medicaid.

This Evaluation Plan addresses all of the required elements outlined in the Special Terms and Conditions and is designed to answer four fundamental questions:

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

The information learned from the evaluation will be used to guide and inform both current and future planning. The evaluation is separate from, but linked to, the state's other quality assessment and improvement activities. It goes beyond quality assurance, quality measurement, and performance improvement by evaluating areas of the Demonstration other than those specified in the Quality Strategy.

AHS is interested in using the evaluation to identify both successes and opportunities for improvement. In addition, the evaluation incorporates different types of measures (e.g., financial, clinical, and program) and different targets (e.g., population groups, payers, and providers).

The state plans to use the results of the evaluation to inform its future policy decisions with respect to the evolution of its health care system and policy planning efforts. In addition to the hypotheses being tested as part of this Evaluation Plan, the state will continue to monitor the program for its impact in relation to the Healthy Vermonters 2020 goals. While the above questions cannot be conclusively answered until the end of the Demonstration, the Evaluation Plan includes ongoing information collection on the incremental progress of the Demonstration; it is designed to measure changes before, during, and after the Demonstration.

Appendix D: Summary of EQRO Reports and Quality Assurance Monitoring

External Quality Review Organization Reports

As a Managed Care model, DVHA adheres to federal rules contained in 42 CFR 438. Since 2007 AHS has contracted 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; and
- Performance Improvement Projects Validation.

EQRO Report 2012 –2013

Performance Measures Evaluation

HSAG validated a set of nine AHS-required performance measures as calculated by DVHA. The nine measures included 35 clinical indicators (or rates). The performance measurement period was calendar year 2011. AHS selected the nine measures from the 2013 HEDIS measures. HSAG determined that all nine measures were fully compliant with HEDIS specifications and were valid and accurate for reporting. All measures received a validation finding of Fully Compliant. DVHA implemented many of HSAG's recommendations from the previous years to reinforce support and commitment to the performance measure reporting process. This was evident through the participation of many DVHA staff members in HSAG's current year audit and the thorough completion of the audit documentation.

Monitoring Compliance with Standards

Under its EQRO contract, AHS requested that HSAG continue to review one of the three sets of CMS standards applicable to Medicaid managed care organizations during each EQRO contract year. For contract year 2012–2013, AHS requested that HSAG conduct a review of the CMS Access Standards.

HSAG reviewed DVHA's performance related to 72 elements across the seven Access standards. Of the 71 applicable requirements, DVHA obtained a score of Met for 69 of the requirements and a score of Partially Met for two elements. As a result, DVHA obtained a total percentage-of-compliance score of 98.59% across the applicable elements, for a rounded score of 99.0% compliant.

Performance Improvement Validation

HSAG conducted a validation of the continuing annual submission of the DVHA PIP, *Increasing Adherence to Evidence-Based Pharmacy Guidelines for Members Diagnosed with Congestive Heart Failure*. The purpose of the study was to improve the appropriate use of medications for the treatment of congestive heart failure (CHF). DVHA's *Increasing Adherence to Evidence-Based Pharmacy Guidelines for Members Diagnosed with Congestive Heart Failure* PIP received a score of

96% for all applicable evaluation elements scored as *Met*, a score of 100% for critical evaluation elements scored as *Met*, and an overall validation status of *Met.*

EQRO Report 2014-2015

Performance Measures Validation

The EQRO conducted the validation of 13 performance measures for 2014 (CY 2013). 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 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.

Monitoring Compliance with Standards

The EQRO also 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. The performance audit focused on the following eight standards:

- Provider Selection;
- Credentialing and Re-Credentialing of Providers;
- Beneficiary Information;
- Beneficiary Rights;
- Confidentiality;
- Grievance System—Beneficiary Grievances;
- Grievance System—Beneficiary Appeals and State Fair Hearings ; and
- Sub-contractual Relationships and Delegation.

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. All programs either *Met* or *Partially Met* the required compliance standards. No programs were graded as having *Not Met* a required standard.

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."

Performance Improvement Validation

The PIP validation audit focused on DVHA's newest PIP, *Follow-up after Hospitalization for Mental Illness* and evaluated the technical methods of the PIP (i.e., the study design and implementation/evaluation). The PIP received an overall *Met* validation status when submitted.

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.

Quality Assurance and Performance Improvement Activities

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 Quality Committee focused during the Demonstration period 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 cost of health care.

In 2014 the Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys were completed. DVHA's contracted vendor, WBA Research, distributed and collated both the Adult and Children's Medicaid CAHPS 5.0H surveys.

Throughout the Demonstration period 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. Training was delivered via the online web portal of DVHA's HEDIS vendor for medical record abstractions.

During the Demonstration period the AHS Performance Accountability Committee (PAC) recommended performance measures for the GC Waiver and for the Medicaid/Shared 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. Now that the Choices for Care waiver has been consolidated with the Global Commitment waiver, the group has added long-term services and

supports (LTSS) measures to 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.

The AHS Quality Improvement Manager engaged members of the PAC in a review of the Quality Strategy based on the findings of the final EQRO Annual Technical Report. In addition, the group has reviewed the CMS Quality Strategy resource documents. To accommodate the quality assessment and improvement activities associated with the Choices for Care 1115 Waiver, which was consolidated with the GC waiver effective January 30, 2015, an updated version of the strategy was reviewed by the AHS Integrated Operations and Planning Team (IOPT) and AHS Executive Committee, and made available for public comment. The final document was forwarded to CMS for review/approval.

Appendix E: Compliance with Public Notice Process

Outlined below is a summary of 42 CFR 431.408 public process requirements and how the state has complied with federal regulations. Also included are comments received, the state's response, and any changes to the waiver that were made as a result of the public process.

Public Comment Period: The CFR requires a 30-day comment period. The state's public comment period on the Global Commitment to Health 1115 Waiver extension request was from November 4 through December 10, 2015.

Public notice of the application: On October 30, 2015, the draft *Global Commitment to Health Demonstration* renewal request, the public notice, and executive summary of the draft were posted online. Materials were available on the following websites: DVHA, the Agency of Human Services, and the Agency of Administration Health Care Reform home pages. All *Global Commitment to Health* Waiver documents, including extension information, are available year-round on DVHA's website.

On 11/1/15, a public notice was published in the *Burlington Free Press* announcing the availability of the draft renewal request, two public hearing dates, the online website, and the deadline for submission of written comments with contact information. Additionally, all district offices of the Department for Children and Families' Economic Services Division, the division responsible for health care eligibility, posted the notice and had proposal copies available, if requested. The *Burlington Free Press* is the state's newspaper with the largest statewide distribution and paid subscriptions.

On 11/13/15, a public notice and link to the renewal documents were included on the banner page for Vermont's Medicaid provider network.

Comprehensive description of the proposed Demonstration extension: The state posted a comprehensive description of the proposed Demonstration request on October 30, 2015, on the above-cited websites. The document included: program description, goals and objectives; a description of the beneficiary groups that will be impacted by the demonstration; the proposed health delivery system and benefit and cost-sharing requirements impacted by the demonstration; estimated increases or decreases in enrollment and in expenditures; the hypothesis and evaluation parameters of the proposal; and the specific waiver and expenditure authorities it is seeking. In addition to the draft posted for public comment, an Executive Summary and the PowerPoint presentation used during each public hearing was also posted to the same state websites noted above

Public Hearings: The state convened to two public hearing on the Global Commitment to Health 1115 Waiver renewal request.

On November 12, 2015, from 2:00 to 2:30 PM, a public hearing was held during the Department of Disabilities, Aging, and Independent Living (DAIL) Advisory Board meeting in Montpelier, Vermont.

On November 23, 2015, from 3:00 to 3:30 PM., a public hearing was held during the Medicaid and Exchange Advisory Board meeting in Winooski

Both hearings offered teleconferencing for individuals who could not attend in person.

Use of an electronic mailing list to notify the public: On 10/30/15, the Draft *Global Commitment to Health Demonstration* extension Request was distributed simultaneously to the Medicaid and Exchange Advisory Board, the committees of jurisdiction in the Vermont legislature, the DAIL Advisory Board, Department of Children and Families (DCF) District Offices, State Innovation Model Stakeholders, DAIL, DMH, VDH, and other external stakeholders as well as internal management teams from across AHS.

Tribal Government Notification: The State of Vermont has no federally recognized Indian tribes or groups.

Public Comments and Associated Responses

All public comment received and the State's responses are posted on the DVHA's website and included for reference as Attachment 2 of this document. The State has made no changes to this extension request. The administration is acting under legislative direction to pursue a no change extension. Under the current Demonstration, the Vermont Medicaid program has the federal authority to engage providers in an Accountable Care Organization and/or other models that that enable the State to engage in payment reform that transitions payment from volume based to quality based. If these flexibilities are compromised as part of the federal approval process, Vermont may need to pursue alternative authorities under the Demonstration to permit it to move forward with health reform. However, any substantive change in the Global Commitment to Health Demonstration model or approaches used in the Medicaid program would also require legislative approval.

Attachment 1:

Interim Demonstration Evaluation Report
October 2013 to January 2015

PHPG

The Pacific Health Policy Group

INTERIM PROGRAM EVALUATION

Global Commitment to Health
Section 1115 Demonstration

11-W-00194/1

On behalf of:

State of Vermont
Agency of Human Services

Prepared by:

The Pacific Health Policy Group

December 2015

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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, 2017, through December 31, 2021. This evaluation reports the Demonstration's progress for the period of October 2013 to January 30, 2015, based on the reporting requirements contained in the Special Terms and Conditions in effect prior to the January 2015 Demonstration Amendment. For this evaluation, preliminary data on Choices for Care has been included; however, prior to the January 2015 Amendment, GC and Choices for Care evaluations were performed separately. The goal areas examined in this evaluation include:

- Increasing access to affordable and high-quality health care, with an emphasis on primary care;
- Improving the health care delivery for individuals with chronic care needs;
- Containing health care costs; and
- Allowing beneficiaries a choice in long-term services and supports and providing an array of home- and community-based alternatives recognized to be more cost-effective than institutional-based supports.

This 2015 interim evaluation relies on 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.

In September 2014 Vermont submitted a separate evaluation of its Vermont Premium Assistance (VPA) program. Specifically, the state may claim Marketplace premium subsidies as allowable expenditures under the GC Section 1115 Demonstration waiver for individuals with incomes up to and including 300% of the Federal Poverty Level (FPL). Vermont provides subsidies on behalf of individuals who are not Medicaid eligible, are eligible for the advance premium tax credit (APTC) for health plans purchased through Vermont Health Connect (VHC), and who have household income up to and including 300% of FPL.

CMS has set annual limits for gross expenditures for which federal financial participation is available. During the transition to Affordable Care Act, Vermont estimated that approximately 19,222 individuals would move from Medicaid waiver expansion programs into the Marketplace. An interim study of the marketplace subsidy program was conducted in 2014. Based on Vermont Health Connect (VHC) data at the time of the evaluation report, approximately 90%, or 17,377 covered persons who may have otherwise been part of this former group were benefiting from the VPA program.

Preliminary VHC data suggest that the program is attracting persons in income categories above 133% who may have otherwise applied for VHAP, Catamount, or Employer-Sponsored Premium Assistance pre-January 1, 2014. As of the fourth quarter of 2015, enrollment in VPA was 16,906.

Vermont has recently submitted to CMS its revised Evaluation Plan for the remainder of the Demonstration period. The revised evaluation design addresses the requirements in the Global Commitment Special Terms and Conditions, as approved on January 30, 2015, Paragraph 63:

> *The state must submit to CMS for approval a draft evaluation design for an overall evaluation of the demonstration no later than 120 days after CMS' approval of the demonstration amendment. At a minimum, the draft design must include a discussion of the goals and objectives set forth in section II "Program Description and Objectives," as well as the specific hypotheses that are being tested, including those indicators that focus specifically on the target populations and the public health outcomes generated from the use of demonstration funds. The evaluation must take into account lessons learned from the evaluation of demonstration periods prior to the current renewal period. The evaluation design must also discuss the state's plans to evaluate the Marketplace subsidy program. The draft design must discuss the outcome measures that will be used in evaluating the impact of the demonstration during the period of approval. It must discuss the data sources and sampling methodology for assessing these outcomes. The draft evaluation design must include how the state will evaluate the impact that charging premiums has on children's coverage. The draft evaluation design must include a detailed analysis plan that describes how the effects of the demonstration must be isolated from other initiatives occurring in the state. The draft design must identify whether the state will conduct the evaluation, or select an outside contractor for the evaluation.*

All of the elements contained in Paragraph 63 will be addressed in future evaluations.

Background on Health Care Reform in Vermont

The Vermont Legislature passed comprehensive health care reforms in 2006, augmented in subsequent years, to expand access to coverage, improve the quality and performance of the health care system, and contain costs. The reforms encompassed 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.

Act 48 of 2011 furthered Vermont's health care reform efforts with the creation of the Green Mountain Care Board. The GMCB is an independent regulatory board charged with ensuring that changes in the health system improve quality while stabilizing costs. The Legislature assigned the GMCB three main health care responsibilities: regulation, innovation, and evaluation. The GMCB regulates health insurance rates, approves benefit plans for the Vermont Health Connect Benefit Marketplace, sets hospital budgets, and issues certificates of need for major hospital expenditures. The Board is the locus of payment and delivery system reform and a co-signatory of Vermont's SIM grant. Additionally, the GMCB acts as an important convener of the stakeholder community. Beyond these responsibilities, the Green Mountain Care Board is empowered by statute to:

- **Improve** the health of Vermonters;
- **Reduce** the rate of growth of Vermont's health care costs;
- **Enhance** the quality of care and experience of patients and providers;
- **Recruit** high-quality health care professionals to practice in Vermont; and
- **Simplify** and streamline administrative and claims processes to reduce overhead and enhance efficiency.

Vermont remains at the forefront of state-based health care reform. Future goals envision the creation of an all-payer model of care. All Payer efforts include the continued alignment of the Global Commitment (GC) to Health Section 1115 Demonstration and current State Innovation Model (SIM) work with the State's pursuit of related Medicare waivers. These efforts aim to increase value-based payments, accelerate payment reform, and put total health care spending on a more sustainable trajectory. Within the overall health reform framework, Vermont's Medicaid goal is to maintain the public managed care model to ensure maximum ability to serve Vermont's most vulnerable and lower-income residents while moving towards broader state and federal health care reform goals.

Background on Global Commitment

For more than two decades, the State of Vermont has been a national leader in making affordable health care coverage available to low-income children and adults, and providing innovative system reforms to support enrollee choice and improved outcomes. Vermont was among the first states to expand coverage for children and pregnant women, accomplished in 1989 through the implementation of the state-funded Dr. Dynasaur program, which later in 1992 became part of the state-federal Medicaid program. When the federal government introduced the Children's Health Insurance Program (CHIP) in 1997, Vermont extended coverage to uninsured and under-insured children living in households with incomes below 300% of the Federal Poverty Level (FPL). Effective January 1, 2014, Vermont incorporated the CHIP program into its Medicaid State Plan, with the upper income limit expanded to 312% FPL (the MAGI-converted income limit).

In 1995, Vermont implemented a Section 1115(a) Demonstration, the Vermont Health Access Plan (VHAP). The primary goal was to expand access to comprehensive health care coverage through enrollment in managed care for uninsured adults with household incomes below 150% (later raised to 185% of the FPL for parents and caretaker relatives with dependent children in the home). VHAP also included a prescription drug benefit for low-income Medicare beneficiaries who did not otherwise qualify for Medicaid. Both Demonstration populations paid a modest premium on a sliding scale based on household income. The VHAP waiver also included a provision recognizing a public managed care framework for the provision of services to persons who have a serious and persistent mental illness, through Vermont's Community Rehabilitation and Treatment program.

While making progress in addressing the coverage needs of the uninsured through Dr. Dynasaur and VHAP, by 2004 it became apparent that Vermont's achievements were being jeopardized by the ever-escalating cost and complexity of the Medicaid program. Recognizing that it could not spend its way out of projected deficits, Vermont worked in partnership with CMS to develop two new innovative 1115 demonstration waiver programs, Global Commitment to Health (GC) and Choices for Care (CFC). As explained in more detail below, the GC and CFC Demonstrations have enabled the state to preserve and expand the affordable coverage gains made in the prior decade, provide program flexibility to more effectively deliver and manage public resources, and improve the health care system for all Vermonters.

Effective January 30, 2015, Vermont received CMS approval to consolidate the Global Commitment and Choices for Care Demonstrations into one 1115(a) Demonstration, the current Global Commitment to Health.

According to the GC's Special Terms and Conditions (STCs), Vermont operates its managed care model in accordance with federal managed care regulations found at 42 CFR 438. The Agency of Human Services

(AHS), as Vermont's Single State Medicaid Agency, is responsible for oversight of the managed care model. The Department of Vermont Health Access (DVHA) operates the Medicaid program as if it were a Managed Care Organization in accordance with federal managed care regulations. Program requirements and responsibilities are delineated in an inter-governmental agreement (IGA) between AHS and DVHA. CMS reviews the IGA annually to ensure compliance with the Medicaid managed care model and the Demonstration Special Terms and Conditions. DVHA also has sub-agreements with the other state entities that provide specialty care for GC enrollees (e.g., mental health services, developmental disability services, and specialized child and family services). As such, since the inception of the GC Demonstration, DVHA and its IGA partners have modified operations to meet Medicaid managed care requirements, including requirements related to network adequacy, access to care, beneficiary information, grievances, quality assurance, and quality improvement. Per the External Quality Review Organization's findings, DVHA and its IGA partners have achieved exemplary compliance rates in meeting Medicaid managed care requirements.

Under the current waiver structure, the State has agreed to an aggregate budget neutrality limit. In addition, total annual funding for medical assistance is limited based on an actuarially determined, per member per month limits. AHS uses prospectively derived actuarial rates for the waiver year to draw federal funds and pay DVHA a per member per month (PMPM). This capitation payment reflects the monthly need for federal funds based on estimated GC expenditures. On a quarterly basis, AHS reconciles the federal claims from the underlying GC expenditures on the CMS-64 filing. As such, Vermont's payment mechanisms function similarly to those used by state Medicaid agencies that contract with private managed care organizations to manage some or all of the Medicaid benefits.

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 interim evaluation of the GC Demonstration and its performance relative its goals. Specifically, PHPG was directed to compile findings related to:

Goal	Evaluation
Goal 1: Increase Access to Care	• Evaluation of Global Commitment's ability to increase Medicaid beneficiary access to primary care
Goal 2: Enhance Quality of Care	• Evaluation of the extent to which Global Commitment has enhanced the quality of care for Medicaid beneficiaries
Goal 3: Control Cost of Care	• 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
Goal 4: Allow Choice of LTSS Setttingss	• Evaluation of Global Commitment's ability to allow choice in LTSS and provide an array of HCBS alternatives that are more cost effective

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

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

- Global Commitment to Health Enrollment 2008-2014
- 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, and 2014)
- 2012-2015 External Quality Review Organization (EQRO) Technical Reports
- 2013-2014 HEDIS Measures
- 2012 and 2014 Consumer Assessment of Health Provider and Systems (CAHPS) Survey
- 2014 Vermont Chronic Care Initiative Annual Report for State Fiscal Year 2013
- 2014 Blueprint for Health Annual Report, as revised January 2015
- 2014 Global Commitment to Health Demonstration Annual and Quarterly Reports to CMS
- Choices for Care Program Evaluations
- Choices for Care Data Report July 2015
- 2014 LTSS Consumer Survey Report
- Vermont 2015: Reforming Vermont's Mental Health System, Report to the Legislature on the Implementation of Act 79, January 2015
- Integrated Family Services: Early Indicators of Success, 2014
- NCQA, State of Health Care Quality 2014.

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 in increasing access to care for Vermont Medicaid beneficiaries as measured in the following areas:

- *Overall Enrollment:* Total enrollment grew by almost 36% between 2005 and 2014.

- *Number of Uninsured:* The 2014 Vermont Household Health Insurance Survey found that Vermont's uninsured rate was cut by 45% over the past two years. The 3.7% rate put Vermont second in the nation in health insurance coverage. By November 1st of 2014, over 140,000 Vermonters had received coverage through Vermont Health Connect, including 32,237 enrolled in Qualified Health Plans

- *HEDIS Measures:* Vermont achieved improvement in HEDIS access-to-care measures and in scores achieved by accredited Medicaid HMO's as reported in the NCQA 2014 *State of Health Care Quality Report*.

  - Significantly higher (14%) than the accredited Medicaid HMO average of 61.6% for Well Child Visits in the First 15 months of Life;
  - Annual dental combined rate significantly higher (20.88%);
  - Higher rates for Child/Adolescent Access to PCP; and
  - High scores related to Adult Access to Preventive and Ambulatory Care, 84.21% to 94.31% across the adult years.

- *Beneficiary Satisfaction:* According to the 2014 CAHPS, most respondents are getting needed care (86%), getting care quickly (83%), and are satisfied with how doctors communicate (88%) and coordinate care (80%).

- *Access to Medicaid Assistance Treatment (MAT) for Opioid-Dependence:* AHS is collaborating with community partners to increase access to MAT for patients through the use of a Specialized Health Home program. CMS approved Specialized Health Home State Plan Amendments for Vermont's Integrated Treatment for Opioid Dependence's "Hub and Spoke" Initiative in January and March of 2014. The initiative includes regional treatment centers (i.e., Hubs) along with community support (i.e., Spokes) integrated with the Blueprint for Health model and office based practices statewide. The "Hubs," which began operations in late CY13, had caseloads of 2,542 statewide as of September 2014. Specialized statewide staff are also in more than 50 different practice settings, including OB-GYN, psychiatry, pain, and primary care specialties.

To support the Hub & Spoke practice reforms, the Blueprint (in collaboration with the VDH Division of Alcohol and Drug Abuse) convened six regional learning collaboratives focused on Medication Assisted Treatment (MAT) for opiate addiction in 2013 and 2014. The opioid addiction treatment collaborative included measures for monthly urine analysis, treatment retention, and rates of patients receiving above the recommended dose or more than 16 mg of Buprenorphine daily (a risk for diversion). From August 2012 to October 2013, the trend line is upward for monthly urine drug screening and continuing treatment at six months, and a downward trend in the number of patients receiving more than the recommended dose of buprenorphin.

- *Access to Mental Health Treatment:* The abrupt closure of Vermont's only state-run psychiatric hospital, due to flooding from Tropical Storm Irene in 2011, resulted in significant legislative investments in the community mental health system. Vermont has continued to enhance the mental health system to reduce its reliance on institutional care. Small-scale psychiatric centers, enhanced mobile crisis teams, peer-run recovery options and hospital diversion programs have been supported as the Department of Mental Health continues to promote a more person-centered, flexible, and community-based system of care.

  Between 2008 and 2013, State Hospital utilization decreased from 0.41 per 1000 population to 0.4, well below the national average in 2013 of 0.47. Utilization of inpatient psychiatric care has increased from 0.46 to 0.72; however, 0.72 is still below the national average of 1.34. The number of individuals served in the community per 1,000 populations in Vermont is 38, or 75% higher than the national figure. These data show that Vermont is achieving success in moving care from the highest levels of hospitalization to least restrictive settings in the community.

- *Blueprint for Health:* Primary care practices gained formal recognition as Patient Centered Medical Homes (PCMHs) for the first time and others re-scored against the National Committee for Quality Assurance (NCQA) quality standards. As of December 2014, there were 124 primary care practices operating in Vermont as PCMHs supported by multi-disciplinary Community Health Teams. These 124 practices represent approximately 58% of the primary care practices licensed in Vermont and an increase from the 121 practices certified in 2012.

Goal 1: Data and Related Initiatives

Global Commitment Enrollment for 2008-2012

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 Evaluation Plan, 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 2008 through FFY 2014.

Table 1-1: Global Commitment Average Number of Enrollees

Federal Fiscal Year (FFY):	2008	2009	2010	2011	2012	2013	2014
Total Lives (Member Months / 12)	129,274	141,323	154,855	162,287	164,414	166,174	172, 121

Table 1-1 shows that enrollment has increased by 33% since 2008.

Department of Financial Regulation (formerly BISHCA) Household Health Insurance Survey (2001-2006; 2008, 2012, and 2014)

According to the Health Insurance Group Profile of Vermont Residents, 2001-2006, and the 2008, 2012, and 2014 Vermont Household Health Insurance Survey, Table 1-2 on the following page summarizes the number of Vermonters insured under the private market, government, and uninsured from 2005 to 2014.

Table 1-2 data is derived from participant self-report and does not include instances where Medicaid may be a secondary payer or those with dual Medicare and Medicaid coverage; thus, information does not correspond to actual enrollments identified in Table 1-1 above. Based on survey findings:

- The number of uninsured Vermonters has decreased by 45% between 2012 and 2014.
- The uninsured rate in Vermont has been consistently below the national rate throughout the life of the GC Demonstration, most recently in 2014, 3.7% compared to 13.4% (national rate for 2013, the most recent U.S. Census data available).

Table 1-2: Vermont Health Insurance Coverage 2005-2014

	2005	2008	2009	2012	2014	2005	2008	2009	2012	2014
Private Insurance*	59.4%	59.9%	57.2%	56.8%	54.4%	369,348	370,981	355,358	355,857	341,077
Medicaid	14.7%	16.0%	17.6%	17.**9%**	21.2%	91,126	99,159	109,353	111,833	132,829
Medicare	14.5%	14.3%	15.3%	16.0%	17.7%	90,110	88,915	95,182	100,505	110,916
Military	1.6%	2.4%	2.2%	2.5%	3%	9,754	14,910	13,917	15,477	18,578
Uninsured	9.8%	7.6%	7.6%	6.8%	3.7%	61,057	47,286	47,460	42,760	23,231

2014 HEDIS Measures

Table 1-3 on the following page shows four HEDIS measures used to evaluate access to primary care for 2013 and 2014. Where available, data are displayed with comparisons made to NCQA-reported averages for accredited Medicaid HMO scores for 2014. 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; Adolescent Well Care; and Child/Adolescent Access to PCP.

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

HEDIS Measure	VT EQRO Year		VT Average: 2013-2014	NCQA Accredited Medicaid HMO Average	VT vs. NCQA HMO Average
	2013	2014			
Well Child Visits 1st 15 Months (6 or more)	75.23%	75.96%	75.59%	61.6%	13.99%
Well Child 3rd, 4th, 5th, 6th year	69.32%	71.49%	70.41%	71.5%	-1.09%
Adolescent Well Care	46.27%	46.97%	46.62%	50.0%	-3.38%

HEDIS Measure	VT EQRO Year		VT Average: 2013-2014	NCQA Accredited Medicaid HMO Average	VT vs. NCQA HMO Average
	2013	2014			
Annual Dental Combined <21 years	68.23%	67.72%	67.98%	47.1%	20.88%
Child/Adolescent Access to PCP					
12-24 months	98.31%	98.55%	98.43%	96.1%	2.33%
25 months-6 years	91.70%	92.13%	91.92%	88.3%	3.62%
7-11 years	94.48%	94.46%	94.47%	90.0%	4.47%
12-19 years	93.73%	93.90%	93.82%	88.5%	5.32%

*n/a – not available

Table 1.3 can be summarized as follows:

- The Well-Child Visits in the First 15 months of Life rate was significantly higher than the accredited Medicaid HMO scores for 2014 (13.99% higher).
- The Annual Dental Combined rate for children less than 21 years was 20.88% higher than the 2014 HEDIS score.
- The Child/Adolescent Access to PCP scores were somewhat higher than the HEDIS score for 2014.
- Well-Child Visits (ages 3 -6 years) and Adolescent Well Care fell slightly below the Medicaid HMO scores in 2014.

The table below shows the comparison of some of Vermont's adult access rates against HEDIS national averages, if available:

Table 1-4 Adult Access Measures

Measure	VT EQRO Year		NCQA Accredited Medicaid HMO Average
	2013	2014	
Adult Access to Preventative/Ambulatory Care			
20-44 years	84.09%	84.21%	n/a
45-64 years	88.93%	89.37%	n/a
65 and over	93.04%	94.31%	n/a
Total	86.94%	87.32%	n/a
Anti-Depressant Medication Mgt			
Effective Acute phase Treatment	68.81%	63.30%	50.5%
Continuation Phase Treatment	51.98%	44.12%	35.2%

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 Vermont achieved a significantly higher score than the national

average for 2014 for Antidepressant Medication Management: Acute and Continuation Phase (by 12.8% and 8.92% respectively).

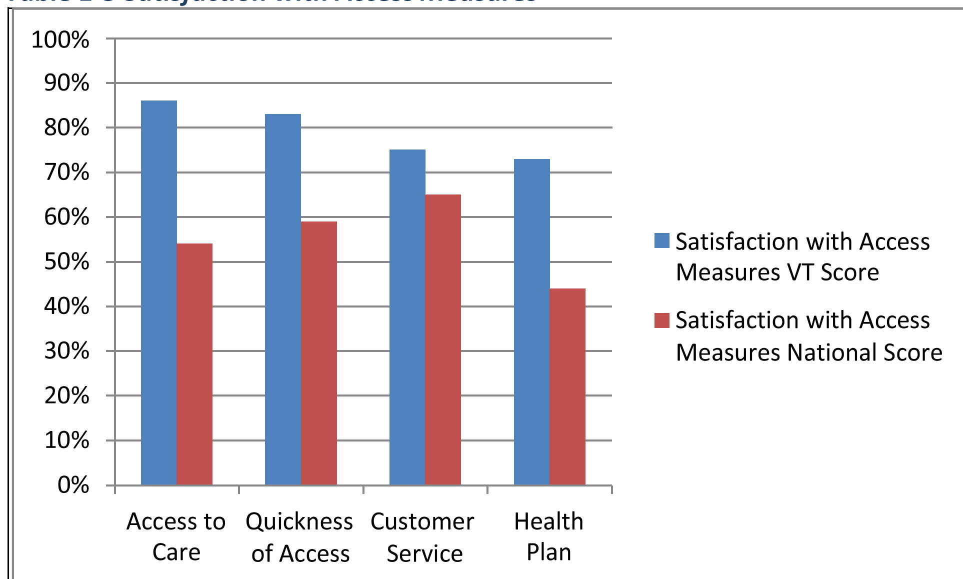
2014 Customer Assessment of Health Care Providers and Systems (CAHPS) Survey

DVHA contracted with a private vendor, WBA Market Research, who assisted in the administration and scoring of the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan 5.0H Adult Medicaid survey. DVHA added questions to the CAHPS Health Plan 5.0H Adult Medicaid survey for a total of 58 questions. Among Vermont adult members, a total of 252 valid surveys were completed between February and May 2014. Specifically, 189 were returned by mail and 63 were conducted over the telephone. The overall response rate for 2014 was 44%. Beneficiaries received an introductory mailing, a survey mailing, and a follow up reminder postcard after which beneficiaries are contacted by phone.

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

- 86% of Vermont beneficiaries report satisfaction with access to care, as compared to 54% of Medicaid beneficiaries nationally.
- 83% of Vermont beneficiaries report satisfaction in getting needed care quickly as compared to 59% of Medicaid beneficiaries nationally.
- 75% of Vermont beneficiaries report satisfaction with customer service as compared to 65% of Medicaid beneficiaries nationally.
- 73% of Vermont beneficiaries report satisfaction with their health plan as compared to 44% of Medicaid beneficiaries nationally.

Table 1-5 Satisfaction with Access Measures



In addition, according to the 2014 CAHPS data, most respondents are satisfied with provider punctuality, availability (in both urgent and non-urgent situations), attentiveness, and coordination of care.

The 2014 CAHPS Child Survey showed similar responses from parents, with parents expressing a satisfaction rate of 87% for their children's access to care, 94% for getting care quickly, 86% for customer service, and 85% for health plan overall.

Hub and Spoke Initiative: Integrated Treatment for Opioid Dependence

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 Community Health Team (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.

As stated above, the Hub and Spoke learning collaboratives have demonstrated positive results in measures relating to monthly urine drug screening, continuing treatment, and the receipt of buprenorphine doses that are higher than recommended.

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, with a focus on beneficiaries with chronic conditions.

Goal 2: Highlights

The GC Demonstration has succeeded in enhancing the quality of care for Vermont Medicaid beneficiaries 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 2014.
- *HEDIS Measures:* Vermont scored above the 75th percentile for several 2014 HEDIS measures related to quality.
- *Performance Improvement Project (PIP):* In 2014 DVHA' s new PIP, *Follow-up after Hospitalization for Mental Illness,* received a score of 100% for all applicable evaluation elements scored as *Met*, a score of 100% for critical evaluation elements scored as *Met*, and an overall validation status of *Met.*
- *Vermont Chronic Care Initiative (VCCI):* VCCI has made improvements in health outcomes for Vermont's highest-risk Medicaid beneficiaries. SFY13 utilization change offers further evidence of this strategy with documented reduction of Acute Ambulatory Care Sensitive Conditions inpatient admissions by 37%, 30-day hospital readmission rates by 34%, and an ED utilization decline of 17% for eligible VCCI members (top 5% utilization category).
- *Blueprint for Health:* Medicaid is an active partner in Vermont's Blueprint for Health. In 2014 Blueprint participants had lower hospitalization rates and lower expenditures on pharmacy and specialty care. In spite of lower expenditures, the results for measures of effective and preventive care for Blueprint participants were either better for participants or similar for both Blueprint and comparison groups (cervical cancer screening, breast cancer screening, imaging studies for low back pain, and five Special Medicaid Services (SMS), such as transportation, residential treatment, dental, and home- and community-based services.

  As of December 2014 there are 124 primary care practices operating in Vermont as patient-centered medical homes (PCMHs) supported by multi-disciplinary community health teams

(CHTs). In this program, each practice is scored against the National Committee for Quality Assurance (NCQA) PCMH recognition program standards for high-quality patient centered care.

- *Integrated Family Services Program (IFS):* 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.). Vermont has worked to integrate a variety of separate and discreet children and family services funded under the Medicaid program. Using a bundled payment approach to provider reimbursement, several disparate Medicaid programs were unified in a single payment model with clear provider expectations for treatment. This unified care coordination should reduce duplication and close gaps in the system, especially at pivotal transition times. In FFY14, the one AHS district with a fully implemented IFS program showed positive outcomes for clients and more efficient service delivery with the same level of funding providers received in previous years. In addition, there was a nearly 50% decrease in crisis interventions needed for children, and a lower rate of children and youth coming into state custody, since the community now has the flexibility to provide supports and services earlier than they were able to under the traditional fee-for-service model. A second IFS district has since been added, for which baseline data are currently being established.

Goal 2: Data and Related Initiatives

2014 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.

Since 2007 HSAG reports observing tremendous growth, maturity, and substantively improved performance results across all three activities. In 2014 Vermont's (public) Medicaid Managed Care model has achieved the following scores relative to the three mandatory areas of EQR:

1. Average Overall Percentage of Compliance Score of 92% for eight standards reviewed, including provider selection and credentialing, beneficiary information and rights, confidentiality, and grievance system, improved from 90% three years ago (the last time these standards were measured);
2. A 100% *Met* score for The *Follow-up after Hospitalization for Mental Illness* PIP critical evaluation elements and overall evaluation elements in the Study Design, Implementation, and Evaluation stages; and
3. A passing score on the validation of 13 performance measures for 2014 (CY 2013). 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.

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 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 that has led to its current role and functioning as a strong, goal-oriented, innovative, and continuously improving Medicaid Managed Care model.

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."

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 2014 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;
  - ✓ Use of appropriate medications for adults age 51-64 with asthma;
  - ✓ Children's and Adolescents' Access to Primary Care Practitioners (all indicators); and
  - ✓ Annual Dental Visits measure, which involve distinct provider specialties.
- Vermont's Performance Improvement Project (PIP), *Increasing Adherence to Evidence-Based Pharmacy Guidelines for Members Diagnosed with Congestive Heart Failure*, received a score in the 2011-2012 EQRO review 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.

<u>Vermont Chronic Care Initiative</u>

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 in eventually self-managing their chronic conditions. VCCI has targeted the top 5% of Medicaid utilizers, who account for 39% of Medicaid costs.

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. The VCCI has now expanded its services to include all age groups and to 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.

SFY13 utilization change offers further evidence of this strategy with documented reduction of Acute Ambulatory Care Sensitive Conditions inpatient admissions by 37%, 30-day hospital readmission rates by 34%, and an ED utilization decline of 17% for eligible VCCI members. In addition, in comparison with non-participants who were also in the top 5% utilization category, VCCI participants showed higher rates of prescription filling and monitoring for asthma, systolic heart failure, coronary artery disease, and depression, and higher rates of testing for diabetes, hypertension, and hyperlipidemia.

Blueprint for Health

In each area of the state, participating Patient Centered Medical Homes (PCMHs) and Community Health Teams (CHTs) have organized their operations to meet the NCQA medical home standards. This process is supported by Practice Facilitators, planning and learning forums, and by the network of self-management programs that help practices meet a particularly challenging section of the standards (Support Self-Care Process). A team based at the University of Vermont, in the Vermont Child Health Improvement Program, scores each practice to assure a consistent and independent assessment of health care quality. As of Blueprint's 2014 annual report, this approach has led to successful recognition of 124 practices serving 347,489 patients, successful re-scoring of 61 practices, and a statewide base of primary care tested against difficult national standards.

Perhaps the most important innovation in the Blueprint is the CHT concept, which recognizes 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. The teams 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.

In 2014 Blueprint participants had lower hospitalization rates and lower expenditures on pharmacy and specialty care. In spite of lower expenditures, the results for measures of effective and preventive care for Blueprint participants were either better for participants or similar for both Blueprint and comparison groups (cervical cancer screening, breast cancer screening, imaging studies for low back pain, and five Special Medicaid Services (SMS), such as transportation, residential treatment, dental, and home and community based services).

In 2014 the Blueprint continued to develop a system of integrated health care services and build on the program's foundation of delivery system and financial reforms. Specifically:

- Primary care practices gained formal recognition as Patient Centered Medical Homes for the first time and others re-scored against the National Committee for Quality Assurance (NCQA) quality standards. As of December 2014, there were 124 primary care practices operating in Vermont as PCMHs supported by multi-disciplinary CHTs. These 124 practices represent approximately 58% of the total number of primary care practices licensed in Vermont and an increase from the 121 practices certified in 2012.
- Community Health Team (CHT) operations matured, and the CHTs worked to coordinate care across medical and community partnering organizations.
- Local multi-stakeholder workgroups, staffed by the Blueprint, focused on bridging health and human services to maximize available resources, improve outcomes, and drive clinical quality improvement.
- A new unified reporting capability for clinical, cost, and utilization measures produced timely reports across all payers at the practice, Health Services Area, and state levels. These reports form the basis for aligning local and statewide quality improvement efforts.

The Centers for Disease Control's Diabetes Prevention Program is a renowned, evidence-based program designed to help adults at high risk of developing Type 2 Diabetes in adopting and maintaining healthy lifestyle choices. In 2014, the Greater Burlington YMCA and the Blueprint continued their strategic partnership to offer the YMCA's Diabetes Prevention Program. The program has shown promising outcomes. The average weight loss has been 5.2% of body weight at completion of the 16-week core

class and 5.9% of body weight at year end. More than 86.4% of participants reported improved overall health with 89.8% reporting reduced portion sizes and 83.1% reporting increased physical activity.

Vermont Health Care Innovation Project (VHCIP)

VHCIP, which is funded by the State Innovation Model (SIM) grant, developed a common set of core measures for the Medicaid and Commercial Insurance shared savings programs. VHCIP also made significant investments in the three Provider Networks (ACOs) to build capacity for quality improvement, data analytics, and care redesign. In 2014 VHCIP awarded $4,903,145 to fourteen provider entities for innovation projects and worked to develop a Care Coordination Collaborative. With the support from VHCIP grants, the Provider Networks, and the Blueprint for Health worked together to plan a unified approach to local health system development and reform.

Vermont convened stakeholders and agreed on a set of quality of care metrics for the Medicaid ACOs in December 2013. These metrics include and add to the 33 metrics used for Medicare shared savings ACOs and are included in the ACO contracts. The metrics include health care quality (e.g., ischemic vascular disease), patient satisfaction (e.g., provider office follow-up after a blood test), health care delivery (e.g., LDL control), and cost (e.g., total cost of care).

2014 HEDIS Measures

HEDIS measures for quality of care are summarized below. Comprehensive Diabetes Care scores have improved slightly from 2013 to 2014, but are still lower than NCQA accredited Medicaid HMO scores; this is an area noted for improvement in the 2014 EQRO report. Although Appropriate Medication for Asthma 12-64 years old scores remain at or above the NCQA average, improvement is needed in both the 5-11 range and the total score. As noted earlier, scores related to Antidepressant Medication Management continue to be well above the national averages for both years.

Table 2-1 HEDIS Quality Measures

HEDIS Measure	VT EQRO Year		VT Average: 2013-2014	NCQA Medicaid Accredited HMO's Average	VT vs. NCQA HMO Average
	2013	2014			
Comprehensive Diabetes Care					
HbA1c testing	64.19%	65.07%	64.63%	83.8%	-19.7%
Eye Exams	46.68%	47.03%	46.86%	53.6%	-6.74%
LDL-C Screens	45.03%	46.24%	45.64%	76.0%	-30.36%
Medical Attention for Nephropathy	60.27%	61.36%	60.82%	79.0%	-18.18%
Appropriate Medication for Asthma					
5-11 yrs	88.24%	90.04%	89.14%	90.2%	-1.06%
12-18 yrs	88.42%	86.43%	87.43%	86.9%	0.53%
19-50	79.93%	75.92%	77.93%	74.4%	3.53%

HEDIS Measure	VT EQRO Year		VT Average: 2013-2014	NCQA Medicaid Accredited HMO's Average	VT vs. NCQA HMO Average
	2013	2014			
51-64	84.65%	80.62%	82.64%	70.3%	12.34%
Total	84.71%	82.41%	83.56%	84.1%	-0.54%
Anti-Depressant Medication Management					
Effective Acute Phase Treatment	68.81%	63.30%	66.06%	50.5%	15.56%
Continuation Phase Treatment	51.98%	44.12%	48.05%	35.2%	12.85%

Behavioral Health System of Care

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 DVHA 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 two-day training on the McKesson/InterQual behavioral health care criteria tool for internal DVHA staff, as well as for Vermont Department of Health, Department of Mental Health, and the Department for Children and Families. 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.

In 2014 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 is developing 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.

2014 Adult Consumer Assessment of Health Care Providers Survey (CAHPS)

Informed and shared decision making is an underlying tenet of Vermont's system of care. Person-centered and self-directed care has been at the forefront of home- and community-based service planning for decades and is a key element 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.

The 2014 CAHPS revealed these results for 2014:

Table 2-2 Person-Centered Care

CAHPS Survey Question	Positive Response
PCP informed and up to date on care	80%
Doctors communicate well	88%
Doctor asked what you thought was best for you	78%
Doctor talked about specific things you could do to prevent illness	73%

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 while adding significant quality and value to the health care system. The effectiveness of the GC cost containment efforts can be summarized as follows:

- *Decreased Expenditures:* The Demonstration generated a surplus associated with overall decreased expenditures relative to the aggregate budget neutrality limit (ABNL). Actual expenditures have been consistently below projected and the Demonstration surplus is projected to be $1.5 billion at the end 2016.
- *VCCI Savings:* In state fiscal year (SFY) 2013, the Vermont Chronic Care Initiative (VCCI) documented net savings of $23.5 million over anticipated expense among the top 5% of eligible Medicaid members (high utilizers).
- *Blueprint for Health Savings:* Year-to-year growth in health care expenditures was lower for Blueprint participants, particularly from 2011 forward as more of the 124 practices underwent preparation, scoring, and began working with community health teams. Participating providers have not seen an increase in payments, in spite of the improved outcomes and decreased costs, since the Blueprint launched in 2008.

  In 2013 per capita expenditures for Blueprint Medicaid practices were $5798, as opposed to $6469 for comparison practices, in spite of higher Blueprint expenditures for specialized services, such as transportation, HCBS, case management, dental, and others. These results suggest that the PCMH and CHT setting was associated with lower expenditures for traditional healthcare, and higher use of services targeted at social and economic disparities.

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:

- Growth in Total Expenditures, by Enrollment Group
- Growth in Expenditures per Member per Month, by Enrollment Group
- Comparison of Estimated Program Expenditures with and without the Demonstration.

<u>Growth in Total Expenditures, by Enrollment Group</u>

Table 3-1 shows total capitated spending for Global Commitment by enrollment group from 2011-2013. Also included in Table 3-1 is the average annual percent change over the three-year period.

Table 3-1: Summary of Expenditure Growth by Enrollment Group, Federal Fiscal Years 2011 - 2013

	Federal Fiscal Year			Average Annual Growth
	2011 (Oct '10-Sept '11)	2012 (Oct '11-Sept'12)	2013 (Oct '12-Sept '13)	
Capitation Payments				
ABD - Non-Medicare - Adult	$ 176,533,340	$ 196,401,943	$ 212,067,557	9.6%
ABD - Non-Medicare - Child	$ 98,394,380	$ 103,926,653	$ 100,722,261	1.2%
ABD - Dual	$ 223,405,044	$ 235,190,575	$ 252,340,195	6.3%
ANFC - Non-Medicare - Adult	$ 76,485,531	$ 86,130,995	$ 93,075,905	10.3%
ANFC - Non-Medicare - Child	$ 236,275,482	$ 257,918,575	$ 265,649,659	6.0%
Global Expansion (VHAP)	$ 180,323,101	$ 196,154,448	$ 207,557,724	7.3%
Global Rx	$ 7,800,691	$ 9,797,150	$ 10,622,700	16.7%
Optional Expansion (Underinsured)	$ 2,353,178	$ 3,030,604	$ 3,591,401	23.5%
VHAP ESI	$ 1,917,976	$ 1,659,423	$ 1,187,965	-21.3%
ESIA	$ 861,905	$ 843,777	$ 784,675	-4.6%
CHAP	$ 40,210,567	$ 40,930,244	$ 45,913,483	6.9%
ESIA Expansion - 200-300% of FPL	$ 298,915	$ 234,532	$ 119,679	-36.7%
CHAP Expansion - 200-300% of FPL	$ 18,276,722	$ 20,278,846	$ 25,819,475	18.9%
Total Capitation Payments	*$ 1,063,136,831*	*$ 1,152,497,766*	*$ 1,219,452,678*	*7.1%*

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 7.1% from 2011 to 2013.
- ✓ Total program expenditures grew more rapidly adult enrollment groups compared to children's enrollment groups.

Growth in Expenditures per Member per Month, by Enrollment Group

Table 3-2 shows total capitated spending per member per month by enrollment group from 2011-2013. Also included in Table 3-2 is the average annual percent change over the three-year period.

Table 3-2: Summary of Per Member, Per Month Expenditure Growth by Enrollment Group Federal Fiscal Years 2011 - 2013

	Federal Fiscal Year			Average Annual Growth
	2011 (Oct '10-Sept '11)	2012 (Oct '11-Sept'12)	2013 (Oct '12-Sept '13)	
ABD - Non-Medicare - Adult	$ 1,063.14	$ 1,166.93	$ 1,234.99	7.8%
ABD - Non-Medicare - Child	$ 2,218.64	$ 2,329.20	$ 2,278.63	1.3%
ABD - Dual	$ 1,151.67	$ 1,164.31	$ 1,225.19	3.1%
ANFC - Non-Medicare - Adult	$ 580.55	$ 632.97	$ 686.74	8.8%
ANFC - Non-Medicare - Child	$ 357.34	$ 388.23	$ 400.18	5.8%
Global Expansion (VHAP)	$ 406.08	$ 441.14	$ 461.89	6.7%
Global Rx	$ 51.33	$ 64.78	$ 70.00	16.8%
Optional Expansion (Underinsured)	$ 176.14	$ 240.41	$ 315.12	33.8%
VHAP ESI	$ 181.73	$ 168.13	$ 127.49	-16.2%
ESIA	$ 144.81	$ 150.43	$ 131.63	-4.7%
CHAP	$ 462.38	$ 441.42	$ 450.30	-1.3%
ESIA Expansion - 200-300% of FPL	$ 94.27	$ 80.93	$ 40.01	-34.8%
CHAP Expansion - 200-300% of FPL	$ 536.32	$ 527.18	$ 643.81	9.6%
Total	**$ 539.89**	**$ 577.82**	**$ 604.86**	*5.8%*

- ✓ Adjusted for caseload growth, the Global Commitment Demonstration experienced average annual expenditure growth of 5.8 percent between 2011 and 2013.
- ✓ Average annual per member per month expenditure growth for traditional Medicaid enrollment groups ranged from a low 1.3 percent (ABD Child) to a high of 8.8 percent (ANFC Adult).

Comparison of Estimated Expenditures with and without Demonstration

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 September 2013, including the federal share of any surpluses or deficits.

Table 3-3: Summary Comparison of Estimated Expenditures With and Without the Demonstration, Federal Fiscal Years 2011 - 2013

	Federal Fiscal Year		
	2011 (Oct '10-Sept '11)	2012 (Oct '11-Sept'12)	2013 (Oct '12-Sept '13)
Expenditures without Waiver			
Aggregate Budget Neutrality Limit	$ 1,165,191,563	$ 1,248,077,166	$ 1,337,393,583
Expenditures with Waiver			
Total Program Expenditures	$ 1,051,414,168	$ 1,140,277,616	$ 1,206,148,349
Annual Surplus (Deficit)	$ 113,777,395	$ 107,799,549	$ 131,245,234
Cumulative Surplus (Deficit)	$ 113,777,395	$ 221,576,944	$ 352,822,178
Percentage Savings	*9.76%*	*8.64%*	*9.81%*

- ✓ Average annual program savings were substantial and relatively consistent over the three-year period, with a range of 8.64 to 9.81 percent.
- ✓ Total program savings exceeded $350 million over the three-year period, with average annual savings of 9.4 percent.

Goal 4: Allow Choice of LTSS Settings

Supporting Individual Choice

The primary goal of Choices for Care is to support individual choice among a range or "menu" of long-term care services and settings. The Choices for Care Data Report for 2014 reveals that a large majority (approximately 85%) of participants receiving Home- and Community-Based Services (HCBS) report that they had good choice and control over home- and community-based services, and that these services were provided when and where they needed them. Consistent with recommendations from the state auditor and the independent evaluator, DAIL has been working with nursing home and enhanced residential care home representatives to collect and share similar information from residents of these facilities. This information would allow a more complete view of how CFC participants perceive their experience.

The results of the 2014 LTC Consumer Perception Survey suggest that the large majority of consumers are satisfied with DAIL programs, satisfied with the services they receive, and consider the quality of these services to be excellent or good. This high level of satisfaction continues a trend observed in the survey results since 2008. The programs are viewed by consumers as providing an important service that allows them to remain in their homes. Table 4-1 below shows some of the survey results specific to choice and quality:

Table 4-1: Summary of Survey Results for Choice and Quality

Measure	Percentage of Satisfied Respondents
Amount of choice and control	81%
Overall quality of help received	89%
Services meet daily needs	89%
Services provided according to person's choice	91%
Current residence is setting of choice	95%
Services received helped improve health	93%

Serving More People

One of the goals of Choices for Care is to serve more people. The number of people served by Choices for Care has increased substantially (by 12.4%) since it began in October 2005. This increase is in total CFC enrollment over time for those participants who meet traditional long-term care eligibility criteria; it excludes the Moderate Needs Group. If the moderate needs group is included, the increase jumps to 52.6%.

Shifting the Balance

Another goal of Choices for Care is to "shift the balance," serving a lower percentage of people in nursing homes and a higher percentage of people in alternative settings. Choices for Care has achieved

progress since 2005, with enrollment in HCBS and Enhanced Residential Care settings exceeding enrollment in nursing homes for the first time in March 2013. The total number of people served has also increased. As of the 2014 Data Report, the percentage of people residing in nursing facilities has decreased by 19% since 2005, whereas the percentage of people residing in community settings has increased by 74%. As of the date of this report, more than 52% of the people eligible for choices for Care were living in community-based settings.

In accordance with the goal of allowing more people to remain in their homes, the Blueprint for Health administers the Support and Services at Home Program (SASH). The SASH teams, based at publically subsidized housing sites, include a coordinator and a Wellness nurse for each panel of 100 people. SASH teams focus on assisting high-risk Medicare beneficiaries to live more satisfying lifestyles and age more safely in their homes.

Expanding the Range of Service Options

Choices for Care aims to expand the range of service options available to participants. In 2014 DAIL implemented Moderate Needs Flexible Choices, intended to give participants more choice and control over the services that they receive. Priority for Moderate Needs funding must be given to people on homemaker and adult day wait lists. The provider is responsible for managing the agency's Moderate Needs budget. In order to do this, each agency will use a Flexible Funding "soft cap" for each person. People can spend less or more, based on the need of the person, other people waiting for services, and the total flexible funding budget for that agency. The case manager will take a person-centered approach, focusing on the needs/goals of the person when determining the actual amount of flexible funding that is needed.

Attachment 2: Public Comment Received and State Responses

Global Commitment to Health Section 1115 Demonstration Renewal Request Response to Public Comment Received 11/4/15 – 12/10/15

1. My comment is that the draft that will be submitted at the end of December should include a description of how the state plans to comply with Home & Community Services and how they tend to do that throughout the waiver and specifically how those rules, how their plan, would impact all of the community based settings.

> ***State Response***: *Information about the State's compliance with federal HCBS regulations as required in the Global Commitment to Health Special Terms and Conditions are described in the State's Comprehensive Quality Strategy (CQS). The CQS, while a separate document from the Special Terms and Conditions, is a required component of Vermont's 1115 Demonstration and Public Managed Care Model. The CQS is where the Agency of Human Services (AHS) sets expectations for how the Public Managed Care Entity (e.g., DVHA, DAIL, DMH, DCF, VDH, AOE) will comply with federal regulations as described in the Special Terms and Conditions.*
>
> *In response to requirements outlined by the AHS through the CQS, the Department of Vermont Health Access and its partners (e.g. the Department of Aging and Independent Living) have engaged in a separate public notice and stakeholder engagement process specific to the Home and Community Based Settings and Person-Centered Planning requirements as required in CQS. We will forward this comment to be included in the CQS public comment process.*

2. My comment is specific to the inner program evaluation, general approach to the evaluation that the state is pursuing in looking at whether its meeting its goals under Global Commitment. While this suggests a strong performance and probably meets the letter of the law in terms of requirements, I'm really concerned about the lack of specificity that this analysis has to medically underserved populations. Probably the largest medically underserved population in the United States is not officially named that by HRSA but that is people with disabilities, specifically even more people with developmental and intellectual disabilities. There is now a significant body of research nationally showing that people with developmental disabilities have higher rates of chronic illness, have lower rates of preventative routine screening, have higher emergency room rates, and in general die earlier than necessary not based on anything to do with their disability. This can also be demonstrated at least partially through Medicaid claims data specifically to Vermont. For example the rate of pulmonary disease is extremely high for people with IDD in Vermont. Emergency room use is very high. And this is regardless of whether people are on a home and community based waiver or not. Use of mammography is extremely low for women of the appropriate age range with intellectual and developmental disabilities. I am really campaigning to urge the state to think about segmenting its data analysis so it has some sensitivity to sub-populations. When the population is small enough it just doesn't have the statistical sort of noise to get noticed in the larger pool. I think we're really missing an opportunity to improve how we're caring for Vermont's most vulnerable people and we're not really noticing it in the kind of reports that we're delivering to CMS.

> ***State Response***: *The State agrees with your observation; one of the key principles of the Comprehensive Quality Strategy (CQS) is performance measurement. AHS defines performance measurement as the ongoing monitoring and communicating of program accomplishments, particularly progress towards achieving predetermined goals.*

Annually, DVHA and its partners are required to measure and report performance using standard measures identified by AHS. The CQS is under review and revision. In addition to measures designed to assess plan-wide performance, AHS will require population-specific performance measures (e.g., those for children, pregnant women, beneficiaries with developmental and/or intellectual disabilities, etc.). By requiring population-specific measures, AHS hopes to maintain sensitivity to outcomes of these sub-populations that might otherwise be overlooked due to their smaller numbers. We will forward this comment to be included in the CQS public comment process.

3. I just wanted to make two points. One is I do think it's important to make clear on the linked website that people need to look at more than just the extension request. My second comment is with respect to Home and Community Based Service pools and specifically in the existing terms and conditions in the current waiver there's reference to Section 7 Long Term Services Support Protection for CFC. There's no mention for other long term services support to consumers. Within that section, that paragraph 32, the state's required to share compliance with the characteristics of home and community based settings found in accordance with 42 CFR 441.301 for those Choices for Care services that could be authorized under Section 1915i of the waiver, again there's no reference to the other long term care services for consumers and I think that should be made clear that those populations are covered requirements for adherence to home and community based services.

***State Response*:** *Regarding clarity of the website, the State took action to update its website posting immediately after receiving this comment on 11/12/15.*

Regarding compliance with federal HCBS regulations, as required in the Global Commitment to Health Special Terms and Condition, these efforts are described in the State's Comprehensive Quality Strategy (CQS). The CQS, while a separate document from the Special Terms and Conditions, is a required component of Vermont's 1115 Demonstration and Public Managed Care Model.

Since 2005, the State has only operated one Long-Term Service and Support Demonstration, Choices for Care. That program was consolidated into the Global Commitment to Health Demonstration in January 2015. The Developmental Services Program is one of several programs that were recognized in 2005 as a Special Health Needs Population under the Global Commitment to Health Public Managed Care Demonstration. As such, the program is governed by Vermont rule and statutes. While the Special Terms and Conditions do not require the State to address HCBS assurances beyond Choices for Care, AHS, at its discretion, has set out requirements for the Public Managed Care Entity to engage in a full assessment of all special health needs programs under the Demonstration. In response, the Department of Vermont Health Access and its governmental partners have started a separate public notice and stakeholder engagement process specific to the Home and Community-Based Settings and Person-Centered Planning requirements as required in CQS. We will forward this comment to be included in the CQS public comment process.

4. I know that Global Commitment includes the developmental service program that was formerly a waiver. About $180 million is spent per year on it. It helps my son. But I don't see how this renewal describes those services and how the state is going to do that. And also, following up on other comments, how the new home and community based rule will be addressed by the state of Vermont because he certainly fits within this goal 4 but there's no indication that you're considering people with

developmental disabilities as beneficiaries of long term services and support. It should be easier for families, it should be easier for self-advocates to know that some very important thing is going to be renewed for five years and we should know really where we fit within it and what you're asking approval from the feds to be able to do. And to upgrade it with the home and community based services.

> ***State Response**: The Developmental Services Program is one of several programs that were recognized in 2005 as a Special Health Needs Population under the Global Commitment to Health Public Managed Care Demonstration. As such the program is governed by Vermont rule and statutes. While the Special Terms and Conditions do not require the State to address HCBS assurances beyond Choices for Care, AHS, at its discretion, has set out requirements for the Public Managed Care Entity to engage in a full assessment of all Special Health Needs programs under the Demonstration. In response, the Department of Vermont Health Access and its governmental partners have started a separate public notice and stakeholder engagement process specific to the Home and Community-Based Settings and Person-Centered Planning requirements as required in CQS. We will forward this comment to be included in the CQS public comment process.*

5. This may not be a good timeline? I am only referring to the fact 2017 is projected to be a dynamic year of uncertainties, and significant policy decisions, would be better if was 2018 to 2022? That doesn't mean it's possible, but this extension will be particularly rough to calculate in projections? State could indeed end up with significant expenses in those last two years?

> ***State response**: The period for each Demonstration is set by the Center for Medicaid and CHIP Services (CMCS). In addition, the Social Security Act outlines the frequency and timelines a State must follow when it seeks to renew those Demonstrations. On 10/03/2013 CMCS approved the Global Commitment to Health Demonstration for a three-year extension through 12/31/2016. This end date requires the State of Vermont to submit a renewal request now (one year prior to its end date) with a proposed effective date of 1/1/2017.*

6. If it is agreed that risk-bearing responsibility should shift from the Department of Vermont Health Access to provider-led clinically-integrated networks, similar to efforts in Medicare and among private insurers, then it makes no sense to continue to require clinicians to engage with multiple quality improvement, utilization and care management entities or for the State to continue expansion of its medical cost management, clinical and quality improvement programming and infrastructure. In fact, continuing to do so could undermine the opportunity for true population health management and clinical transformation. Yet in the Extension Request it says, "Vermont's Medicaid goal is to maintain the public managed care model to ensure maximum ability to serve Vermont's most vulnerable and lower-income residents while moving towards broader state and federal health care reform goals." As such, would DVHA participate in a public/private partnership and transition those responsibilities to one or more ACOs?

- The 1115 waiver should align delegation of population-level financial risk and health management risk to health care providers with steps being taken by other payers. The State has the opportunity in the 1115 waiver to shift financial risk-bearing responsibility for utilization changes from the Department of Vermont Health Access to provider-led clinically-integrated networks, similar to efforts in Medicare and among private insurers. This would allow for the fullest shift from volume-based care to outcomes-based care. OneCare Vermont is a national pioneer in its willingness and readiness to take on risk-based

payments to improve care. This model would represent a logical next step from the current VMSSP, which ends after 2016. The first-year success of the VMSSP in generating savings against the state's projected spend gives us confidence in the accountable provider network model.

***State Response**: The Global Commitment Demonstration affords the State with great flexibility to transform the health care system. If Vermont is able to retain the current flexibilities under the Demonstration, we will be able to partner with other payers and providers to develop reforms that are best for the State. The Vermont Medicaid program currently has the federal authority to engage providers in an Accountable Care Organization and/or other models that that enable the State to engage in payment reform that transitions payment from volume based to quality based. If these flexibilities are compromised as part of the federal approval process, Vermont may need to pursue alternative authorities under the Demonstration to permit it to move forward with health reform.*

Any substantive change in the Global Commitment to Health model or approaches used in the Medicaid program would also require legislative approval.

7. Will the State work with community organizations and risk-bearing health care organizations (such as OneCare Vermont) to achieve common aims for improving patient outcomes, and help identify clear financial incentives for collaboration in order to reduce clinical and payment fragmentation?

- The 1115 waiver should include incentives for provider-community collaboration. Federally Qualified Health Centers, Behavioral health organizations, community organizations and social services agencies are essential to providing the highest-quality care to Medicaid patients. The State has the opportunity in the 1115 waiver to offer these groups clear financial incentives to collaborate with risk-bearing health care organizations to achieve common aims for improving patient outcomes. Reducing clinical and payment fragmentation through shared responsibility for outcomes would bring considerable lasting benefit to Vermont's health care system.

***State Response:** The current Demonstration provides Vermont with the flexibility to create incentives for collaboration and investment in programs designed to increase integration. Any use of funds to support such initiatives in our public system must be approved by the Vermont Legislature through the budget process.*

8. Will the State pursue new federal funds for population health infrastructure and/ or agree to work with ACO's on using the GC Waiver to obtain and provide additional support for community and provider led efforts?

- The 1115 waiver should increase investments in population health infrastructure. In recent 1115 waivers, most notably in New York, the federal government has invested substantial sums in supporting provider networks as they develop the capacity to improve population health outcomes. Risk-based payments could be coupled with supplementary programs to reward utilization and quality outcomes with funds to support the infrastructure required for ongoing transformation. Clinical infrastructure could include embedded case managers in primary care offices and community based organizations, interdisciplinary teams visiting patients at home after discharge, co-located behavioral health and primary care services,

and other proven interventions. It is important to acknowledge that OneCare Vermont does not simply seek to have delegated responsibility to replicate more centralized managed care organization models as they currently exist, but to build a balanced model of central technology, support capabilities and process definition with a model which enables approaches embedded in day-to-day care processes delivered in local communities as close to the patient as possible. We hope that the flexibility and additional spending capacity under a GC waiver, that DVHA would work with OneCare Vermont to provide additional resources to enable our efforts beyond the care delivery cost targets under fixed revenue risk. We also encourage investigation of the Delivery System Reform Incentive Payment (DSRIP) program or other programs available to Vermont, as a way to obtain new federal funds for forward-thinking providers to improve care through ACOs in deploying resources as close to the patient-provider interaction as possible.

State Response: *The Section 1115 Demonstration process does not automatically grant the State access to new federal funds, nor does it exclude the State from pursuing additional federal monies that may become available. Any new federal funds would be secured using the process identified for the relevant fund. Any new or redistributed State funds in support of population health infrastructure in the provider community would need to be approved by the legislature through the budget process.*

The current Demonstration enables the State to make managed care investments to fund the same types of activities that are funded by DSRIPs. Vermont has the flexibility to invest in public-private partnerships, public health approaches, and alternative services and programs designed to improve access to care and enhance quality of care. Other states have obtained similar flexibility through DSRIPs. However, DSRIP programs tend to be more narrowly defined as compared to Vermont's model, and recently approved DSRIP programs have become more prescriptive. The DSRIP programs must define the types of programs and providers to be funded, describe a detailed funding approval process, and define federal reporting requirements. Also, the waiver terms stipulate that federal support for a DSRIP program is discontinued if pre-defined performance targets are not met. DSRIP funds would still require State match and would need to be approved by the Legislature through the budget process.

9. Will AHS partner with ACO's for Quality Measurement and Improvement?

- In order to evaluate quality and impact in our health care systems, OneCare Vermont is investing heavily in data analytics and quality improvement processes. We believe that we could be helpful in showing the value of the Global Commitment investments. Rigorous application of analytics to those investments would go a long way toward addressing the opportunities raised in the Pacific Health Policy Group and Vermont State Auditor reports.

State Response: *The Global Commitment to Health Section 1115 Demonstration requires the development of a Comprehensive Quality Strategy and includes requirements for Performance Improvement Projects. In addition, the AHS is aggressively pursuing a modernization of our Health Service Enterprise and Information Technology platforms. Aligning these efforts with our ACO and Health Care Reform efforts is essential to streamlining data collection, improving data quality, and ultimately improving the State's ability to support meaningful performance measurement across all of our programs.*

10. We have been assured in previous communications by AHS Secretary Cohen and DVHA Commissioner Costantino that all of these provisions are within the scope of the application to renew the 1115 waiver and that the AHS and DVHA agree that these steps are necessary and desirable for implementation to be successful. Secretary Cohen wrote, "We are committed to ensuring we retain all the flexibility required to undertake the initiatives enumerated in your white paper. We are partnering closely with the Agency of Administration and the GMCB to make sure that the Medicaid program is well positioned to take part in Vermont's All-Payer health care reform initiative." We would request that the waiver extension should explicitly and transparently embrace the vision that we are collectively pursuing.

At OneCare Vermont believes that our population health model and willingness to lead will be assets to the State as it negotiates with the federal government. Few other states can count on a major clinical organization ready to accept the responsibility of improving health and controlling cost. We hope that our commitment will serve to strengthen Vermont's application and serve to accelerate change and make our state a model for health care in the United States.

> ***State Response*: ***If Vermont is able to retain the current flexibilities under the Demonstration, we will be able to partner with other payers and providers to develop reforms that are best for the State. The Vermont Medicaid program currently has the federal authority to engage providers in an Accountable Care Organization and/or other models that that enable the State to engage in payment reform that transitions payment from volume based to quality based. If these flexibilities are compromised as part of the federal approval process, Vermont may need to pursue alternative authorities under the Demonstration to permit it to move forward with health reform.*
>
> *The State has included a discussion of our future goals in the Global Commitment Extension Request. As final health care reform models and the details of Vermont's provider agreements are defined, we will assess whether the design requires additional State and Federal approval. Pursuit of any substantive change in the Global Commitment to Health model or approaches used in the Medicaid program would also require legislative approval.*

11. The 1115 waiver should align delegation of risk to health care providers with steps being taken by other payers. The State has the opportunity in the 1115 waiver to shift financial risk-bearing responsibility from DVHA to provider-led clinically-integrated networks, similar to efforts in Medicare and among private insurers. This would allow for the fullest shift from volume-based care to outcomes-based care and allow for the reduction in duplicative capacity and infrastructure.

> ***State Response****: Please see the State's response to Question #6*

12. Changing payment models is simply not possible through existing shared-savings constructs that provide bonuses but do not change basic revenue models. Moreover, prolonging a system that requires clinicians to engage with multiple care management entities undermines the opportunity for true clinical transformation.

> ***State Response****: Please see the State's response to Question #6*

13. The 1115 waiver should include incentives for provider/community collaboration. Federally Qualified Health Centers, behavioral health organizations, home health agencies and social services agencies are

essential to providing the highest-quality care to Medicaid patients. The State has the opportunity to offer these groups clear financial incentives to collaborate with risk-bearing health care organizations to achieve common aims for improving patient outcomes. Reducing clinical and payment fragmentation through shared responsibility for outcomes would bring considerable lasting benefit to Vermont's health care system.

State Response*: Please see the State's response to Question #7*

14. The 1115 waiver should increase investments in population health infrastructure. Risk-based payments could be coupled with supplementary programs to reward utilization and quality outcomes with funds to support the infrastructure required for ongoing transformation.

State Response*: Please see the State's response to Question #8*

15. Clinical infrastructure could include embedded case managers in primary care offices, interdisciplinary teams visiting patients at home after discharge, co-located behavioral health and primary care services, and other proven interventions. Whether through a Delivery System Reform Incentive Payment (DSRIP)-type program or a concept unique to Vermont, the State should pursue new federal funds to improve care through supporting ACOs in deploying resources as close to the patient-provider interaction as possible.

State Response*: Please see the State's response to Question #8*

16. The 1115 waiver request should articulate the importance of the strategic integration of the Blueprint of Health with the anticipated statewide ACO, in order to avoid having separate programs to address chronic disease.

State Response*: Please see the State's response to Question #6*

17. The all-payer model being negotiated by the State of Vermont would require the participation of the Medicaid program, as well as Medicare and commercial insurers, in creating value-based payment models and establishing more standardized approaches to care delivery, care management, and performance measurement. We recommend that the 1115(e) waiver be explicit on the importance of alignment between the 1115 waiver and all-payer waiver. Most importantly, in order to constrain the cost shift, the State must develop a responsible funding model for the expansion of Medicaid that ends the cost shift to employers and insurers.

State Response*: Please see the State's response to Question #10*

18. We recommend that the 1115(e) extension request indicate planned changes to DVHA's current population health management (PHM) infrastructure and capabilities if they are duplicative of those needed by a single statewide private-sector health care provider network (ACO) that is assuming fixed revenue risk for the Medicaid population. If they are duplicative of those needed by a single statewide ACO or similar organization, reducing DVHA's current population health management infrastructure and capabilities could provide significant savings and help reduce the administrative cost of Vermont's Medicaid program.

***State Response**: Please see the State's response to Question #10*

19. I submit these comments on behalf of Planned Parenthood of Northern New England. At this time it is our understanding the State of Vermont has voluntarily chosen not to accept the federal 90/10 match for family planning services. The Social Security Act section 1903(a)(5) requires the federal government to supply each state a 90 percent match for family planning services, without exception. There is also no legal avenue by which a state could waive this federal match. Indeed, Congress drafted the 90/10 match provision, as well as other, related protections for family planning services, to ensure that individuals would have robust coverage of family planning services and supplies and would be able to receive family planning care in a timely manner.

While it is uncertain how Vermont could forego the 90 percent match, it is disconcerting to hear that the state may not be receiving the federal funds it is entitled to for family planning supplies and services. Without drawing down the match the state is losing the opportunity to save hundreds of thousands of dollars for critical women's health and reproductive health services such as family planning counseling services and patient education, well-woman exams, testing and treatment for sexually transmitted infections, laboratory examinations and tests, and medically approved family planning methods, procedures, pharmaceutical supplies, and devices to prevent conception and infertility. As DVHA moves forward to finalize this waiver extension proposal, we strongly urge the state to make clear that family planning services and supplies require a 90/10 match and that the state is not forfeiting its ability to claim the 90 percent match for such services.

***State Response:** The Global Commitment to Health Demonstration operates using a Medicaid Managed Care financial model; however that does not preclude the State from seeking enhanced match in certain circumstances. We are currently analyzing our options in preparation for our discussions with CMS.*

State of Vermont

Agency of Human Services
(AHS)

2014–2015
External Quality Review Technical Report

February 2015

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HSAG HEALTH SERVICES ADVISORY GROUP

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1. Executive Summary

Background

The Balanced Budget Act of 1997 (BBA), Public Law 105-33, and as described in the Code of Federal Regulations (CFR) [42 CFR §438.364], requires state Medicaid agencies to contract with an external quality review organization (EQRO) to prepare an annual report that describes the manner in which data from activities conducted in accordance with 42 CFR §438.358 were aggregated and analyzed. The report must also describe how conclusions were drawn as to the quality and timeliness of, and access to, care furnished by the Medicaid managed care organizations (MCOs) and prepaid inpatient health plans (PIHPs). The Vermont Agency of Human Services (AHS) chose to meet this requirement by contracting with Health Services Advisory Group, Inc. (HSAG), an EQRO, beginning in contract year (CY) 2007–2008 to conduct the three Centers for Medicare & Medicaid Services (CMS) required activities and to prepare the EQR annual technical report bringing together the results from the activities it conducted. This report meets the requirements of 42 CFR §438.364 and does not disclose the identity of any member.

The Vermont Agency of Human Services (AHS)

AHS is the State agency responsible for administrating the Medicaid managed care program in Vermont. In fall 2005, the Vermont Legislature approved implementation of the Global Commitment to Health Waiver, a demonstration initiative operated under an 1115 waiver. The waiver allowed the State to designate the Office of Vermont Health Access (OVHA), now the **Department of Vermont Health Access** (**DVHA**), as the first statewide public managed care model organization. Subsequently, through a restructuring of the AHS, the organization became an AHS department. While a department of the State, **DVHA**'s role, responsibility, and funding are equivalent to that of other state Medicaid agencies' contracted MCOs. **DVHA** has written intergovernmental agreements (IGAs) with other AHS departments to which it delegates certain administrative functions and the provision of direct services; contracts with community-based service providers; and contracts with entities to which it delegates certain administrative functions (e.g., beneficiary services and pharmacy benefit management services).

During AHS' contract year 2013–2014, **DVHA**, as the State's single statewide Medicaid managed care organization, provided health care services to the State's Medicaid beneficiaries and collected performance data. During the EQRO contract year (February 2014–February 2015), HSAG conducted the three mandatory external quality review (EQR) activities and an evaluation and analysis of **DVHA**'s performance data from the prior year. The results of HSAG's review are contained in this 2014–2015 Technical Report.

As stated, in part, in its Strategic Plan, AHS strives to improve the health and well-being of Vermonters. AHS' vision includes the assurance of high-quality health care for all Vermonters. In referring to "health," AHS includes physical health, mental health, and health in the area of substance abuse.

The State of Vermont's leadership, from the governor down, and AHS continue to be recognized nationally as well as by HSAG:

- As proactive leaders and innovators in designing and implementing health care reforms, implementing creative and effective health care delivery and financing models, and for their effective quality improvement and cost saving initiatives.
- For their collaboration relationships with other states to maximize and share tangible and intellectual resources, experiences, and best practices in designing and implementing creative, effective, and cost-efficient changes. The State's and its multistate health care partners are frequently featured and highlighted in national literature, health care reports, and media for their:
  - Visionary models and initiatives.
  - Collaborative, innovative, and inclusive approach to building stronger, more effective and cost-efficient models for delivering care.

The Department of Vermont Health Access (DVHA)

DVHA is the State department responsible for the management of Medicaid, the Vermont Children's Health Insurance Program (CHIP), and other publically funded health insurance programs in Vermont. **DVHA** is the largest insurer in Vermont in terms of dollars spent and the second largest in terms of covered lives. It is also responsible (1) state oversight and coordination of Vermont's expansive Health Care Reform initiatives which are designed to increase access, improve quality, and contain the cost of health care for all Vermonters; (2) Vermont's health information technology strategic planning, coordination, and oversight; and (3) the Blueprint for Health.

DVHA's stated mission as the statewide Medicaid managed care model organization is to:

- Provide leadership for Vermont stakeholders to improve access, quality, and cost effectiveness in health care reform.
- Assist Medicaid beneficiaries in accessing clinically appropriate health services.
- Administer Vermont's public health insurance system efficiently and effectively.
- Collaborate with other health care system entities in bringing evidence-based practices to Vermont Medicaid beneficiaries.

Scope of HSAG's 2014–2015 EQR Activities

HSAG's external quality review in contract year 2014–2015 consisted of conducting the following activities:

- ***Validation of* DVHA's *performance improvement project (PIP)***. HSAG reviewed **DVHA**'s PIP to ensure that the organization designed, conducted, and reported on the project in a methodologically sound manner, allowing measurement of any real improvements in care and services, and giving confidence in the reported improvements.

- ***Validation of* DVHA's *performance measures***. HSAG validated the accuracy of the AHS-required performance measures that **DVHA** reported. The validation also determined the extent to which Medicaid-specific performance measures calculated by **DVHA** followed specifications established by AHS.
- ***Review of* DVHA's *compliance with standards***. HSAG conducted a review to determine the organization's compliance with performance standards (sets of requirements) described in the federal Medicaid managed care Structure and Operations Standards at 42 CFR §438.214–230 and with the associated requirements contained in the AHS Intergovernmental Agreement (i.e., contract) with **DVHA**.
- ***Preparation of the external quality review annual technical report***. HSAG compiled and analyzed all data from its 2014–2015 EQR activities and drew conclusions related to the quality and timeliness of, and access to, care and services **DVHA** furnished to its Medicaid beneficiaries. This report describes the results of that process.

Summary of Findings

The following sections summarize HSAG's findings for each of the three activities it conducted.

Validation of the Performance Improvement Project (PIP)

HSAG conducted a validation of **DVHA**'s new PIP, *Follow-up After Hospitalization for Mental Illness*. The methodology HSAG used to validate the PIP was based on CMS' PIP validation protocol.[1-1] The validation covered Activities I through VIII.

The purpose of the study was to improve follow-up after an inpatient stay for selected mental health disorders. Follow-up after discharge is important for continuity of care between treatment settings and in ensuring that members receive needed care and services. Members receiving appropriate follow-up care can reduce the risk of repeat hospitalization. **DVHA**'s goal is to increase the percentage of members six 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 and 30 days of discharge. **DVHA** used data from calendar year 2013 to establish its baseline measurement.

DVHA's *Follow-up After Hospitalization for Mental Illness* PIP received a score of 100 percent for all applicable evaluation elements scored as *Met*, a score of 100 percent for critical evaluation elements scored as *Met*, and an overall validation status of *Met*, as displayed in Table 1-1.

[1-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 3: Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for External Quality Review (EQR), Version 2.0*, September 2012. Available at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html.

Table 1-1—2014–2015 PIP Validation Summary Overall Score	
Percentage Score of Evaluation Elements Met*	100%
Percentage Score of Critical Elements Met**	100%
Validation Status***	***Met***

*The percentage score is calculated by dividing the total *Met* by the sum of the total *Met*, *Partially Met*, and *Not Met*.
**The percentage score of critical elements *Met* is calculated by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.
****Met* indicates high confidence/confidence that the PIP was valid. *Partially Met* indicates low confidence that the PIP was valid. *Not Met* indicates reported PIP results that were not credible.

Table 1-2 displays **DVHA**'s performance across all PIP activities. The second column represents the total number of evaluation elements *Met* compared to the total number of applicable evaluation elements for each activity reviewed, including critical elements. The third column represents the total number of critical elements *Met* for each activity reviewed compared to the total number of applicable critical evaluation elements.

Review Activities	Total Number of Evaluation Elements *Met*/Total Number of Applicable Evaluation Elements	Total Number of Critical Elements *Met*/Total Number of Applicable Critical Evaluation Elements
I. Select the Study Topic	2/2	1/1
II. Define the Study Question(s)	1/1	1/1
III. Define the Study Population	1/1	1/1
IV. Select the Study Indicator(s)	1/1	1/1
V. Use Sound Sampling Techniques	0/0	0/0
VI. Reliably Collect Data	3/3	1/1
VII. Analyze Data and Interpret Study Results	3/3	1/1
VIII. Implement Intervention and Improvement Strategies	5/5	3/3
IX. Assess for Real Improvement	Not Assessed	Not Assessed
X. Assess for Sustained Improvement	Not Assessed	Not Assessed

The validation results indicated an overall score of 100 percent across all applicable evaluation elements and a finding of high confidence in the reported results. The solid structure of the PIP will allow the State and other stakeholders to have confidence in subsequent remeasurements and any real and sustained improvement that is reported as this PIP progresses.

Validation of Performance Measures

HSAG validated a set of 13 AHS-required performance measures as calculated by **DVHA**. The 13 measures included 47 clinical indicators (or rates). HSAG conducted the validation activities consistent with CMS' *EQR Protocol 2*: *Validation of Performance Measures Reported by the MCO:*

A Mandatory Protocol for External Quality Review (EQR), Version 2.0, September 2012.[1-2] The performance measurement period was calendar year 2013. AHS selected the 13 measures from the 2014 Healthcare Effectiveness Data and Information Set (HEDIS®[1-3]). HSAG determined that all 13 measures were fully compliant with HEDIS specifications and were valid and accurate for reporting.

DVHA Reporting Capabilities

All measures received a validation finding of *Fully Compliant*. **DVHA** continues to implement HSAG's recommendations from the previous years to reinforce support and commitment to the performance measure reporting process. This was evident by the staff members' dedication to quality improvement and operational changes that have been made to improve performance measure reporting, specifically using hybrid methodology to test rate increases. **DVHA** also contracted with a software vendor that passed the NCQA measure certification to calculate and report the HEDIS 2014 performance measures. The data systems **DVHA** used to process and collect claims and encounters, provider data, and membership data were assessed and determined to meet all applicable audit standards. **DVHA** is implementing hybrid reporting methodology for rate testing purposes only at this point. **DVHA** has been urged to report using the hybrid methodology, but for this year, all measures were reported using the administrative method.

Performance Measure Results

Table 1-3 below displays the performance measure results, including a comparison to the prior year's rates and the HEDIS 2013 national Medicaid percentiles.

Table 1-3—DVHA HEDIS 2014 Results

	Performance Measure	HEDIS 2013 Rate	HEDIS 2014 Rate	Percentage Point Change	HEDIS 2013 Percentile Ranking
1.	*Well-Child Visits in the First 15 Months of Life—0 Visits*[¥]	2.06%	1.59%	-0.47	25th–50th
2.	*Well-Child Visits in the First 15 Months of Life—1 Visit*	1.29%	0.91%	-0.38	10th–25th
3.	*Well-Child Visits in the First 15 Months of Life—2 Visits*	1.83%	1.36%	-0.47	10th–25th
4.	*Well-Child Visits in the First 15 Months of Life—3 Visits*	2.22%	2.60%	+0.38	10th–25th
5.	*Well-Child Visits in the First 15 Months of Life—4 Visits*	5.40%	5.39%	-0.01	10th–25th
6.	*Well-Child Visits in the First 15 Months of Life—5 Visits*	11.97%	12.20%	+0.23	10th–25th
7.	*Well-Child Visits in the First 15 Months of Life—6 or More Visits*	75.23%	75.96%	+0.73	75th–90th

[1-2] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 2: Validation of Performance Measures Reported by the MCO: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html.

[1-3] HEDIS is a registered trademark of the National Committee for Quality Assurance (NCQA).

Table 1-3—DVHA HEDIS 2014 Results					
	Performance Measure	HEDIS 2013 Rate	HEDIS 2014 Rate	Percentage Point Change	HEDIS 2013 Percentile Ranking
8.	*Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*	69.32%	71.49%	+2.17	25th–50th
9.	*Adolescent Well-Care Visits*	46.27%	46.97%	+0.70	25th–50th
10.	*Annual Dental Visits—Ages 2–3*	46.96%	46.47%	-0.49	75th–90th
11.	*Annual Dental Visits—Ages 4–6*	72.78%	71.61%	-1.17	75th–90th
12.	*Annual Dental Visits—Ages 7–10*	78.02%	77.85%	-0.17	75th–90th
13.	*Annual Dental Visits—Ages 11–14*	72.76%	72.19%	-0.57	75th–90th
14.	*Annual Dental Visits—Ages 15–18*	65.56%	65.64%	+0.08	>95th
15.	*Annual Dental Visits—Ages 19–21*	44.72%	43.02%	-1.70	75th–90th
16.	*Annual Dental Visits—Combined Rate*	68.23%	67.72%	-0.51	75th–90th
17.	*Children's and Adolescents' Access to Primary Care Practitioners—12–24 Months*	98.31%	98.55%	+0.24	90th–95th
18.	*Children's and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years*	91.70%	92.13%	+0.43	75th–90th
19.	*Children's and Adolescents' Access to Primary Care Practitioners—7–11 Years*	94.48%	94.46%	-0.02	75th–90th
20.	*Children's and Adolescents' Access to Primary Care Practitioners—12–19 Years*	93.73%	93.90%	+0.17	90th–95th
21.	*Chlamydia Screening in Women—16–20 Years*	--	47.35%	--	25th–50th
22.	*Chlamydia Screening in Women—21–24 Years*	--	54.85%	--	10th–25th
23.	*Chlamydia Screening in Women—Total*	--	50.55%	--	10th–25th
24.	*Adults' Access to Preventive/Ambulatory Health Services—20–44 Years*	84.09%	84.21%	+0.12	50th–75th
25.	*Adults' Access to Preventive/Ambulatory Health Services—45–64 Years*	88.93%	89.37%	+0.44	50th–75th
26.	*Adults' Access to Preventive/Ambulatory Health Services—65+ Years*	93.04%	94.31%	+1.27	90th–95th
27.	*Adults' Access to Preventive/Ambulatory Health Services—Total*	86.94%	87.32%	+0.38	75th–90th
28.	*Comprehensive Diabetes Care—HbA1c Testing*	64.19%	65.07%	+0.88	<5th
29.	*Comprehensive Diabetes Care—Eye Exams*	46.68%	47.03%	+0.35	25th–50th

Table 1-3—DVHA HEDIS 2014 Results					
Performance Measure		HEDIS 2013 Rate	HEDIS 2014 Rate	Percentage Point Change	HEDIS 2013 Percentile Ranking
30.	*Comprehensive Diabetes Care—LDL-C Screening*	45.03%	46.24%	+1.21	<5th
31.	*Comprehensive Diabetes Care—Medical Attention for Nephropathy*	60.27%	61.36%	+1.09	<5th
32.	*Follow-Up After Hospitalization for Mental Illness—7-day Follow-up*	--	41.61%	--	25th–50th
33.	*Follow-Up After Hospitalization for Mental Illness—30-day Follow-up*	--	61.77%	--	25th–50th
34.	*Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (Initiation)—13-17 Years*	--	42.63%	--	50th–75th
35.	*Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (Initiation)—18 Years and Older*	--	33.88%	--	10th–25th
36.	*Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (Initiation)—Total*	--	34.33%	--	10th–25th
37.	*Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (Engagement)—13–17 Years*	--	18.91%	--	50th–75th
38.	*Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (Engagement)—18 Years and Older*	--	13.26%	--	50th–75th
39.	*Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (Engagement)—Total*	--	13.56%	--	50th–75th
40.	*Use of Appropriate Medications for People With Asthma—5–11 Years*	88.24%	90.04%	+1.80	10th–25th
41.	*Use of Appropriate Medications for People With Asthma—12–18 Years*	88.42%	86.43%	-1.99	50th–75th
42.	*Use of Appropriate Medications for People With Asthma—19–50 Years*	79.93%	75.92%	-4.01	50th–75th
43.	*Use of Appropriate Medications for People With Asthma—51–64 Years*	84.65%	80.62%	-4.03	75th–90th
44.	*Use of Appropriate Medications for People With Asthma—Total*	84.71%	82.41%	-2.30	25th–50th
45.	*Antidepressant Medication Management—Effective Acute Phase Treatment*	68.81%	63.30%	-5.51	90th–95th
46.	*Antidepressant Medication Management—Effective Continuation Phase Treatment*	51.98%	44.12%	-7.86	75th–90th
47.	*Breast Cancer Screening*	--	38.10%	--	5th–10th

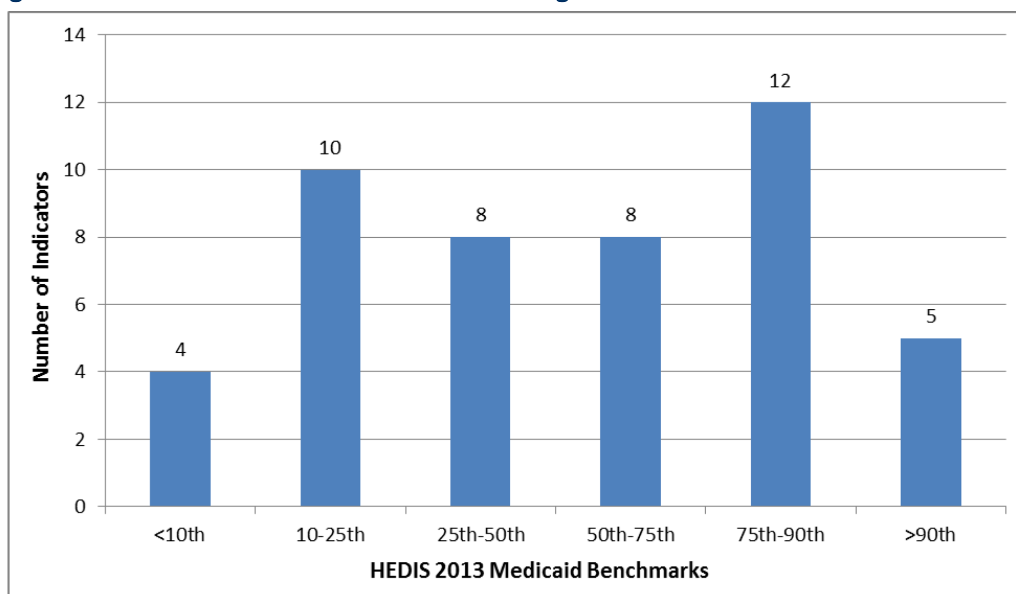
¥ A lower rate indicates better performance for these indicators. Therefore, lower rates lead to higher percentile rankings. A negative Percentage Point Change value indicates improvement.

DVHA performed well on certain clinical indicators and below the 25th percentile on other clinical measures. Of the 47clinical indicators reported, performance for five (*Annual Dental Visits—Ages 15–18, Children's and Adolescents' Access to Primary Care Practitioners—12–24 Months, Children's and Adolescents' Access to Primary Care Practitioners—12–19 Years, Adults' Access to Preventive/Ambulatory Health Services—65+ Years,* and *Antidepressant Medication Management—Effective Acute Phase Treatment)* exceeded the national Medicaid HEDIS 2013 90th percentile. In addition to those five indicators, another 12 surpassed the 75th percentile. High performance was also observed in the *Antidepressant Medication Management* measure (both indicators), *Children's and Adolescents' Access to Primary Care Practitioners* measure (all indicators), *Annual Dental Visits* measure (all indicators), *Well-Child Visits in the First 15 Months of Life—Six or More Visits* indicator, *Adults' Access to Preventive/Ambulatory Health Services–Total* indicator, and *Use of Appropriate Medications for People with Asthma—51–64 Years* indicator.

DVHA performed below the 25th percentile on 14 indicators, including *Well-Child Visits in the First 15 Months of Life—1, 2, 3, 4,* and *5 Visits; Comprehensive Diabetes Care—HbA1c Testing, LDL-C Screening, and Medical Attention for Nephropathy; Use of Appropriate Medications for People With Asthma—5–11 Years; Chlamydia Screening in Women 21–24 Years* and *Total; Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (Initiation)—18 Years and Older,* and *Total;* and *Breast Cancer Screening*.

The graph below shows the distribution of how the reported indicators compare to the 2013 HEDIS national Medicaid benchmarks. The horizontal axis displays the following HEDIS 2013 Medicaid benchmark ranges: below 10th percentile, 10th to 25th percentile, 25th to 50th percentile, 50th to 75th percentile, 75th to 90th percentile, and greater than 90th percentile. The vertical axis shows the number of performance indicators that fall into each of the percentile groups. As shown in this graph, four indicators are in the below 10th percentile group, 10 indicators in the 10th to 25th percentile, eight in the 25th to 50th percentile, eight in the 50th to 75th percentile, 12 in the 75th to 90th percentile, and five are in the greater than 90th percentile category.

Figure 1-1—Number of Indicator Rates Meeting the HEDIS 2013 Medicaid Benchmarks



Review of Compliance With Standards

Under its EQRO contract, AHS requested that HSAG continue to review one of the three sets of federal Medicaid managed care standards during each EQRO contract year. For EQRO contract year 2014–2015, AHS requested that HSAG conduct a review of the Structure and Operations standards.

HSAG conducted the review consistent with CMS' *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012.[1-4] HSAG reviewed **DVHA**'s written operating policies and procedures, program plans, meeting minutes, numerous written reports, and other data and documentation related to **DVHA**'s performance during the previous year. Reviewers also conducted staff interviews related to each of the eight standards to allow **DVHA** staff members to elaborate on the written information HSAG reviewed, to assess the consistency of staff responses given during the interviews against the written documentation, and to clarify any questions reviewers had following the document review.

The primary objective of HSAG's review was to identify and provide meaningful information to AHS and **DVHA** about **DVHA**'s performance strengths and any areas requiring corrective action. The information included HSAG's report of its findings related to the extent to which **DVHA**'s performance complied with the applicable federal Medicaid managed care regulations and AHS' associated IGA contract requirements for providing accessible, timely, and quality services to beneficiaries.

Table 1-4 presents a summary of **DVHA**'s performance results for the eight standard areas reviewed. The information includes:

- The total number of elements (i.e., requirements) and the number of applicable elements for each of the standards.
- The number of elements for each of the standards that received a score of *Met*, *Partially Met*, or *Not Met*, or a designation of *NA* (not applicable), as well as the totals across the eight standards.
- The total compliance score for each of the standards.
- The overall compliance score across all standards.

Table 1-4—Standards and Compliance Score

Standard #	Standard Name	Total # of Elements	Total # of Applicable Elements	# *Met*	# *Partially Met*	# *Not Met*	# *Not Applicable*	Total Compliance Score
I	Provider Selection	12	12	12	0	0	0	100%
II	Credentialing and Recredentialing	1	1	1	0	0	0	100%
III	Beneficiary Information	20	20	12	8	0	0	80%
IV	Beneficiary Rights	5	5	4	1	0	0	90%

[1-4] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html.

Table 1-4—Standards and Compliance Score								
Standard #	Standard Name	Total # of Elements	Total # of Applicable Elements	# *Met*	# *Partially Met*	# *Not Met*	# *Not Applicable*	Total Compliance Score
V	**Confidentiality**	**2**	**2**	**2**	**0**	**0**	**0**	**100%**
VI	**Grievance System—Beneficiary Grievances**	**14**	**14**	**13**	**1**	**0**	**0**	**96%**
VII	**Grievance System—Beneficiary Appeals and State Fair Hearings**	**33**	**33**	**29**	**4**	**0**	**0**	**94%**
VIII	**Subcontractual Relationships and Delegation**	**6**	**6**	**6**	**0**	**0**	**0**	**100%**
	Totals	**93**	**93**	**79**	**14**	**0**	**0**	**92%**

Total # of Elements: The total number of elements in each standard.

Total # of Applicable Elements: The total number of elements within each standard minus any elements that received a score of *NA*.

Total Compliance Score: The overall percentages were calculated by adding the number of elements that received a score of *Met to* the weighted (multiplied by 0.50) number that received a score of *Partially Met*, then dividing this total by the total number of applicable elements.

As displayed in Table 1-4, HSAG reviewed **DVHA**'s performance related to 93 elements across the eight standards. Of the 93 requirements, **DVHA** obtained a score of *Met* for 79 of the requirements and a score of *Partially Met* for 14 elements. As a result, **DVHA** obtained a total percentage of compliance score of 92 percent across the applicable elements.

With scores at or above 90 percent in seven of the eight standard areas reviewed, **DVHA** demonstrated numerous performance strengths in meeting the federal structure and operations regulations and AHS contract requirements. Four of the seven standards indicated significant areas of strength, with scores of 100 percent. For the only standard area with a score below 90 percent—Beneficiary Information—**DVHA** scored *Partially Met* on eight of the 20 evaluation elements and, therefore, has targeted opportunities for improvement in those areas.

DVHA's performance represented improvement compared to its overall performance for HSAG's 2010–2011 review of the same standards. For that review, **DVHA** scored 90 percent across the eight standard areas as compared to 92 percent this year. All but one standard area either maintained the previous high performance or improved. The score for only one standard declined from the previous review—Beneficiary Information.

Overall Conclusions and Performance Trending

Performance Trends

Performance Improvement Project Trends

This was the first year **DVHA** conducted its PIP—*Follow-up After Hospitalization for Mental Illness*. **DVHA**'s performance suggests its thorough application of the PIP design. The PIP's sound study design will provide the foundation for **DVHA** to progress to subsequent stages. **DVHA** appropriately conducted the data collection activities of the Design stage. These activities ensured that **DVHA** collected the necessary data to produce accurate study indicator rates. **DVHA** provided

baseline results for the first year's submission; therefore, trending is not yet possible but will be included in subsequent reports.

Performance Measure Trends

DVHA used software from a vendor whose measure source code was certified by NCQA to calculate and report the HEDIS 2014 measures. Table 1-5 below displays the rates for measures **DVHA** reported for HEDIS 2011, 2012, 2013, and 2014, and the overall trended rate. The trends displayed are calculated from the first reported rate to the HEDIS 2014 rate. Measures with no rates displayed (--) were not reported in prior years; therefore, trending was not applicable.

Table 1-5—HEDIS 2011, 2012, 2013, and 2014 Rates and Trended Results									
Performance Measure	HEDIS 2011		HEDIS 2012		HEDIS 2013		HEDIS 2014		Overall Trend
	N	Rate	N	Rate	N	Rate	N	Rate	Change
Well-Child Visits in the First 15 Months of Life—0 Visits[¥]	2,966	2.16%	3,131	1.72%	3,109	2.06%	3,082	1.59%	-0.57
Well-Child Visits in the First 15 Months of Life—1 Visit	2,966	1.55%	3,131	1.05%	3,109	1.29%	3,082	0.91%	-0.64
Well-Child Visits in the First 15 Months of Life—2 Visits	2,966	1.72%	3,131	1.72%	3,109	1.83%	3,082	1.36%	-0.36
Well-Child Visits in the First 15 Months of Life—3 Visits	2,966	3.03%	3,131	3.29%	3,109	2.22%	3,082	2.60%	-0.43
Well-Child Visits in the First 15 Months of Life—4 Visits	2,966	6.74%	3,131	5.94%	3,109	5.40%	3,082	5.39%	-1.35
Well-Child Visits in the First 15 Months of Life—5 Visits	2,966	12.61%	3,131	12.36v	3,109	11.97%	3,082	12.20%	-0.41
Well-Child Visits in the First 15 Months of Life—6 or More Visits	2,966	72.18%	3,131	73.91%	3,109	75.23%	3,082	75.96%	+3.78
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	12,794	69.02%	13,137	69.70%	13,186	69.32%	13,170	71.49%	+2.47
Adolescent Well-Care Visits	22,022	46.25%	22,547	46.17%	22,441	46.27%	22,630	46.97%	+0.72
Annual Dental Visits—Ages 2–3	6,522	44.59%	6,407	47.15%	6,418	46.96%	6,378	46.47%	+1.88
Annual Dental Visits—Ages 4–6	9,495	73.06%	9,857	73.36%	9,981	72.78%	9,947	71.61%	-1.45
Annual Dental Visits—Ages 7–10	12,027	78.13%	12,441	78.05%	12,659	78.02%	12,782	77.85%	-0.28
Annual Dental Visits—Ages 11–14	11,481	74.21%	11,869	73.48%	12,123	72.76%	12,139	72.19%	-2.02
Annual Dental Visits—Ages 15–18	9,705	67.06%	9,841	66.15%	9,740	65.56%	10,098	65.64%	-1.42
Annual Dental Visits—Ages 19–21	3,114	44.70%	3,119	40.53%	2,641	44.72%	2,664	43.02%	-1.68
Annual Dental Visits—Combined Rate	52,344	68.13%	53,534	68.10%	53,562	68.23%	54,008	67.72%	-0.41
Children's and Adolescents' Access to Primary Care Practitioners—12–24 Months	3,344	98.18%	3,487	98.34%	3,423	98.31%	3,453	98.55%	+0.37
Children's and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	15,764	91.56%	16,004	92.18%	16,175	91.70%	16,077	92.13%	+0.57
Children's and Adolescents' Access to Primary Care Practitioners—7–11 Years	13,301	94.05%	13,834	94.54%	14,221	94.48%	14,460	94.46%	+0.41
Children's and Adolescents' Access to Primary Care Practitioners—12–19 Years	17,427	93.52%	17,999	93.56%	18,212	93.73%	18,485	93.90%	+0.38
Chlamydia Screening in Women—16–20 Years	--	--	--	--	--	--	3,092	47.35%	--
Chlamydia Screening in Women—21–24 Years	--	--	--	--	--	--	2,299	54.85%	--

Table 1-5—HEDIS 2011, 2012, 2013, and 2014 Rates and Trended Results									
Performance Measure	HEDIS 2011		HEDIS 2012		HEDIS 2013		HEDIS 2014		Overall Trend
	N	Rate	N	Rate	N	Rate	N	Rate	Change
Chlamydia Screening in Women—Total	--	--	--	--	--	--	5,391	50.55%	--
Adults' Access to Preventive/Ambulatory Health Services—20–44 Years	28,803	83.09%	30,444	81.39%	30,936	84.09%	31,658	84.21%	+1.12
Adults' Access to Preventive/Ambulatory Health Services—45–64 Years	18,716	84.88%	20,393	83.59%	20,947	88.93%	21,700	89.37%	+4.49
Adults' Access to Preventive/Ambulatory Health Services—65+ Years	7,531	82.09%	7,488	79.49%	7,615	93.04%	7,718	94.31%	+12.22
Adults' Access to Preventive/Ambulatory Health Services—Total	55,050	83.56%	58,325	81.92%	59,498	86.94%	61,076	87.32%	+3.76
Comprehensive Diabetes Care—HbA1c Testing	5,764	62.02%	6,073	63.84%	6,152	64.19%	6,364	65.07%	+3.05
Comprehensive Diabetes Care—Eye Exams	5,764	45.18%	6,073	46.69%	6,152	46.68%	6,364	47.03%	+1.85
Comprehensive Diabetes Care—LDL-C Screening	5,764	47.24%	6,073	46.70%	6,152	45.03%	6,364	46.24%	-1.00
Comprehensive Diabetes Care—Medical Attention for Nephropathy	5,764	59.21%	6,073	59.72%	6,152	60.27%	6,364	61.36%	+2.15
Follow-Up After Hospitalization for Mental Illness—7-day Follow-up	--	--	--	--	--	--	1,567	41.61%	--
Follow-Up After Hospitalization for Mental Illness—30-day Follow-up	--	--	--	--	--	--	1,567	61.77%	--
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (Initiation)—13-17 Years	--	--	--	--	--	--	312	42.63%	--
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (Initiation)—18 Years and Older	--	--	--	--	--	--	5,715	33.88%	--
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (Initiation)—Total	--	--	--	--	--	--	6,027	34.33%	--
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (Engagement)—13–17 Years	--	--	--	--	--	--	312	18.91%	--
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (Engagement)—18 Years and Older	--	--	--	--	--	--	5,715	13.26%	--
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (Engagement)—Total	--	--	--	--	--	--	6,027	13.56%	--
Use of Appropriate Medications for People With Asthma—5–11 Years	744	93.68%	632	92.72%	621	88.24%	552	90.04%	-3.64
Use of Appropriate Medications for People With Asthma—12–18Years	*	*	523	87.57%	518	88.42%	501	86.43%	-1.14
Use of Appropriate Medications for People With Asthma—19–50 Years	*	*	823	79.10%	857	79.93%	897	75.92%	-3.18
Use of Appropriate Medications for People With Asthma—51–64 Years	*	*	185	81.62%	202	84.65%	227	80.62%	-1.00

Table 1-5—HEDIS 2011, 2012, 2013, and 2014 Rates and Trended Results									
Performance Measure	HEDIS 2011		HEDIS 2012		HEDIS 2013		HEDIS 2014		Overall Trend
	N	Rate	N	Rate	N	Rate	N	Rate	Change
Use of Appropriate Medications for People With Asthma—Total	*	*	2,163	85.34%	2,198	84.71%	2,177	82.41%	-2.93
Antidepressant Medication Management—Effective Acute Phase Treatment	1,923	66.98%	2,147	68.42%	2,578	68.81%	4,161	63.30%	-3.68
Antidepressant Medication Management—Effective Continuation Phase Treatment	1,923	51.38%	2,147	54.54%	2,578	51.98%	4,161	44.12%	-7.26
Breast Cancer Screening	--	--	--	--	--	--	7,543	38.10%	--

¥ A lower rate (decline) indicates better performance for this indicator.
* The reported age bands changed for this measure for HEDIS 2012; therefore, HEDIS 2011 results are not presented.

Overall, 16 of the 35 indicators with rates that could be trended showed an increase in performance since the first reported rate. All *Adults' Access to Preventive/Ambulatory Health Services* indicators demonstrated overall increases, ranging from 1.12 to 12.22 percentage points. Of the 19 measures that showed decreases in performance, none of the rates exhibited an overall decline of more than 7.26 percentage points. The average decline for those indicators was only 1.80 percentage points.

Compliance With Standards Trends

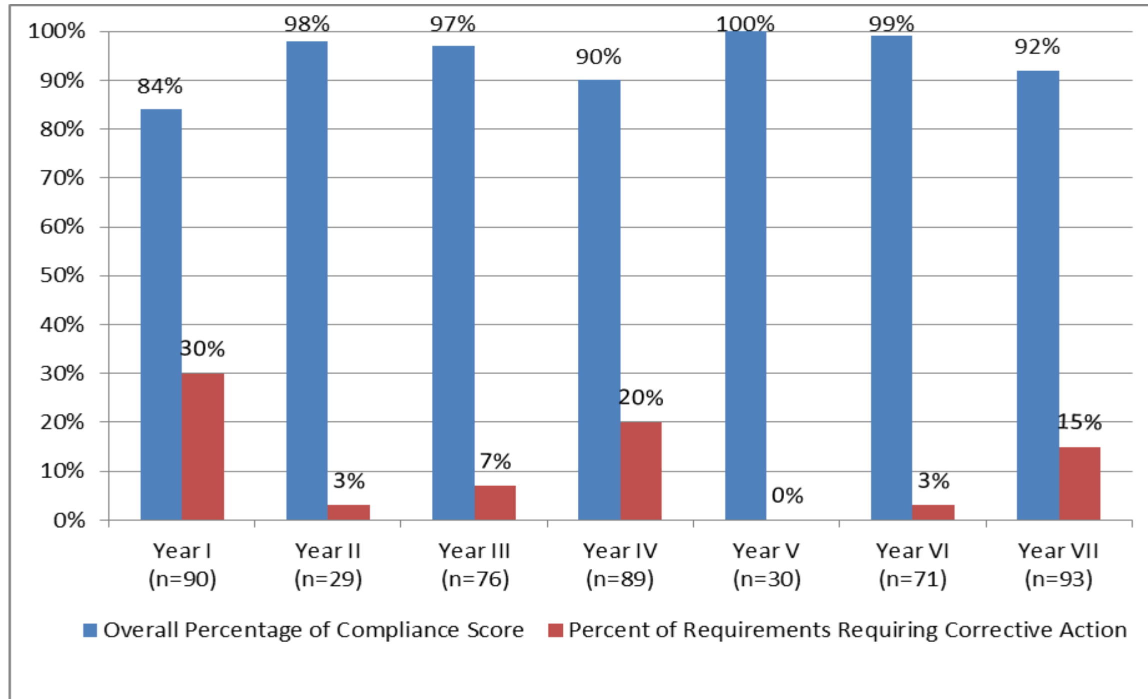
As noted previously, HSAG reviewed a different set of standards for evaluating **DVHA** compliance with federal CMS Medicaid managed care regulations and the associated AHS/**DVHA** IGA requirements during each year within its three-year cycle of reviews. The number and focus of the standards varied for each year's review. For this, the seventh year of reviews, HSAG again reviewed the Structure and Operations standards, the same standards it had reviewed in the first and fourth years of the EQRO contract.

Table 1-6 documents **DVHA**'s performance across seven years of HSAG's compliance reviews.

Table 1-6—Comparison/Trending of DVHA Performance for Compliance with Standards																					
	CY 2008			CY 2009			CY 2010			CY 2011			CY 2012			CY 2013			CY 2014		
Standards Reviewed	Ele-ments	Score	Correc. Action* %	Ele-ments	Score	Correc. Action* %	Ele-ments	Score	Correc. Action* %	Ele-ments	Score	Correc. Action* %	Ele-ments	Score	Correc. Action* %	Ele-ments	Score	Correc. Action* %	Ele-ments	Score	Correc. Action* %
Structure and Operations Standards	90	84%	30%							89	90%	20%							93	92%	15%
Measurement and Improvement Standards				29	98%	3%							30	100%	0%						
Access Standards and Enrollment & Disenrollment							76	97%	7%							71	99%	3%			

* The percentage of requirements for which HSAG scored DVHA's performance as either partially meeting or not meeting the requirement.

Figure 1-2—Trends in Performance



The bar graph displays **DVHA**'s overall performance score and the percent of requirements requiring corrective actions for the current and previous six years.

- Year I: 84 percent compliance with 30 percent of the requirements requiring corrective actions
- Year II: 98 percent compliance with 3 percent of the requirements requiring corrective actions
- Year III: 97 percent compliance with 7 percent of the requirements requiring corrective actions
- Year IV: 90 percent compliance with 20 percent of the requirements requiring corrective action
- Year V: 100 percent compliance with none of the requirements requiring corrective action
- Year VI: 99 percent compliance with 3 percent of the requirements requiring corrective action
- Year VII: 92 percent compliance with 15 percent of the requirements requiring corrective action

Quality, Timeliness, and Access to Care Domains

The federal Medicaid managed care regulations state that "each contract with a Medicaid managed care organization must provide for an annual external independent review conducted by a qualified independent entity of the quality outcomes and timeliness of, and access to, the care and services for which the organization is responsible."[1-5] CMS has chosen the domains of quality, access, and timeliness as keys to evaluating the performance of MCOs and PIHPs. Definitions HSAG used to evaluate and draw conclusions about **DVHA**'s performance in each of these domains are as follows.

[1-5] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Legislative Summary: Balanced Budget Act of 1997 Medicare and Medicaid Provisions.*

Quality

CMS defines quality in the final rule at 42 CFR §438.320 as follows: "Quality, as it pertains to external quality review, means the degree to which an MCO or PIHP increases the likelihood of desired health outcomes of its recipients through its structural and operational characteristics and through provision of health services that are consistent with current professional knowledge."[1-6]

Timeliness

NCQA defines timeliness relative to utilization decisions as follows: "The organization makes utilization decisions in a timely manner to accommodate the clinical urgency of a situation."[1-7] NCQA further discusses the intent of this standard to minimize any disruption in the provision of health care. HSAG extends this definition of timeliness to include other managed care provisions that impact services to beneficiaries and that require a timely response by the managed care organization—e.g., processing expedited appeals and providing timely follow-up care.

Access

In the preamble to the federal Medicaid Managed Care Rules and Regulations,[1-8] CMS discusses access to, and the availability of, services to Medicaid beneficiaries as the degree to which MCOs and PIHPs implement the standards set forth by the State to ensure that all covered services are available to beneficiaries. Access includes the availability of an adequate and qualified provider network that reflects the needs and characteristics of the beneficiaries served by the MCO or PIHP.

To draw conclusions about the quality and timeliness of, and access to, care **DVHA** provided, HSAG determined which components of each EQR activity could be used to assess these domains (as indicated in Table 1-7).

[1-6] Department of Health and Human Services Centers for Medicare & Medicaid Services. *Federal Register. Code of Federal Regulations*. Title 42, Vol 3, October 1, 2005.

[1-7] National Committee for Quality Assurance. Standards and Guidelines for Health Plans.

[1-8] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Federal Register*, Vol. 67, No. 115, June 14, 2002.

Table 1-7—EQR Activity Components Assessing Quality, Timeliness, and Access			
PIP	**Quality**	**Timeliness**	**Access**
Follow-up After Hospitalization for Mental Illness	✓	✓	
Performance Measures	**Quality**	**Timeliness**	**Access**
Well-Child Visits in the First 15 Months of Life	✓		
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	✓		
Adolescent Well-Care Visits	✓		
Annual Dental Visits	✓		✓
Children's and Adolescents' Access to Primary Care Practitioners			✓
Adults' Access to Preventive/Ambulatory Health Services			✓
Comprehensive Diabetes Care	✓		
Use of Appropriate Medications for People With Asthma	✓		
Antidepressant Medication Management	✓	✓	✓
Chlamydia Screening in Women	✓		
Follow-Up After Hospitalization for Mental Illness	✓	✓	✓
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment			✓
Breast Cancer Screening	✓		
Compliance Review Standards	**Quality**	**Timeliness**	**Access**
Standard I—Provider Selection	✓		✓
Standard II—Credentialing and Recredentialing	✓		
Standard III—Beneficiary Information	✓		
Standard IV—Beneficiary Rights	✓		
Standard V—Confidentiality	✓		
Standard VI—Grievance System: Beneficiary Grievances	✓	✓	
Standard VII—Grievance System: Beneficiary Appeals and State Fair Hearings	✓	✓	
Standard VIII—Subcontractual Relationships and Delegation	✓		

EQR Assessment of DVHA's Strengths and Weaknesses

Performance Improvement Project

DVHA showed strength in conducting its study by receiving *Met* scores for all applicable evaluation elements in Activities I through VIII, demonstrating a sound application of the PIP process. **DVHA**'s strong performance in the Design and Implementation stages indicated that the PIP was designed appropriately to measure outcomes and improvement.

Performance Measures

As in previous years, HSAG found **DVHA**'s electronic claims and eligibility data validity to be of high quality. Staff members were dedicated to positive operational changes to assist in reporting performance measures. Efforts to improve care and outcomes for Medicaid beneficiaries were also seen by the addition of new performance measures, increasing from 35 to 47 indicators this measurement year. Overall, 16 existing indicators have seen positive improvement over the last four years. *Adults' Access to Preventive/Ambulatory Health Services—65+ Years* had the largest increase (12.22 percentage points) over the four-year span.

The indicators for *Comprehensive Diabetes Care* continued to be a challenge for **DVHA**. Three of the four diabetes indicators reported this year performed below the national Medicaid 5th percentile. Although HSAG recommended reporting this measure using hybrid methods, due to insufficient planning time for medical record procurement and abstraction, **DVHA** decided to forgo hybrid reporting for HEDIS 2014. The *Use of Appropriate Medications for People With Asthma—5–11 Years* and several indicators for the *Well-Child Visits in the First 15 Months of Life* measure (i.e., 1, 2, 3, 4, and 5 Visits) also presented opportunities for improvement. For the *Use of Appropriate Medications for People With Asthma—5–11 Years* indicator, the HEDIS 2014 rate showed a decline from HEDIS 2011 of 3.64 percentage points, resulting in a rank below the national Medicaid 25th percentile. Although there have been minor changes in the *Well-Child Visits in the First 15 Months of Life* measure, most of the indicators for this measure ranked below the national Medicaid 25th percentile and have seen a downward trend. Many of the newly added measures are also below the national Medicaid 25th percentile. These measures include *Chlamydia Screening in Women*, *Initiation and Engagement of Alcohol and Other Drug Dependence Treatment*, and *Breast Cancer Screening*.

Compliance With Standards

DVHA had strengthened its organizational structure; management and administrative processes; and the quality, frequency, and level of detail and meaningful information in its written documents, including Operating Principles (i.e., policies and procedures), reports related to numerous activities, and IGAs with partner delegates. It was evident that **DVHA** had enhanced oversight of its partner delegates and contractors/vendors, resulting in 100 percent compliance in standards related to provider selection processes, credentialing and recredentialing, and subcontractors and delegates.

DVHA also performed strongly in administering a compliant grievance system (encompassing processes for beneficiary grievances, appeals, and the State fair hearing). However, **DVHA** was required to initiate corrective actions related to providers' access to complete beneficiary grievance and appeal information, its definition of "action" in policies and manuals, timeliness of appeal acknowledgments, timeliness of appeal resolutions and notices to beneficiaries, and inclusion of a process for members or providers/designated representatives to request reconsiderations.

For compliance with standards related to beneficiary information, rights, and confidentiality, **DVHA** demonstrated strengths in meeting many of the requirements, but received recommendations or required actions in all three areas. The Beneficiary Information standard received the lowest score of all standards reviewed, and resulted in required actions for **DVHA** to revise its member handbook and include adequate information on confidentiality rights, appeal rights afforded to providers, and the rights and process for requesting disenrollment.

Recommendations and Opportunities for Improvement

Performance Improvement Project

All applicable evaluation elements received *Met* scores; however, there were two *Points of Clarification* identified during HSAG's 2014–2015 validation process.

DVHA received the following recommendations for improving future PIP submissions:

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

Performance Measures

HSAG continues to offer the following recommendations related to improving **DVHA**'s data collection and reporting processes:

- **DVHA** staff should conduct additional root cause analysis on performance measures with low rates and incorporate national/regional benchmarks to manage rates.
- **DVHA** should continue its review practice and enhance it to identify rates that fall below the national 10th percentiles.
- **DVHA** would benefit from monitoring encounters to ensure federally qualified health centers (FQHCs) submit all services rendered in addition to the case rate.
- **DVHA** abstracted data from medical records but did not include the results for this reporting year. **DVHA** is encouraged to report in future years using medical record review for measures

that appear to have incomplete lab data. The hybrid project should be carefully planned next year, requesting auditor's assistance as needed.

- While **DVHA** has integrated some staff members, it is recommended that **DVHA** continue this integration and expand data monitoring and validation activities. This will help to identify declining rates and reasons for the decline.

Compliance With Standards

DVHA was required to ensure that:

- The next revision to the member handbook describes (1) at a high level, the members' right to confidentiality; (2) **DVHA**'s processes for ensuring the members' right to, the process for, and all relevant information needed to enable them to initiate/request disenrollment; and (3) information about the appeal rights that the State of Vermont makes available to providers to challenge **DVHA**'s failure to cover a service.
- It informs members about their right to terminate enrollment and provide enrollment termination procedures.
- Through the provider handbook or other informational materials, it provides substantive written information to network providers about member grievances and related requirements.
- Its policies and procedures, manuals, handbooks, and any other internal documents that define an "action" consistently include the provision regarding the failure to act within time frames as required by 42 CFR: 438.400(b)(1) and State rule.
- Members are provided with a written acknowledgement within five calendar days of receipt of the appeal as required by State rule.
- **A**ppeals are resolved and members receive written notice of the resolution within the maximum time frames for standard and expedited appeals, including any extensions.
- If AHS continues to offer members the option of requesting a reconsideration, **DVHA** reviews and revises its documentation (i.e., notice of decision form, provider manual, and any other relevant documents) to consistently allow for the member, the provider, or designated representative to request a reconsideration as required in the AHS/**DVHA** IGA.

Suggestions for DVHA

While not rising to the level of noncompliance requiring corrective action, HSAG reviewers encouraged **DVHA** to consider:

- Expanding the information it currently provides to members about (1) emergency services and when/how to access them, and (2) what poststabilization services are and how to access them.
- Conducting unannounced visits that include a walk-through of the facilities to determine any visible evidence of failure to protect confidential/privileged information (e.g., confidential documents lying face-up on desks, monitors with confidential information on the screen visible for those passing by or nearby, and confidential information being discussed in rooms with the doors open).

Background

According to 42 CFR §438.202, each state Medicaid agency is required to:

I. Have a written strategy for assessing and improving the quality of managed care services offered by all MCOs and PIHPs.
II. Obtain the input of recipients and other stakeholders in the development of the strategy and make the strategy available for public comment before adopting it.
III. Ensure that MCOs, PIHPs, and prepaid ambulatory health plans (PAHPs) comply with standards established by the State, consistent with this subpart.
IV. Conduct periodic reviews to evaluate the effectiveness of the strategy, and update the strategy periodically as needed.
V. Submit to CMS the following:
   a. A copy of the initial strategy and a copy of the revised strategy whenever significant changes are made.
   b. Regular reports on the implementation and effectiveness of the strategy.

The AHS quality strategy establishes standards related to access to care, structure and operations, quality measurement and improvement, performance objectives, provisions for external quality review, and mechanisms to monitor compliance with the standards and objectives set forth in the quality strategy.

To meet requirements set forth in the federal regulations and described in the AHS quality strategy, AHS contracted with HSAG to conduct the EQR activities beginning in EQRO contract year 2007–2008. This report covers the EQR activities conducted during 2014–2015, the EQRO contract year. The mandatory EQR activities were conducted consistent with the CMS protocols established under 42 CFR §438.352.

During the 2014–2015 contract year, and consistent with the applicable CMS protocols, HSAG performed the following EQR activities and provided to AHS and **DVHA** draft and final reports for each activity:

- Validated **DVHA**'s PIP
- Validated a set of **DVHA**'s performance measures
- Reviewed **DVHA**'s compliance with the federal Medicaid managed care standards described at 42 CFR§438.214 through 438.230 and the related AHS/**DVHA** IGA (i.e., contract) requirements
- Prepared this annual external quality review technical report

Purpose

Under its federal Medicaid demonstration waiver, the State of Vermont uses a managed care model to deliver services and is subject to the Medicaid Managed Care standards/regulations found at 42 CFR §438. This report meets the federal requirement (42 CFR §438.364) for preparation of an annual technical report that describes how data from activities conducted in accordance with 42 CFR §438.358 were aggregated and analyzed and how conclusions were drawn as to the quality and timeliness of, and the access to, care furnished by **DVHA**, Vermont's statewide Medicaid managed care model organization.

The report also includes HSAG's assessment of **DVHA**'s strengths and, as applicable, improvement recommendations in response to less than fully compliant performance and suggestions for **DVHA** to consider in further enhancing its processes, documentation, and/or performance results in providing quality, timely, and accessible care and services to its beneficiaries. Finally, the report describes **DVHA**'s self-reported improvement actions taken, still in progress, or planned in response to HSAG's prior year recommendations for each of the three activities HSAG conducted (review of compliance with standards, validation of **DVHA**'s PIP, and validation of **DVHA**'s performance measures).

Organization of the Report

Section 1—Executive Summary: This section provides contextual information about the federal Medicaid managed care requirements, AHS, and **DVHA**. This section also presents a summary of findings and conclusions about **DVHA**'s strengths and weaknesses, as derived from the EQR activities performed during 2014–2015. Section 1 also includes recommendations and opportunities for improvement in quality, timeliness, and access to care, as provided to **DVHA**. Finally, trends over time are presented as appropriate to the data available.

Section 2—Introduction: Section 2 outlines the purpose and organization of the report. This section also describes the methodology HSAG used to develop the EQR annual technical report, to categorize the results, and to draw conclusions regarding **DVHA**'s performance results related to each EQR activity.

Section 3—Description of External Quality Review Activities: For each activity HSAG performed, Section 3 provides information related to the objectives of the activity, a description of the data obtained, technical methods of data collection and analysis, and a description of how overall conclusions were drawn related to **DVHA**'s performance.

Section 4—Follow-Up on Prior Year Recommendations: This section presents **DVHA**'s self-report of the improvement actions the organization took in response to HSAG's recommendations made as a result of conducting the previous year's EQR activities and the findings for each, and the extent to which **DVHA** was successful in improving its performance results.

Methodology for Preparing the EQR Technical Report

To fulfill the requirements of 42 CFR §438.358, HSAG compiled the overall findings for each EQR activity it conducted and assessed **DVHA**'s strengths, areas requiring improvement, and opportunities to further strengthen its processes, documentation, and/or performance outcomes with respect to the quality and timeliness of, and access to, health care services.

HSAG used the following criteria for its evaluation and the data presented in this report:

1. Reliability: Reliable data consistently identify the event targeted for measure, and the results are reproducible.
2. Validity: Valid data make sense logically and capture the intended aspects of care.
3. Comparability: The data have comparable data sources and data collection methods, as well as precise specifications.
4. Meaningfulness: The data used are meaningful to the AHS, **DVHA**, beneficiaries, providers, IGA partners/vendors, and other interested stakeholders.
5. Controllability: The data used measure an aspect of care that is within AHS' and **DVHA**'s control.

Data Sources

HSAG used the following data sources to complete its assessment and to prepare this annual EQR technical report:

- Results of HSAG's validation of **DVHA**'s PIP.
- Results of HSAG's validation of **DVHA**'s performance measures.
- **DVHA**'s performance measure rates and trending of the prior year's results.
- Results of HSAG's monitoring of **DVHA**'s compliance with the selected standards in the Medicaid managed care regulations and the associated AHS/**DVHA** IGA/contract requirements; a comparison of **DVHA**'s 2014–2015 performance to the results of HSAG's review of the same set of requirements in contract year 2010–2011; and trends in **DVHA**'s performance results across the eight HSAG EQR contract years.

Categorizing Results

Once the data sources were identified, HSAG determined whether the results of the components reviewed related to the quality and/or timeliness of and/or access to health care services based on the definitions included in the executive summary of this report.

Identifying DVHA's Strengths and Opportunities for Improvement

For each of the three EQR activities, HSAG conducted a thorough review and analysis of the data. Because the activities varied in terms of the types of data HSAG collected and used, the

methodology for identifying strengths and weaknesses was designed to accommodate the data available for and specific to each activity.

Validation of PIP

HSAG considers a PIP that has achieved an overall *Met* validation status and improved study indicator outcomes an area of strength. For *Partially Met* or *Not Met* evaluation components, HSAG considers these areas of weakness and makes recommendations for improvement. In addition, for any component of the PIP activities (including *Met* elements) evaluated by HSAG during its validation, HSAG may provide a *Point of Clarification* to the organization, to assist with improved processes or documentation the next time the PIP is submitted.

Validation of Performance Measures

HSAG analyzed the performance measure data with respect to the performance levels. For each performance measure for which **DVHA** reported results, HSAG identified a high and a low performance level based on a comparison of **DVHA**'s rate to the distribution of national Medicaid percentiles. High performance (a strength) was identified as any performance measure rate meeting or exceeding the most recent (2013) national Medicaid HEDIS 90th percentile, as published by NCQA. Low performance (a weakness) was identified as any performance measure rate at or below the 2013 national Medicaid HEDIS 10th percentile.

Monitoring Compliance With Standards

HSAG determined which information, documentation, and data reflected specific aspects of care and services **DVHA** provided related to each of the standards HSAG reviewed. HSAG then analyzed and drew conclusions about the results of the compliance review with respect to the domains of quality, timeliness, and access. In reviewing specific documents and reported data and in considering **DVHA** staff responses to specific interview questions, which focused on each of the standards, HSAG recognized that information will often not be specific to only one domain but may provide insight into **DVHA**'s performance across multiple domains.

For its review of **DVHA**'s compliance with CMS' and AHS' requirements, HSAG considers a total score of 90 percent or greater for a given standard to be a relative strength. A total score below 90 percent for a given standard is considered an area of relative weakness. Any standard area with *Partially Met* or *Not Met* scores for one or more evaluation elements requires **DVHA** to take action(s) to improve performance and to come into full compliance with the requirement. In addition, while not rising to a level to be considered "noncompliance," HSAG may make additional suggestions and recommendations for improving performance in some areas.

3. Description of External Quality Review Activities

Validation of Performance Improvement Project

During the seventh year of its EQRO contract with AHS, HSAG validated one PIP that **DVHA** conducted. This section describes the processes HSAG used to complete the validation activities. HSAG described the details related to its approach, methodologies, and findings from the PIP validation activities in its Performance Improvement Project Validation Report—*Follow-up After Hospitalization for Mental Illness* for the Department of Vermont Health Access provided to AHS and **DVHA**.

Objectives and Background Information

The AHS quality strategy required **DVHA** to conduct a PIP in accordance with 42 CFR §438.240. The purpose of a PIP is to achieve, through ongoing measurements and interventions, significant improvement sustained over time in clinical or nonclinical areas. This structured method of assessing and improving the Medicaid managed care model organizations' processes is expected to have a favorable effect on health outcomes and beneficiary satisfaction. AHS contracted with HSAG as the EQRO to meet the federal Medicaid managed care requirement for validating **DVHA**'s PIP. Validation of PIPs is one of the three CMS mandatory activities.

The primary objective of HSAG's PIP validation was to determine **DVHA**'s compliance with requirements set forth in 42 CFR §438.240(b)(1), including:

- Measurement of performance using objective quality indicators.
- Implementation of systematic interventions to achieve improvement in quality.
- Evaluation of the effectiveness of the interventions.
- Planning and initiation of activities for increasing or sustaining improvement.

Description of Data Obtained

HSAG reviewed the documentation **DVHA** submitted for the one PIP validated by HSAG. The PIP was submitted using HSAG's PIP Summary Form, which HSAG developed to collect all required data elements for the PIP validation process. **DVHA** completed the PIP Summary Form following instructions provided by the HSAG PIP Review Team regarding the level of documentation required to address each PIP evaluation element. **DVHA** was also instructed to submit any supporting documentation that could provide further details and background information. HSAG provided technical assistance to **DVHA** before the PIP submission to answer **DVHA**'s questions. After HSAG validated the PIP, **DVHA** had the opportunity to incorporate HSAG's recommendations and resubmit the PIP for a final validation.

Technical Methods of Data Collection/Analysis

HSAG conducted the validation consistent with the CMS protocol, *EQR Protocol 3: Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. HSAG, with AHS' input and approval, developed the PIP Validation Tool to ensure uniform and consistent validation of the PIP. Using this tool, HSAG determined the overall methodological validity of the PIP, as well as the overall success in achieving improved study indicator outcomes, and evaluated the following CMS protocol activities:

- Activity I—Select the Study Topic
- Activity II—Define the Study Question(s)
- Activity III—Define the Study Population
- Activity IV—Select the Study Indicator(s)
- Activity V—Use Sound Sampling Techniques
- Activity VI—Reliably Collect Data
- Activity VII—Analyze Data and Interpret Study Results
- Activity VIII—Implement Intervention and Improvement Strategies
- Activity IX—Assess for Real Improvement
- Activity X—Assess for Sustained Improvement

HSAG's PIP validation process consisted of two independent reviews that included a review by team members with expertise in statistics, study design and methodology, and quality and performance improvement. The PIP validation process was conducted as follows:

- HSAG reviewed the PIP submission documentation to ensure that all required documentation had been received. If documents were missing, HSAG notified **DVHA** and requested the missing documentation if it was available.
- The validation review was conducted and the PIP Validation Tool was completed.
- The scores were reconciled by a secondary review. If scoring discrepancies were identified, the PIP Review Team discussed the discrepancies and reached a consensus for the final evaluation element score(s).
- Each required protocol activity consisted of evaluation elements necessary to complete the validation of that activity. The PIP Review Team scored the evaluation elements within each activity as *Met*, *Partially Met*, *Not Met*, *Not Applicable* (*N/A*), or *Not Assessed*. To ensure a valid and reliable review, HSAG designated some of the elements as critical elements. All critical elements must have received a *Met* score to produce valid and reliable results. The scoring methodology included the *N/A* designation for situations in which the evaluation element did not apply to the PIP. HSAG used the *Not Assessed* scoring designation when the PIP had not progressed to the remaining activities. HSAG used a *Point of Clarification* when documentation for an evaluation element included the basic components to meet the requirements for the evaluation element (as described in the narrative of the PIP); however, enhanced documentation would demonstrate a stronger application of the CMS protocols for completing a PIP.

- HSAG's criteria for determining the score were as follows:
  - *Met*: All critical elements were *Met* and 80 percent to 100 percent of all (critical and noncritical) elements were *Met.*
  - *Partially Met:* All critical elements were *Met* and 60 percent to 79 percent of all elements were *Met*, or one or more critical element was *Partially Met.*
  - *Not Met:* All critical elements were *Met* and less than 60 percent of all elements were *Met*, or one or more critical elements were *Not Met.*
  - *Not Applicable (N/A):* Elements designated *N/A* (including critical elements) were removed from all scoring.
  - *Not Assessed*: Elements (including critical elements) were removed from all scoring.
- In addition to a validation status (e.g., *Met*), HSAG gave the PIP an overall percentage score for all evaluation elements (including critical elements), which was calculated by dividing the total elements *Met* by the sum of all applicable elements that were assessed (as *Met*, *Partially Met*, and *Not Met*). A critical element percentage score was then calculated by dividing the total critical elements *Met* by the sum of the applicable critical elements that were assessed (as *Met*, *Partially Met*, and *Not Met*).
- After completing the validation review, HSAG prepared the draft and final **DVHA** Performance Improvement Project Validation Report—*Follow-up After Hospitalization for Mental Illness* for AHS and **DVHA**.

Determining Conclusions

HSAG analyzed **DVHA**'s PIP process and documentation to draw conclusions about the validity of the PIP and about **DVHA**'s quality improvement efforts.

The PIP validation process was designed so that a well-planned, strategically conducted, fully documented, and valid PIP could score 100 percent on HSAG's PIP Validation Tool. PIPs scoring at least 80 percent produce appropriately valid and generalizable results for improving the health, functional status, or outcomes for beneficiaries. HSAG's validation process accommodates for each PIP's stage of development for scoring purposes. As a result, the process does not penalize PIPs for being partially completed.

HSAG assessed the PIP's findings based on the validity and reliability of the results as follows:

- *Met*: High confidence/confidence in the reported PIP results
- *Partially Met*: Low confidence in the reported PIP results
- *Not Met*: Reported PIP results were not credible

Validation of Performance Measures

Validation of performance measures is one of three CMS mandatory activities. As set forth in 42 CFR §438.358, states are required to ensure that their contracted MCOs and PIHPs collect and report performance measures annually using standardized, state-required measures. AHS identified a set of performance measures calculated and reported by **DVHA** for validation. HSAG conducted

the validation activities following CMS' *EQR Protocol 2*: *Validation of Performance Measures Reported by the MCO: A Mandatory Protocol for External Quality Review (EQR),* Version 2.0, September 2012.

Objectives and Background Information

The primary objectives of HSAG's validation process were to:

- Evaluate the accuracy of the performance measure data **DVHA** collected.
- Determine the extent to which the specific performance measures calculated by **DVHA** followed the specifications established for each performance measure.

AHS selected 13 HEDIS measures, totaling 47 indicators, for HSAG's validation. The measurement period addressed in this report was calendar year 2013.

Description of Data Obtained

As identified in the CMS protocol, the types of data the EQRO should use to complete the performance measure validation task include:

- The **Information Systems Capabilities Assessment Tool (ISCAT),** which was completed by **DVHA**. The ISCAT provides background information on **DVHA**'s policies, processes, system capabilities, and data in preparation for the on-site validation activities.
- **Supporting documentation,** including file layouts, system flow diagrams, system log files, policies and procedures, data collection process descriptions, and file consolidations logic or extracts.
- **Current performance measure results,** which were obtained from **DVHA**.
- **On-site interviews and demonstrations,** which were conducted by HSAG. Information was obtained through interaction, discussion, and formal interviews with key **DVHA** staff members, as well as observation of data processing functions and demonstrations.

Note: Typically, the EQRO also reviews the source code used to calculate the performance measures. Since all the performance measures under the scope of this validation were approved by NCQA under the measure certification program, **DVHA** continued to contract with a software vendor to calculate the measures. HSAG did not perform additional source code review.

Technical Methods of Data Collection/Analysis

HSAG followed the same process when validating each performance measure, which included the following steps:

Pre-On-Site Activities:

- HSAG reviewed the completed ISCAT and flagged areas for on-site follow-up. The review team used the ISCAT to determine if the systems' capabilities were sufficient to report the HEDIS measures.

- HSAG reviewed all supporting documents, including prior performance measure reports, data flow diagrams, data integration logic, and NCQA's measure certification report for the selected vendor.
- HSAG provided AHS and **DVHA** with an agenda for the on-site visit. The agenda included a brief description of each session's purpose and discussion items.
- HSAG conducted a pre-on-site conference call with **DVHA** to discuss any outstanding ISCAT questions and preparations for the on-site visit.

On-Site Review Activities:

- HSAG completed an opening meeting to review the purpose, required documentation, basic meeting logistics, and queries to be performed.
- HSAG observed the data systems and processing functions, focusing on the processing of claims and encounters, Medicaid eligibility data, and provider data.
- HSAG led verbal discussions related to the ISCAT and supporting documentation, including a review of processes used for collecting, storing, validating, and reporting the performance measure data. This interactive session with key staff members allowed HSAG to obtain a complete picture of the degree of compliance with written documentation. HSAG conducted interviews to confirm findings from the document review, expand or clarify outstanding issues, and determine if **DVHA** used and followed written policies and procedures in daily practice.
- HSAG completed an overview of data integration and control procedures, including discussion and observation of programming logic and a review of how all data sources were combined. HSAG and **DVHA** discussed the processes for extracting and submitting data to the certified software vendor. HSAG also performed primary source verification, which further validated the output files; reviewed backup documentation on data integration; and addressed data control and security procedures during this session.
- HSAG conducted a closing conference to summarize its preliminary findings based on the review of the ISCAT and on-site activities, including any measure-specific concerns, and discussed follow-up actions.

Post-On-Site Activities:

- HSAG evaluated follow-up documentation **DVHA** provided to address measure-specific issues.
- HSAG evaluated **DVHA**'s performance measure results and compared them to the prior year's performance and HEDIS 2013 national Medicaid benchmarks.

Determining Conclusions

Upon HSAG's evaluation of the performance measure results, HSAG assigned a validation finding to each performance measure.

Monitoring of Compliance With Standards

Monitoring compliance with federal Medicaid managed care regulations and the applicable state contract requirements is one of the three mandatory activities a State must conduct. AHS contracted

with HSAG to conduct the compliance review of **DVHA**. HSAG followed the guidelines in the 2012 CMS protocol, *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012.

Objectives and Background Information

According to 42 CFR §438.358, a review to determine an MCO's or a PIHP's compliance with state standards must be conducted within a three-year period by a state Medicaid agency, its agent, or an EQRO. Based on 42 CFR §438.204(g), these standards must be as stringent as the federal Medicaid managed care standards described in 42 CFR §438—Managed Care, which address requirements related to access, structure and operations, and measurement and improvement. To meet these requirements, AHS:

- Continued to ensure that its IGA with **DVHA** included most of the applicable CMS Medicaid managed care requirements and that they were at least as stringent as the CMS requirements.
- Contracted with HSAG as its EQRO to conduct reviews to assess **DVHA**'s performance in complying with the federal Medicaid managed care regulations and AHS' associated IGA with **DVHA**.
- Maintained its focus on encouraging and supporting **DVHA** in targeting areas for continually improving its performance in providing quality, timely, and accessible care to beneficiaries.
- Requested that, as allowed by CMS, HSAG continue its three-year cycle of reviewing **DVHA** performance in complying with the federal Medicaid managed care regulations. This allows **DVHA** time to focus its improvement efforts and implement new initiatives. For the review covered by this report, AHS requested that HSAG review the CMS Structure and Operations standards described at 42 CFR 438.214–230 and the associated AHS IGA requirements. The primary objective of HSAG's review was to provide meaningful information to AHS and **DVHA** to use to**:**
  - Evaluate the quality and timeliness of, and access to, care and services **DVHA** and its IGA partners furnished to beneficiaries.
  - Identify, implement, and monitor interventions to continue to drive performance improvement for these aspects of care and services.

HSAG assembled a review team to:

- Collaborate with AHS to determine the scope of the review as well as the scoring methodology, data collection methods, desk review and on-site review activities and timelines, and on-site review agenda.
- Collect data and documents from AHS and **DVHA** and review them before and during the on-site review.
- Conduct the on-site review.
- Aggregate and analyze the data and information collected.
- Prepare the report of its findings and any recommendations or suggestions for improvement.

HSAG prepared and submitted to AHS, for its review and approval, a data collection tool to assess and document **DVHA**'s compliance with the Medicaid managed care regulations, State rules, and the associated AHS/**DVHA** IGA requirements. The review tool included requirements that addressed eight performance areas associated with the CMS Medicaid managed care regulations described at 42 CFR 438.214–230.

I. Provider Selection

II. Credentialing and Recredentialing

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

As these same standards were reviewed in 2010–2011, HSAG was able to evaluate **DVHA**'s current performance and perform a comparison to the earlier review of these same standards.

Description of Data Obtained

Table 3-1—Description of DVHA's Data Sources	
Data Obtained	**Time Period to Which the Data Applied**
Documentation **DVHA** submitted for HSAG's desk review and additional documentation available to HSAG during the on-site review	May 15, 2014–July 19, 2014
Information from interviews conducted on-site	July 17–19, 2014
HSAG's review of a sample of **DVHA**'s and/or its IGA partners' processing of beneficiary appeals and grievances	October 1, 2013–January 31, 2014

Technical Methods of Data Collection/Analysis

Using the AHS-approved data collection tool, HSAG performed a pre-on-site desk review of **DVHA**'s documents and an on-site review that included reviewing additional documents and conducting interviews with key **DVHA** staff members. Pre-on-site review activities included:

- Developing the compliance review tool and the record review tools HSAG used to document its findings from the review of a sample of **DVHA**'s documentation related to (1) beneficiary or provider appeals of **DVHA**'s denials of provider or beneficiary requests for services or **DVHA**'s

reductions/suspensions and terminations of previously authorized services, and (2) beneficiary grievances filed with **DVHA** or an IGA partner delegate and **DVHA**'s/IGA partner's responses to the beneficiaries.

- Preparing and forwarding to **DVHA** a customized desk review request form and instructions for submitting the requested documentation to HSAG for its desk review. The form provided information about HSAG's compliance review activities and the timelines/due dates for each.
- Developing and providing to **DVHA** the detailed agenda for each day of the 2½-day on-site review.
- Responding to any questions **DVHA** had about HSAG's desk- and on-site review activities and the documentation required from **DVHA** for HSAG's desk review.
- Conducting a pre-on-site desk review of **DVHA**'s key documents and other information obtained from AHS. The desk review enabled HSAG reviewers to increase their knowledge and understanding of **DVHA**'s operations, identify areas needing clarification, and begin compiling and documenting preliminary findings and interview questions before the on-site review.

For the on-site review activities, two HSAG reviewers conducted the 2½-day on-site review, which included:

- An opening conference, with introductions; **DVHA** staff members' overview of **DVHA** and its relationship with its IGA partners, providers, and any subcontractors; **DVHA** updates on any changes and challenges occurring since HSAG's previous review; a review of the agenda and logistics for HSAG's on-site activities; HSAG's overview of the process it would follow in conducting the on-site review; and, the tentative timelines for providing to **DVHA** and AHS its draft report for AHS' and **DVHA**'s review and comment.
- Review of the documents HSAG requested that **DVHA** have available on-site.
- Interviews with **DVHA**'s key administrative and program staff members. Separate interviews were scheduled and conducted for each of the standards included in the review tool.
- Review of a sample of files/records related to **DVHA**'s or its IGA partners' processing of beneficiary appeals and grievances.
- A closing conference during which HSAG reviewers summarized their preliminary findings. For each standard, the findings included HSAG's assessment of **DVHA**'s performance strengths; any anticipated required corrective actions and reviewers' suggestions that had the potential to further enhance **DVHA**'s processes; documentation; performance results; and the quality, access to, and timeliness of services provided to beneficiaries.

HSAG reviewers documented their findings in the data collection (compliance review) tool. The tool served as a comprehensive record of HSAG's findings, the performance scores it assigned to **DVHA**'s performance for each requirement, and a limited number of required corrective actions. While not requiring formal corrective action, HSAG also made suggestions to further strengthen and drive continued improvement in **DVHA**'s performance. The completed tool was included as one section of HSAG's compliance report. Table 3-1 lists the major data sources HSAG used in determining **DVHA**'s performance in complying with requirements and the time period to which the data applied.

Table 3-2 presents a more detailed, chronological description of the above activities that HSAG performed during its review.

Table 3-2—The Compliance Review Activities HSAG Performed	
Step 1:	**Established the review schedule.**
	Before the review, HSAG coordinated with AHS and **DVHA** to set the schedule and assigned HSAG reviewers to the review team.
Step 2:	**Prepared the data collection tool for review of the eight standards and submitted it to AHS for review and comment.**
	To ensure that all applicable information was collected, HSAG developed a compliance review tool consistent with CMS protocols. HSAG used the requirements in the IGA between AHS and **DVHA** to develop the standards (groups of requirements related to broad content areas) to be reviewed. HSAG also used the federal Medicaid managed care regulations described at 42 CFR 438, with revisions issued June 14, 2002, and effective August 13, 2002. Additional criteria used in developing the monitoring tool included applicable Vermont and federal requirements. Prior to finalizing the tool, HSAG submitted the draft to AHS for its review and comments.
Step 3:	**Prepared and submitted the Desk Review Form to DVHA.**
	HSAG prepared and forwarded a desk review form to **DVHA** and requested that it submit specific information and documents to HSAG within a specified number of days of the request. The form included instructions for organizing and preparing the documents related to the review of the eight standards, submitting documentation for HSAG's desk review, and having additional documents available for HSAG's on-site review.
Step 4:	**Forwarded a Documentation Request and Evaluation Form to DVHA.**
	HSAG forwarded to **DVHA**, as an accompaniment to the desk review form, a documentation request and evaluation form containing the same standards and AHS IGA (i.e., contract) requirements as the tool HSAG used to assess **DVHA**'s compliance with each of the requirements within the standards. The desk review form included detailed instructions for completing the "Evidence/Documentation as Submitted by **DVHA**" portion of this form. This step (1) provided the opportunity for **DVHA** to identify for each requirement the specific documents or other information that provided evidence of its compliance with the requirement, and (2) streamlined the HSAG reviewers' ability to identify all applicable documentation for their review.
Step 5:	**Developed an agenda for each review day and submitted the agendas to DVHA.**
	HSAG developed the agendas to assist **DVHA** staff members in their planning to participate in HSAG's on-site review, assembling requested documentation, and addressing logistical issues. HSAG considers this step essential to performing an efficient and effective on-site review and minimizing disruption to the organization's day-to-day operations. An agenda sets the tone and expectations for the on-site review so that all participants understand the process and time frames.

Table 3-2—The Compliance Review Activities HSAG Performed	
Step 6:	**Provided technical assistance.**
	As requested by **DVHA**, and in collaboration with AHS, HSAG staff members responded to any **DVHA** questions about the requirements for which HSAG would evaluate its performance and about the required **DVHA** documentation.
Step 7:	**Received DVHA's documents for HSAG's desk review and evaluated the information before conducting the on-site review.**
	HSAG compiled and organized the information and documentation, and reviewers used the documentation **DVHA** submitted for HSAG's desk review to gain insight into areas such as **DVHA**'s structure and relationship with its IGA partners, providers, and delegates; information provided to beneficiaries and providers; processes for responding to appeals and grievances; and **DVHA**'s operations, resources, and delegated functions. Reviewers then: ◆ Documented in the review tool their preliminary findings after reviewing the materials **DVHA** submitted as evidence of its compliance with the requirements. ◆ Identified any information not found in the desk review documentation in order to request it prior to the on-site review. ◆ Identified areas and questions requiring further clarification or follow-up during the on-site interviews.
Step 8:	**Conducted the on-site portion of the review.**
	During the 2½-day on-site review, HSAG: ◆ Conducted an opening conference that included introductions, HSAG's overview of the on-site review process and schedule, **DVHA's** overview of its structure and processes, and, a discussion about any changes needed to the agenda and general logistical issues. ◆ Conducted interviews with **DVHA**'s staff members. HSAG used the interviews to obtain a complete picture of **DVHA**'s compliance with the federal Medicaid managed care regulations and associated AHS IGA requirements, explore any issues not fully addressed in the documents that HSAG reviewed, and increase HSAG reviewers' overall understanding of **DVHA**'s performance. ◆ Reviewed additional documentation. HSAG reviewed additional documentation while on-site and used the review tool to identify relevant information sources and document its review findings. HSAG summarized findings on the last day of the on-site portion of the review. As the final on-site review activity, HSAG reviewers conducted a closing conference to provide **DVHA** staff members and AHS participants with a high-level summary of HSAG's preliminary findings. For each of the eight standards, the findings included HSAG's assessment of **DVHA**'s strengths; any areas requiring corrective action; and any HSAG suggestions for further strengthening **DVHA**'s processes, performance results, and/or documentation.

Table 3-2—The Compliance Review Activities HSAG Performed	
Step 9:	**Documented reviewer findings in the Documentation Request & Evaluation Tool**
	Beginning prior to and continuing through the on-site review, HSAG reviewers documented their preliminary findings related to **DVHA**'s performance for each requirement. Following the on-site review, the reviewers completed their documentation in the tool and finalized their documentation of **DVHA**'s strengths; required corrective actions; and any suggestions for further strengthening **DVHA**'s performance related to its written documentation and to providing accessible, timely, and quality services to beneficiaries.
Step 10:	**Calculated the individual scores and determined the overall compliance score for performance.**
	HSAG evaluated and analyzed **DVHA**'s performance in complying with the requirements in each of the eight standards contained in the review tool. HSAG used *Met*, *Partially Met*, and *Not Met* scores to document the degree to which **DVHA** complied with each of the requirements. A designation of *NA* was used if an individual requirement did not apply to **DVHA** during the period covered by the review. For each of the eight standards, HSAG calculated a percentage-of-compliance score and then an overall percentage-of-compliance score across the eight standards.
Step 11:	**Prepared a draft and final report.**
	After completing the documentation of findings and scoring for each of the standards, HSAG prepared a draft report that described HSAG's compliance review findings, the scores it assigned for each requirement within the eight standards, and HSAG's assessment of **DVHA**'s strengths. HSAG also documented any areas requiring **DVHA** corrective action, as well as HSAG's suggestions for further strengthening **DVHA**'s performance results, processes, and/or documentation. HSAG forwarded the report to AHS and **DVHA** for their review and comment. Following AHS' final approval of the draft, HSAG issued the final report to AHS and **DVHA**.

Determining Conclusions

HSAG used scores of *Met*, *Partially Met*, and *Not Met* to indicate the degree to which **DVHA**'s performance complied with the requirements. HSAG used a designation of *N/A* when a requirement was not applicable to **DVHA** during the period covered by HSAG's review. This scoring methodology is defined as follows:

Met indicates full compliance, defined as both of the following:

- All documentation listed under a regulatory provision, or component thereof, is present.
- Staff members are able to provide responses to reviewers that are consistent with each other and with the documentation.

Partially Met indicates partial compliance, defined as either of the following:

- There is compliance with all documentation requirements, but staff members are unable to consistently articulate processes during interviews.
- Staff members can describe and verify the existence of processes during the interview, but documentation is incomplete or inconsistent with practice.

Not Met indicates noncompliance, defined as either of the following:

- No documentation is present and staff members have little or no knowledge of processes or issues addressed by the regulatory provisions.
- For a provision with multiple components, key components of the provision could be identified and any findings of *Not Met* or *Partially Met* would result in an overall finding of noncompliance for the provision, regardless of the findings noted for the remaining components.

From the scores it assigned to **DVHA**'s performance for each of the requirements, HSAG calculated a total percentage of compliance score for each of the eight standards and an overall percentage of compliance score across the standards. HSAG calculated the total score for each standard by summing the weighted scores for the requirements in the standard—*Met* (value: 1 point), *Partially Met* (value: 0.50 points), *Not Met* (value: 0.00 points), and *Not Applicable* (value: 0.00 points)—and dividing the summed weighted scores by the total number of applicable requirements for that standard. HSAG determined the overall compliance score across the eight standards by following the same method used to calculate the scores for each standard (i.e., by summing the weighted values of the scores and dividing them by the total number of applicable requirements).

4. Follow-Up on Prior EQR Recommendations

Introduction

This section presents **DVHA**'s responses and a description of actions it took or is taking to address HSAG's recommendations made in the prior year's EQR report. The report included HSAG's recommendations to improve **DVHA**'s performance related to HSAG's findings from validation of **DVHA**'s performance improvement project and performance measures, and the review of its performance in complying with the select federal Medicaid managed care regulations and associated AHS IGA requirements in select performance areas. **DVHA**'s responses were self-reported and, at the time this report was published, not all of them had yet been validated by AHS or HSAG.

Validation of Performance Improvement Project

During the previous EQRO contract year (2013–2014), HSAG validated **DVHA**'s PIP related to its Chronic Care Initiative, *Increasing Adherence to Evidence-Based Pharmacy Guidelines for Members Diagnosed With Congestive Heart Failure*. The validation process included **DVHA**'s submission of the PIP and HSAG's completion of the validation tool. For the 10 review activities **DVHA** completed and HSAG assessed, **DVHA**'s percentage of evaluation elements receiving a score of *Met* was 96 percent.

Table 4-1—Performance Improvement Project—Recommendations/Suggestions and DVHA Responses

HSAG Recommendations	DVHA Response/Actions/Outcomes
In its report of findings provided to **DVHA** and AHS, HSAG recommended that **DVHA** should: ◆ If it has not already done so, conduct further drill-down analysis to ensure that the barriers identified were specific to the population and that targeted interventions are implemented which directly address the barriers.	Based on information collected from pharmacy claims and direct report from members engaged in Vermont Chronic Care Initiative (VCCI) services, care managers continue to find that members generally are compliant with taking medications prescribed by their physicians. Therefore, interventions regarding evidence-based medications have continued to focus more heavily on the prescribers than the members. Using lessons learned from previous PIPs, recommendations from HSAG, and feedback from consultants, **DVHA** staff members continue to improve their skills in conducting PIPs. For **DVHA**'s current PIP, *Follow-up After Hospitalization for Mental Illness*, the PIP team conducted a barrier analysis using the fishbone technique and will conduct further drill-down analysis upon reviewing the first interim data analysis.

Table 4-1—Performance Improvement Project—Recommendations/Suggestions and DVHA Responses	
HSAG Recommendations	**DVHA Response/Actions/Outcomes**
◆ Continue to review interim evaluations of results in addition to the annual evaluation.	Medication adherence for heart failure is assessed periodically through the patient health registries focused on this condition, and annually for year-end reporting. For its current PIP, **DVHA** has developed interim measures to evaluate the progress of the PIP.
◆ Use data mining/analysis techniques and **DVHA**'s knowledge of member characteristics, utilization statistics, and provider practice patterns to identify any disparate subgroup within the study population and implement interventions that target a specific barrier or the disparate subgroup, if one is identified.	During meetings with providers to review patient health registries on heart failure, **DVHA**'s care management staff members discuss historical trends within the practice. The current vendor contract is being rebid, and a planned enhancement that will be made with the new vendor will be to show practices how their adherence rates compare with the rates in other practices. **DVHA** has developed a data management plan for the current PIP which included a significant amount of work on data clean-up for the first year. As the PIP moves forward, **DVHA** will use this recommendation as it considers both provider and beneficiary interventions.
◆ Having not sustained improvement, investigate the data collected to ensure that **DVHA** has correctly identified the barriers and implemented appropriate and effective interventions; and if **DVHA** has not done so, revise interventions and collect additional data to remeasure and evaluate outcomes for improvement, thereby creating a cyclical process until **DVHA** has sustained statistically significant improvement.	**DVHA** has continued to address identified barriers and evaluate progress; however, statistical analyses have not yet been completed. **DVHA** has identified the finding that heart failure diagnoses are more reliable when two claims with this diagnosis are required, rather than just one. The incidence of members reporting that they were inaccurately included in the intervention population now appears to be negligible. As **DVHA**'s current PIP is in year 2 and its first intervention has been implemented, the team has begun discussions of data analysis and the possibility of the need to revise interventions. The team will use quality improvement (QI) tools to identify barriers and possible revised interventions.

Validation of Performance Measures

HSAG validated performance measures for nine areas of performance (with one diabetes measure including four indicators) for a total of 12 indicators. HSAG auditors determined that all 12 were compliant with AHS' specifications and the rates could be reported. As a result of HSAG's desk review and on-site audit, HSAG described the following areas for improvement.

Table 4-2—Performance Measure—Recommendations/Suggestions and DVHA Responses	
HSAG Recommendations	**DVHA Response/Actions/Outcomes**
◆ **DVHA** should use prior year utilization figures to identify gaps or trends in service categories, such as laboratory (lab) and pharmacy data. As also recommended in the prior year, **DVHA** should aggressively pursue options for obtaining Logical Observation Identifiers, Names, and Codes (LOINC) data from Hewlett-Packard (HP), as it was apparent that some lab providers were reporting LOINC codes, but HP was not retaining or using them for payment purposes.	Lab information is currently not retained by HP when the information is presented on the claim. **DVHA** will not be able to address this until the new MMIS is implemented in calendar year (CY) 2017.
◆ **DVHA** should integrate its quality improvement staff into all areas related to performance measure reporting in order to coordinate data analysis efforts and prepare for future PMV activities. It would be beneficial for **DVHA**'s Information Technology (IT) staff to consider all data sources and bring content experts/stakeholders to regular HEDIS team meetings so that everyone understands the flow of data.	The **DVHA** Data Unit and Quality Unit have been able to improve on integration with the addition of quality staff. A staff person from the data unit has been identified as the primary contact for the Quality Unit. The two units now work closely on producing performance measures and on performance improvement projects. The Quality Unit is the lead for training staff to perform chart extractions for the hybrid measures. Quality Unit staff members participate in the calls with their HEDIS vendor, Verisk Health.
◆ As **DVHA** becomes more familiar with HEDIS and PMV processes, it may be beneficial to consider alternative methods for reviewing data (for example, reviewing per member per month [PMPM] or per member per hybrid reporting) and make use of all available resources and industry experts in order to ensure a successful outcome. **DVHA** is encouraged to carefully plan its hybrid project for next year.	**DVHA** has worked with a contractor to train staff on performing chart reviews for the hybrid measures. Staff members are also working with **DVHA**'s HEDIS vendor and attending several trainings on how to use the tools to perform the extractions. The Quality Unit has developed a manual which outlines procedures to ensure consistency and staff members have been identified to be trainers for clinical reviewers.
◆ HSAG encourages **DVHA** to provide an organizational overview PowerPoint presentation for next year's audit highlighting its performance improvement project work, system or processes changes, and any other quality-related initiatives or outreach efforts. ◆ **DVHA** is encouraged to actively pursue	This recommendation will be considered during preparation for the next audit. **DVHA** has been working closely with its HEDIS vendor, Verisk Health, with hybrid implementation.

Table 4-2—Performance Measure—Recommendations/Suggestions and DVHA Responses

HSAG Recommendations	DVHA Response/Actions/Outcomes
acquiring these data for 2013 if possible, in order to administratively increase rates for measures that do not incorporate hybrid methodology.	
◆ Because of its ambitious plans, **DVHA** should carefully plan the hybrid project (for HEDIS 2014) to include *Controlling High Blood Pressure* and *Prenatal* and *Postpartum Care* to ensure success. HSAG recommends **DVHA** obtain guidance from subject matter experts and other industry resources as it begins these efforts.	**DVHA** contracted for training of staff to perform the hybrid chart reviews. Staff members are also participating in ongoing trainings with **DVHA**'s HEDIS vendor on performing chart extractions.

Monitoring Compliance With Standards

HSAG evaluated **DVHA**'s performance related to seven standards (groups of related requirements). The standards included requirements in the following performance areas: Availability of Services, Furnishing of Services, Cultural Competency, Coverage and Authorization of Services, Emergency and Post Stabilization Services, and Enrollment and Disenrollment.

Table 4-3—Monitoring Compliance With Standards—Recommendations/Suggestions and DVHA Responses

HSAG Recommendations	DVHA Responses/Actions/Outcomes
◆ In the area of coverage and authorization of services, specifically related to the content of notices of actions, **DVHA**'s notices did not consistently include all required information. **DVHA** must ensure that written notice of action from the MCE, and those of its partner delegates, meet all content requirements described in 42 CFR 438.404(b) and in the AHS-**DVHA** IGA.	**DVHA** reported that its notices now contain standardized language designed to comply with the AHS-DVHA IGA and 42 CFR 438.404(b). Furthermore, a new e-mail group was formed to quickly review changes in notice letter templates to ensure clarity and compliance.
◆ Related to the requirements for coverage and authorization of services, **DVHA** must ensure that a written notice of action is provided to the beneficiary at the time of denial of claims payment for covered services. (Note: This requirement to notify the beneficiary does not apply to payment denials based on procedural issues [e.g., the provider was not billing the services on time or the provider used the incorrect procedure code]). ◆ It is also recommended that **DVHA** modify its Notice of Action Policy to conform to these requirements.	**DVHA**'s MMIS does not currently support this capability, but it is being added to **DVHA**'s new MMIS, which is still under procurement. **DVHA** members are protected from financial liability in that the provider agreement forbids any provider from billing a member for a service that was billed to Medicaid (even if the claim is denied).
◆ Related to Emergency and Post Stabilization	These changes have been incorporated into **DVHA**'s

Table 4-3—Monitoring Compliance With Standards—Recommendations/Suggestions and DVHA Responses	
HSAG Recommendations	**DVHA Responses/Actions/Outcomes**
Services, and while not rising to the level of requiring corrective action, **DVHA** is encouraged to consider adding to the provider manual and the member handbooks that **DVHA** does not limit or define what constitutes an emergency medical condition based on a list of diagnoses or symptoms.	next printing of the member handbook (which it will begin mailing out by 2/28/15).
◆ Also in the area of Emergency and Post Stabilization Services, HSAG encourages **DVHA** to ensure that providers were fully informed about the changes to requirements related to billing and reimbursement for emergency and poststabilization services provided to members.	**DVHA** added language to its provider manual to address this recommendation (see Section 7.3.1 on page 50).
◆ Related to requirements for enrollment and disenrollment, HSAG encouraged **DVHA** to consider using other wording in the member handbook addressing "excessive" no shows without prior cancellations, and to consider only member in-office behaviors that were inappropriate and not due to diminished mental or emotional capabilities.	**DVHA** removed the language about disenrollment due to "no-shows" and replaced it with language reminding members that they are responsible for keeping appointments. See page 20 of the member handbook.

VERMONT PREMIUM ASSISTANCE PROGRAM:

Designated State Health Program for State Funded Marketplace Subsidies

PROGRAM EVALUATION

Conducted by:

The Pacific Health Policy Group

On behalf of:

State of Vermont

Agency of Human Services

Secretary's Office

September 18, 2014

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Overview

As Vermont prepared for the transition to the Affordable Care Act (ACA) in 2013, a preliminary comparison of cost-sharing obligations between existing Vermont Medicaid coverage groups and the ACA found that in some instances ACA cost sharing would be substantially higher than the State's existing Medicaid waiver programs such as VHAP and Catamount Health.

Concerned that the ACA could result in a financial challenge for those currently with health care coverage through VHAP and Catamount Health, Vermont sought CMS guidance on supplementing the federal subsidies under the ACA for premiums and out-of-pocket expenses. In October of 2013, Vermont received approval to further subsidize monthly premiums to ensure greater affordability for low- and middle-income Vermonters effective January 1, 2014.

Specifically, the State may claim Marketplace premium subsidies as allowable expenditures under the Global Commitment to Health (GC) Section 1115 Demonstration waiver for individuals with incomes up to and including 300 percent of the Federal Poverty Level (FPL). Vermont provides subsidies on behalf of individuals who:

(1) are not Medicaid eligible;
(2) are eligible for the advance premium tax credit (APTC); and
(3) have household income up to and including 300% of FPL.

CMS has set the following annual limits for gross expenditures for which federal financial participation is available:

Calendar Year	Subsidy Limit
2014	$9,616,669
2015	$10,247,721
2016	$11,055,193

Program Goals and Objectives

Vermont goals for its marketplace subsidy program align with its overarching health care reform objective to bring universal health care to all Vermonters. Specifically, the Vermont Premium Assistance program was approved by CMS to:

- Ensure coverage under the ACA remained affordable for Vermonters who were formerly part of the VHAP and Catamount Medicaid Expansion populations under the GC Demonstration, and
- Create incentives for uninsured Vermonters to gain coverage under the ACA.

Implementation Activities

Legislative approval for the premium reduction was sought during the 2012 and 2013 legislative session as part of Vermont's overall health care reform efforts and the State's transition to the ACA. Section E.307 of Act 50 (Vermont's 2014 Budget Bill) granted the Administration the authority to pursue development of the State-based premium subsidy. CMS provided approval of federal participation in the program financing effective January 1, 2014, as part of the GC Demonstration renewal on October 2, 2013.

As part of its CMS-approved ACA transition plan, the Agency of Human Services, through the Department for Children and Families, Economic Services Division, began a comprehensive revision of the State's Medicaid eligibility rules and State Plan eligibility groups.

Emergency rules were promulgated and approved on September 30, 2013, that formerly recognized the Marketplace subsidy program. That rule filing was followed by another emergency rule to extend necessary eligibility changes while final proposals were under development. The second filing was approved on December 30, 2013, extending the program changes for another three months. On March 21, 2014, the State's final proposed rule to align Medicaid eligibility under the ACA was submitted for legislative review. The March submission became final rules for the Medicaid program on July 30, 2014. The premium assistance program retained its original guidelines and descriptions throughout the public filing process and various drafts. The subsequent final rules did not significantly change the premium assistance section as submitted in September 2013.

Program Policies and Procedures

The Vermont Premium Assistance (VPA) program is an extension of the existing federal APTC formula used when health coverage payment obligations are calculated. Specifically, persons applying for Qualified Health Plan (QHP) coverage in Vermont do so using Vermont Health Connect (VHC), the State's health benefit marketplace. Premiums for VHC plans are assessed based the individual's choice of plan and their coverage type (single, two person, or family). The individual's share of the premium is based on a calculation of their "applicable percentage." Applicable percentage is an income-sensitive formula depicted in Exhibit 1 on the following page and based on federal poverty level and household size.

Exhibit 1 – Applicable Percentage by FPL for APTC Calculations

Household Income Percentage of FPL	Applicable Percentage Range for APTC	
	Lowest FPL %	Highest FPL %
Less than 133%	2.0	2.0
At least 133% but less than 150%	3.0	4.0
At least 150% but less than 200%	4.0	6.3
At least 200% but less than 250%	6.3	8.05
At least 250% but less than 300%	8.05	9.5
At least 300% but not more than 400%	9.5	9.5

The Applicable Benchmark Plan (ABP) used for APTC is typically the second-lowest cost silver plan offered through VHC for single-person and family plans. The product of the applicable percentage (from above) and household income is subtracted from the premium for the ABP to obtain the federal subsidy amount that will be provided on behalf of the qualified individual.

The VPA further decreases an individual's share of the premium by subtracting a flat 1.5 percent from the federal applicable percentage for individuals who are expected to have household income that does not exceed 300 percent of the FPL for the benefit year for which coverage is requested. This adjustment results in the following applicable percentages.

Exhibit 2 – Applicable Percentage by FPL for VPA Calculations

Household income percentage of FPL	Applicable % with VT Premium Reduction	
	Lowest FPL %	Highest FPL %
Less than 133%	0.5	0.5
At least 133% but less than 150%	1.5	2.5
At least 150% but less than 200%	2.5	4.8
At least 200% but less than 250%	4.8	6.55
At least 250% but not more than 300%	6.55	8.0

The example below illustrates how VPA works:

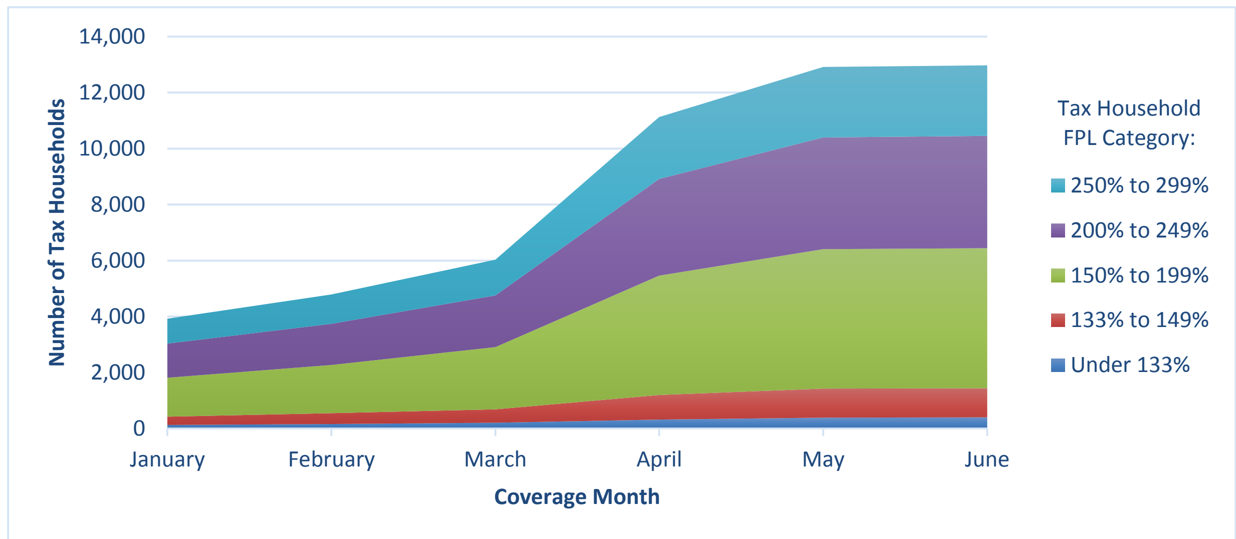
> *Person A is single and has expected income equal to 200 percent FPL, or $1916 per month (using the 2013 FPLs, which are currently used for the APTC calculation). The federal applicable percentage for an individual with income at 200 percent FPL is 6.3 percent. Using the federal applicable percentage, Person A's premium obligation would be $120.71 per month for enrollment in the ABP. The VPA*

decreases the applicable percentage for Person A to 4.8 percent (6.3 minus 1.5 percent), which reduces Person A's premium obligation from $120.71 to $91.97 per month. The VPA brings Person A's monthly premium obligation closer to the $60 per month he or she would have paid under Vermont's Catamount Health Assistance Program.

Program Characteristics and Findings to Date

Since its effective date of January 1, 2014, VPA awards have been steadily increasing from a low of 3,923 tax households for coverage in January 2014 to the current 12,979 tax households for coverage in June 2014. Data suggest that, through May 2014, approximately 13 percent of tax households applying for premium assistance have experienced glitches in the enrollment process that were corrected in subsequent months with "catch-up" payments. In other words, payments were made by VHC to ensure the consumer received their full benefit regardless of any problems experienced with the application process. See Exhibit 3 below for monthly enrollment growth by FPL category.

Exhibit 3 – Monthly Enrollment (Tax Households) by FPL in the VPA Program for Coverage Months January through June 2014



The VPA program has provided subsidies for 13,060 households as of June 30, 2014. These tax households represent QHP coverage for 17,377 individuals in Vermont. The FPL range with the greatest number of premium assistance recipients is 150 to 199 percent FPL, followed by 200 to 249 percent.

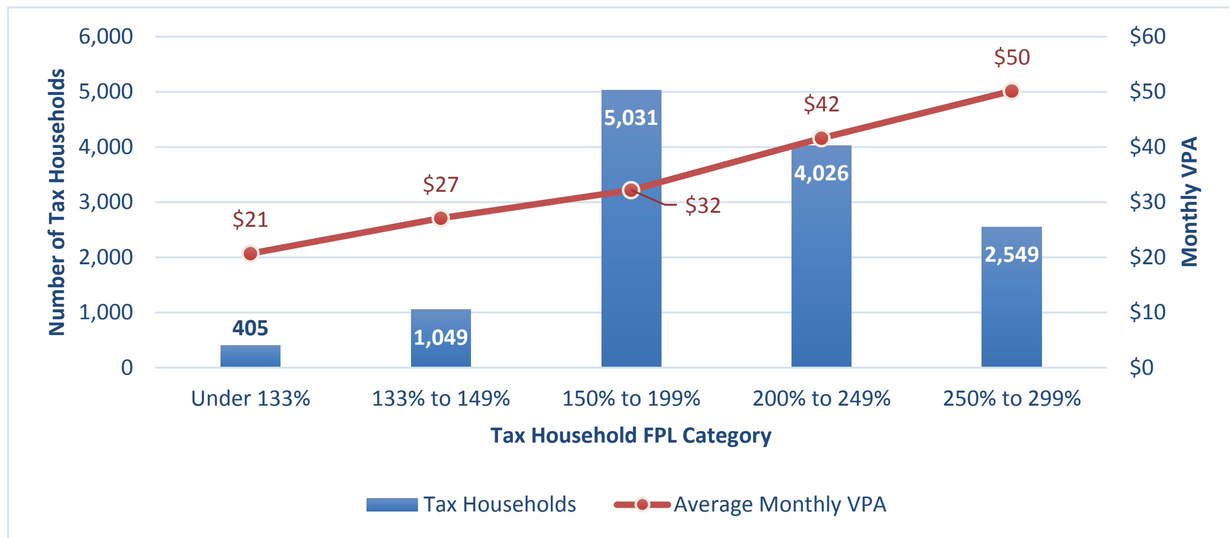
Exhibit 4 below presents the number of households, covered individuals, average household income, and average VPA for each FPL category.

Exhibit 4 Vermont Premium Reduction Households, Average Monthly Reduction and Household Income by FPL

Tax Household FPL Category	Tax Households	Individuals Covered in QHP	Average Monthly VPA	Average Tax HH Income
Under 133%	405	511	$21	$17,251
133% to 149%	1,049	1,331	$27	$21,474
150% to 199%	5,031	6,521	$32	$26,092
200% to 249%	4,026	5,413	$42	$33,062
250% to 299%	2,549	3,601	$50	$39,953
Total	**13,060**	**17,377**	**$38**	**$30,301**

The average premium reduction paid through May 2014 (for June 2014 coverage) across all income levels is $38 per month. Average premium reductions range from $21 to $50, depending on the FPL category. The VPA is applied as a 1.5 percent reduction at all income levels; thus, a higher income will result in a higher average reduction amount. See Exhibit 5 below.

Exhibit 5 – Enrollment Distribution and Average VPA Payment by FPL for All Tax Households Ever Enrolled for Coverage Months January to June 2014



Total VPA payments made for QHP coverage months January through June 2014 (i.e., VPA payments made December 2013 through May 2014) total approximately $2 million (see Exhibit 6 below).

Exhibit 6 – VPA Payments by FPL

Tax Household FPL Category	Aggregate VPA Payments
Under 133%	$34,364
133% to 149%	$110,089
150% to 199%	$629,447
200% to 249%	$668,001
250% to 299%	$530,115
Total	**$1,972,016**

During the transition to ACA, Vermont enrollment projections estimated that approximately 19,222 individuals would move from Medicaid waiver expansion programs into the Marketplace (Wakely 2012)[1]. Based on current VHC data, approximately 90 percent, or 17,377 covered persons who may have otherwise been part of this former group are benefiting from the VPA program.

Preliminary VHC data suggest that the program is attracting persons in income categories above 133 percent who may have otherwise applied for VHAP, Catamount, ESIA and VHAP-ESI pre-January 1, 2014. Given the steady increase in enrollments seen in the first six months, it is reasonable to expect that the program will reach a similar number of persons as were served under Vermont's former Medicaid expansion programs for households above 133 percent FPL.

The transition to ACA resulted in a replacement of coverage options and currently does not include competing programs or additional State efforts for enrollment incentives. As such, it does not appear that other external influences or reform efforts would confound findings for the VHC and premium assistance efforts reviewed in this report.

Elements for Future Evaluation Efforts

The VPA program is one element in the larger framework of the GC Demonstration and in the State's overall Health Care Reforms. The renewal request for the GC Special Terms and Conditions included elements necessary for the transition to ACA on January 1, 2014, and the consolidation of the State's two Section 1115 waiver programs into one single framework. As such, the renewal package has been negotiated with a bifurcated approval process with ACA elements approved in October 2014 and other elements still under review. The State anticipates that final negotiations to consolidate the CFC and GC

[1] *Vermont Agency of Human Services: Vermont Enrollment Projections September 2012 Wakely Consulting*

Demonstrations will be completed by October 1, 2014, at which time the State will revise and update its overall Section 1115 waiver evaluation plan. That plan will include a more comprehensive review and evaluation of the VPA program.

Future VPA evaluation efforts will address the goals and outcomes of the program including: impact on former expansion program recipients and the success of the State's efforts to enroll more persons in a QHP under the ACA. This may include, but not be limited to the following elements:

- Consumer surveys or feedback on questions such as: Did the State's premium assistance make health coverage affordable for you and your family? Would you have applied for a QHP if a subsidy were not available?
- Analysis of the trends in demographic information for households receiving the premium assistance, including but not limited to: age, income, FPL, and household size.
- Analysis of payment trends by income, amount, and month.
- Analysis of the number of individuals receiving subsidy assistance who were former VHAP, Catamount, or ESIA expansion program recipients.

Data sources may include, but not be limited to: the VHC file extracts, Medicaid eligibility files from December 2013, and consumer survey responses.

FORM CMS-416: ANNUAL EPSDT PARTICIPATION REPORT

State Code | **Fiscal Year**

		Totals	Age Group <1	Age Group 1-2	Age Group 3-5	Age Group 6-9	Age Group 10-14	Age Group 15-18	Age Group 19-20
1a. Total individuals eligible for EPSDT	CN:	56,494	1,942	6,303	9,416	12,584	14,294	10,227	1,728
	MN:	1,505	27	86	75	109	146	421	641
	Total:	57,999	1,969	6,389	9,491	12,693	14,440	10,648	2,369
1b. Total Individuals eligible for EPSDT for 90 Continous Days	CN:	56,255	1,870	6,287	9,391	12,554	14,242	10,191	1,720
	MN:	1,503	27	86	75	109	146	421	639
	Total:	57,758	1,897	6,373	9,466	12,663	14,388	10,612	2,359
1c. Total Individuals Eligible under a CHIP Medicaid Expansion	CN:	6,864	118	555	691	1,424	1,969	1,618	489
	MN:	0	0	0	0	0	0	0	0
	Total:	6,864	118	555	691	1,424	1,969	1,618	489
2a. State Periodicity Schedule			7	5	3	4	5	4	2
2b. Number of Years in Age Group			**1**	**2**	**3**	**4**	**5**	**4**	**2**
2c. Annualized State Periodicity Schedule			7.00	2.50	1.00	1.00	1.00	1.00	1.00
3a. Total Months of Eligibility	CN:	650,369	15,207	73,444	109,963	147,432	167,085	118,890	18,348
	MN:	17,417	236	1,010	871	1,291	1,722	4,962	7,325
	Total:	667,786	15,443	74,454	110,834	148,723	168,807	123,852	25,673
3b. Average Period of Eligibility	CN:	0.96	0.68	0.97	0.98	0.98	0.98	0.97	0.89
	MN:	0.97	0.73	0.98	0.97	0.99	0.98	0.98	0.96
	Total:	0.96	0.68	0.97	0.98	0.98	0.98	0.97	0.91
4. Expected Number of Screenings per Eligible	CN:		4.76	2.43	0.98	0.98	0.98	0.97	0.89
	MN:		5.11	2.45	0.97	0.99	0.98	0.98	0.96
	Total:		4.76	2.43	0.98	0.98	0.98	0.97	0.91
5. Expected Number of Screenings	CN:	71,057	8,901	15,277	9,203	12,303	13,957	9,885	1,531
	MN:	1,699	138	211	73	108	143	413	613
	Total:	72,756	9,039	15,488	9,276	12,411	14,100	10,298	2,144
6. Total Screens Received	CN:	43,885	7,479	12,631	6,375	6,281	6,838	4,035	246
	MN:	727	173	178	59	48	73	118	78
	Total:	44,612	7,652	12,809	6,434	6,329	6,911	4,153	324
7. SCREENING RATIO	CN:	0.62	0.84	0.83	0.69	0.51	0.49	0.41	0.16
	MN:	0.43	1.00	0.84	0.81	0.44	0.51	0.29	0.13
	Total:	0.61	0.85	0.83	0.69	0.51	0.49	0.40	0.15
8. Total Eligibles Who Should Receive at Least One Initial or Periodic Screen	CN:	55,036	1,870	6,287	9,203	12,303	13,957	9,885	1,531
	MN:	1,463	27	86	73	108	143	413	613
	Total:	56,499	1,897	6,373	9,276	12,411	14,100	10,298	2,144

* Includes 12-month visit
Note: "CN" = Categorically Needy, "MN"= Medically Needy

FORM CMS-416: ANNUAL EPSDT PARTICIPATION REPORT

State Code **Fiscal Year**

		Totals	Age Group <1	Age Group 1-2	Age Group 3-5	Age Group 6-9	Age Group 10-14	Age Group 15-18	Age Group 19-20
9. Total Eligibles Receiving at least One Initial or Periodic Screen	CN:	29,863	1,870	5,263	5,825	6,102	6,676	3,890	237
	MN:	460	27	74	52	47	71	113	76
	Total:	30,323	1,897	5,337	5,877	6,149	6,747	4,003	313
10. PARTICIPANT RATIO	CN:	0.54	1.00	0.84	0.63	0.50	0.48	0.39	0.15
	MN:	0.31	1.00	0.86	0.71	0.44	0.50	0.27	0.12
	Total:	0.54	1.00	0.84	0.63	0.50	0.48	0.39	0.15
11. Total Eligibles Referred for Corrective Treatment	CN:	0	0	0	0	0	0	0	0
	MN:	0	0	0	0	0	0	0	0
	Total:	0	0	0	0	0	0	0	0
12a. Total Eligibles Receiving Any Dental Services	CN:	34,149	10	1,636	5,795	9,416	10,122	6,509	661
	MN:	660	0	24	41	73	103	237	182
	Total:	34,809	10	1,660	5,836	9,489	10,225	6,746	843
12b. Total Eligibles Receiving Preventive Dental Services	CN:	33,775	9	1,629	5,760	9,337	10,017	6,387	636
	MN:	639	0	24	41	73	102	225	174
	Total:	34,414	9	1,653	5,801	9,410	10,119	6,612	810
12c. Total Eligibles Receiving Dental Treatment Services	CN:	12,589	1	233	1,599	3,691	3,743	2,978	344
	MN:	313	0	4	9	33	44	116	107
	Total:	12,902	1	237	1,608	3,724	3,787	3,094	451
12d. Total Eligibles Receiving a Sealant on a Permanent Molar Tooth	CN:	4,048				2,116	1,932		
	MN:	34				17	17		
	Total:	4,082				2,133	1,949		
12e. Total Eligibles Reciving Dental Diagnostic Services	CN:	30,759	9	1,441	5,273	8,549	9,130	5,785	572
	MN:	566	0	21	38	70	93	193	151
	Total:	31,325	9	1,462	5,311	8,619	9,223	5,978	723
12f. Total Eligibles Receiving Oral Health Services provided by a Non-Dentist Provider	CN:	1,170	51	521	369	162	32	30	5
	MN:	17	0	11	3	1	1	1	0
	Total:	1,187	51	532	372	163	33	31	5
12g. Total Eligibles Reciving Any Dental Or Oral Health Service	CN:	34,578	60	1,969	5,837	9,416	10,123	6,512	661
	MN:	668	0	32	41	73	103	237	182
	Total:	35,246	60	2,001	5,878	9,489	10,226	6,749	843
13. Total Eligibles Enrolled in Managed Care	CN:	53,881	1,902	6,093	9,050	12,030	13,484	9,635	1,687
	MN:	1,505	27	86	75	109	146	421	641
	Total:	55,386	1,929	6,179	9,125	12,139	13,630	10,056	2,328
14. Total Number of Screening Blood Lead Tests	CN:	5,282	23	4,422	837				
	MN:	89	0	70	19				
	Total:	5,371	23	4,492	856				

* Includes 12-month visit
Note: "CN" = Categorically Needy, "MN"= Medically Needy

Medicaid & Exchange Advisory Board
Meeting Minutes
April 27, 2015

Board Members Present: Trinka Kerr, Lisa Maynes, Bram Kleppner, Kay Van Woert, Joan Lavoie, Rebecca Heintz, Sharon Winn, Madeleine Mongan (phone), Gladys Mooney, Larry Goetschius, Jackie Majoros, Christina Colombe, Julie Tessler (phone), Paul Bakeman, Clifton Long, Nate Waite, Dale Hackett, Sharon Henault (phone), and Sheila Reed.
Board Members Absent: Peter Espenshade, Vaughn Collins, Donna Sutton Fay, Laura Pelosi, Amy Vaughan, Shannon Wilson, Cathy Davis and Tim Ford.

Other Interested Parties Present: Susan Gretkowski (phone), Lucy Guerin (phone), Kelly Barnier, and Betty Morse.

Staff Present: DVHA: Dylan Frazier, MaryBeth Bizarri and Clark Eaton.

HANDOUTS

- Agenda
- Medicaid & Exchange Advisory Board (MEAB) March 23, 2015 Meeting Minutes
- MEAB Draft Work Group Operating Guidelines (4/27/15)
- Individuals & Families Work Group Meeting Minutes (4/13/15)
- Health Care Advocate Quarterly Report (1st Quarter, 2015)
- Adult Quality Grant Quality Measures for Medicaid-Eligible Adults (4/27/15)
- Adult Measures Quality Grant: Breast Cancer Screening Project (4/27/15)
- Vermont Health Connect (VHC) Update (4/27/15)
- Global Commitment (GC) & Medicaid Managed Care (4/27/15)
- GC 1115 Medicaid Waiver – Driver Diag. & Comprehensive Quality Strategy(4/27/15)

*all are posted to the VHC website

CONVENE
Bram Kleppner chaired the meeting.

Welcome/ Introductions/Approval of Minutes
Board members and meeting attendees introduced themselves around the room. The meeting minutes for March 23, 2015 were reviewed and adopted (unanimously).

MEAB Work Group Updates – Work Group Chairs
MEAB Work Group Operating Guidelines – Donna Sutton Fay had prepared a new draft of the MEAB Work Group Operating Guidelines for review. With Donna absent from the meeting, the board decided to delay review of the guidelines until the May meeting, when Donna will be present.
Provider Reimbursement Discussion – The Provider Reimbursement Work Group has not met in recent months. Larry Goetschius expressed concern that although the initial state budget proposal for SFY 2016 included provisions for a Medicaid provider reimbursement rate increase, the most current budget proposal in the legislature is now void of a Medicaid provider rate increase. The MEAB had prepared a resolution on Provider Reimbursement Principles/Direct Care Provider Reimbursement back in September, 2014. This resolution was forwarded to all the Commissioners in the Agency of Human Services last October so that the recommendations could be considered in budget development. The MEAB voted to resend the resolution to the

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legislature, so that the MEAB's reimbursement principles can be stressed again for the current and future sessions.

VHC Individuals and Families Work Group – Trinka Kerr reported on the April 13th Work Group's meeting on behalf of Work Group Chair, Donna Sutton Fay. The group took a final look at the Consumer Experience Survey that will be conducted soon by UMass. Data entry and analysis will be conducted over the early summer, and a final report should be ready by the end of August. The survey will go out to 4000 QHP enrollees and 2000 Medicaid enrollees by email, phone and on line. UMass expects a 30% response rate. The target number of responses is 1200 QHP enrollees and 600 Medicaid enrollees. The survey is intentionally looking at more QHP enrollees to get a larger sub-sample of new QHP enrollees. Trinka and Rebecca Heintz next discussed terminations and dunning notices that have started going out from BCBSVT. Approximately 3500 APTC and 1500 non-APTC dunning/termination notices were mailed, and the impact should be known during the month of May. In addition to the termination/dunning notices for nonpayment of premiums, approximately 2900 retroactive terminations are also being done based on VHC information. The hope is that many of those who are retroactively terminating are people who intended to drop their coverage. Trinka also reviewed the potential focus areas for the Work Group moving forward. This included the likely need to take on work related to future VHC plans and the Green Mountain Care Board's activity related to these plans.

DVHA Updates/Discussion – Steven Costantino

Steven Costantino, DVHA Commissioner, provided an update on the Governor's proposed SFY '16 budget which is currently in the legislative process. Moving out of the House to the Senate, the Medicaid program has been reduced by $3.5 mil, with the Vermont Health Connect (VHC) budget also being reduced by $3.3 mil. This impacts initially proposed provider rates and support for work being conducted by VHC. More deliberations will occur in the next few weeks toward reaching an approved budget. Larry Goetschius reemphasized the importance of achieving a rate increase for providers. Jackie Majoros noted that nursing homes do receive cost of living adjustments. Steven stressed the importance of working on the next Global Commitment Waiver early on so that funding needs are appropriately addressed. Kay Van Woert discussed the importance of expanding DVHA's relationship – concerning the budget process – with other AHS Departments. The Commissioner also reviewed the milestones that have been set for VHC this year to improve the functionality of the system; this topic will be covered in more depth during the VHC portion of the agenda.

Adult Medicaid Quality Grant – Aletta Powel/Erin Carmichael

Aletta Powel, Grant Program Manager, DVHA Quality Unit, provided an update on work on two performance improvement projects that were initiated in early 2013 that are part of a two year grant (approximately $2 mil) that was awarded to DVHA in December, 2012. The project was scheduled to end in December, 2014, but DVHA requested and received a 12 month extension to continue work until the end of 2015. DVHA has tested and evaluated methods for collecting and reporting on the initial core measures set, and also has developed the capacity to report, evaluate and use the performance data. DVHA started with 17 core measures, but is now reporting on 20 core measures. Aletta described the staff development process for the measures. The two performance improvement projects involve: 1) breast cancer screening and 2) alcohol and other drug treatment. Two-year results of the project will be compiled in late 2015.

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Trinka Kerr asked how this grant effort integrates with the Medicaid ACO effort. Measure sets do line up with many of the ACO measures, including the measures in the two performance improvement projects.

Health Care Advocate Quarterly Report – Trinka Kerr

Trinka Kerr, Chief Health Care Advocate, provided a handout and brief overview of the office's most recent quarterly report for the quarter ended March 31, 2015. The Health Care Advocate (HCA) office call volume hit a record high level for a single quarter. Calls relating to problems with VHC continue to increase – these calls typically involved billing, computer functionality, changes in circumstances functionality and tax related questions. Trinka encouraged members to review the full report and the HCA's recommendations to DVHA.

Vermont Health Connect (VHC) Update – Robert Skowronski/Jacqueline Rose/Brady Hoffman

Renewals and Enrollments – Jacqueline Rose, VHC Outreach and Education Manager, outlined the progress that has been made on renewals – more than 85% had been completed by 4/24. Vermonters on Qualified Health Plans (QHPs) increased by nearly 4,000 from December to March; the number on Medicaid increased by nearly 6,000. VHC is on track to complete all renewals in mid-May.
Customer Statistics – Considering Medicaid/Dr. Dynasaur and premium assistance, nearly 9 of 10 VHC customers get help for affordable coverage. For customers in private health plans in 2015, 3 out of 5 (62%) qualify for Advanced Premium Tax Credits (APTC). More than half (52%) qualified for Vermont Premium Assistance and Cost-Sharing Reductions (CSRs).
Call Center and Customer Service – There has been significant improvement this year when measuring missed calls. Last year's Open Enrollment abandon rate of nearly 36% was cut to just fewer than 2% this year. Average wait time on calls is down to 40 seconds; 4 out of 5 calls were answered in less than 30 seconds.
Assister Program – Brady Hoffman, Assister Program Manager, is completing an evaluation of the overall Assister Program. Assisters have completed more than a million unique outreach interactions with customers, and there have been more than 29,000 Assister Outreach events across the state. The current grant period funding Assisters runs through 6/30/15.
Data & Financial Reconciliation – Robert Skowronski reviewed the data & financial reconciliations for both 2014 and 2015 and the steps being taken to fix mismatches, investigate root causes of issues, and fix problems.
1095-A's and Tax Filing Updates – Jacqueline Rose briefed the board on the status of the 1095-A Tax Correction forms. More than 25,000 1095-A's were sent initially and about 6,000 corrected 1095A's were mailed. The IRS announced that taxpayers wouldn't have to amend a tax return if a corrected 1095-A form arrives after they have filed. Issues surrounding these tax forms are being addressed and resolved.
Change of Circumstance Updates – VHC is preparing for full Change of Circumstance (COC) functionality by May 31st. The Governor set 3 milestones: 1) COC functionality in May, 2) renewal functionality in October, and 3) COC processing time by October. Initial deployment of the automated COC system is known as Release 1(R1), and it will be starting very soon.
Data Systems Updates – Release 1 is starting well, but all work must be done on a very tight timeline that will be dependent on collaborative insurer development/testing and VHC minimizing backlogs and reconciling enrollment and premium data.

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Verification Proposal – This work is ongoing, including verification for current enrollees concerning income, SSNs, citizenship and immigration status.
Federal Poverty Level and Eligibility – The 2015 Federal Poverty Levels (FPLs) were published on January 22, 2015. Due to functionality limitations, VHC cannot implement the 2015 FPLs for Medicaid until mid to late June, 2015. VHC is currently sizing the impact of this issue (number of customers affected) in order to determine next steps.

Members should contact Jacqueline Rose with any comments or suggestions on future VHC data/information presentations. Current VHC information and activities can always be viewed at www.vermonthealthconnect.gov

Combined Global Commitment (GC) and Choices for Care Waivers – Monica Light
Monica Light, previously the Director of Health Care Compliance & Improvement at AHS, discussed the Global Commitment (GC) Waiver. The GC demonstration provides VT with the flexibility to apply managed care concepts in order to increase access to care, improve quality of care and control program costs. Vermont's GC demonstration has been extended through 12/31/2016, and the Choices For Care (CFC) Waiver is now combined (eff. 1/30/15) as part of the GC demonstration. Typically, the Waiver is intended to offer flexibility and authority to encourage state innovation and savings for its Medicaid program. Waiver demonstrations are for five year terms, and can be extended with three year renewals. By integrating the CFC Waiver, Medicaid member protections have been retained for LTC recipients.

AHS Medicaid Quality Strategy for GC to Health – Shawn Skaflestad
Shawn Skaflestad, AHS Quality Improvement Manager, introduced and discussed two key concepts for quality improvement relating to the Vermont GC to Health Waiver: 1) the GC to Health Driver Diagram, including key goals, (handout), and 2) a detailed outline of Vermont's GC to Health Comprehensive Quality Strategy (also a handout). These are "drafts" of what the state eventually will be sharing with CMS as part Vermont's quality strategy. The GC Driver Diagram is a tool used to display the goals of the waiver, identifies their drivers, shows how the drivers are connected, and ultimately provides the basis for how Vermont will measure its performance relative to the goals. The Comprehensive Quality Strategy (CQS) Outline serves as a blueprint or road map for VT and its public MCO in assessing the quality of care that beneficiaries receive, as well as for setting forth measurable goals and targets for improvement. Kay Van Woert stressed the need to encourage looking at shoring up the basics when we make decisions on reinvestment of savings as it pertains to the waiver. Jackie Majoros noted that the driver diagram was aspirational; the state needs to be sure that the drivers are operational, and reflect the reality of what's really going on. Shawn indicated that input is welcome on both handout documents. Drafts won't go to CMS until the end of May; he will schedule more time with the MEAB in the June or July timeframe.

MEAB Discussion – Board Members
The co-chairs asked board members to consider and review potential agenda items (listed below) for the May 26 MEAB meeting.

Public Comment Opportunity – Co-Chairs
There was no public comment at the meeting.

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Medicaid & Exchange Advisory Board
Meeting Minutes
April 27, 2015

Adjournment
The meeting was adjourned at 3:00PM.

Topics for Regular Update:
- Vermont Health Connect Topics/Discussion
- Commissioner Updates (Current Topics Discussion)
- Duals/VHIP/SIM Update/Discussion
- GC Waiver (as Necessary)
- Medicaid Shared Savings Program
- MEAB Work Group Meeting Reports
- Quarterly Advocate Report (Legal Aid)

Draft Topics for May 26 Meeting:
- DVHA SFY '16 Update/Discussion
- Media Reports of an Unexpected Medicaid Deficit
- Delay in Using 2015 FPL's to determine Medicaid Eligibility
- Status of Medicaid Renewals

Future Meeting Topics:
- Health Care Reform - single payer models
- Reinvestment in Community Based Services
- Affordability and reinvestment pertaining to provider rates
- Minimizing administrative complexity for businesses that offer insurance

Data Request(s) for Future Meeting:
Termination Data from Carriers
Total Medicaid Budget – what portion is entitlement/what is not?

Issue Tracker List:
- Inventory of Perverse Incentives
- Out-of-State travel
- Specialist or preferred providers
- Mental Health fee schedule changes
- Prior Authorization concerns
- Coordination of Benefits between Medicare and Medicaid

Ongoing Small Group Works
- EPSDT Work Group
- Improving Access Work Group
- Small Employer Work Group
- Individuals and Families Work Group
- Caregiver Reimbursement Work Group

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Next Meeting
May 26, 2015
Time: 11:00AM – 3:00PM
Site: DVHA, 312 Hurricane Ln, Williston, VT
Please visit the Advisory Board website for up-to-date information:
http://info.healthconnect.vermont.gov/advisory_board/meeting_materials

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Companion Aide Pilot Summary - January 2016

In March 2015, Vermont implemented a Companion Aide Pilot Project to provide assistance to nursing facilities in advancing culture change with a focus on person-centered dementia care. The goal of the pilot is to provide an enhanced Medicaid rate to five interested and eligible facilities that are committed to person-centered dementia care through dedicated "Companion Aide" staff. The Companion Aide is a trained licensed nursing assistant (LNA) who will champion person-centered dementia care with the goal of improving the lives of people with dementia, as evidenced by positive changes such as a reduction of the use of psychotropic drugs, incidence of resident to resident altercations, and improved staff satisfaction.

The following 5 facilities were chosen to participate in the pilot using pre-determined criteria:

- Brookside in White River Junction, VT
- Derby Green in Derby, VT
- Helen Porter in Middlebury, VT
- Mayo in Northfield, VT
- Mountain View in Rutland, VT

Due to a shortage of staff and hiring competition with surrounding medical providers, Brookside nursing facility was unable to successfully hire backfill employees for the three companion aide staff that were identified for the pilot. On July 24, 2015, Brookside notified DAIL that they were voluntarily withdrawing from the pilot. DAIL is working with the Division of Rate Setting to review the currently regulations and determine whether or not to approve another provider.

Pilot facilities have submitted quarterly summary reports and participated in training and State facilitated peer sessions to learn from each other's experiences and . Facilities also submitted their first annual report in for data collected March - November 2015. NOTE: While the facilities spent the first 1-4 months hiring and training staff for the pilot the initial data showed the following:

- An average of 10 resident-to-resident incidents were reported.
- An average of nine uses of antipsychotics were reported.
- Resident/family survey responses showed an average of 90% excellent to good overall satisfaction.
- Zero involuntary discharges occurred due to behavioral issues that could not be addressed by the facilities.
- Care Practice Artifacts of Change scores ranged from 45 to 58 out of a possible 70.
- Family and Community Artifact of Change scores ranged from 0 to 20 out of a possible 30.

Success Stories

The reported success stories are many. Here are a few:

Success Story #1: One facility was able to accept a female resident from our local hospital. She had a diagnosis of dementia with both anxiety and behaviors. She had been transferred to the hospital from her a residential care home due to overall decline including her cognitive status/behaviors. The residential care home was unable to accept her back. Both in the home and hospital, this resident had behaviors ranging from refusals of care to verbal/physical altercations. At the time of transfer, the hospital was unwilling to let the family transport in private car due to her behaviors as it was felt it was unsafe. As a result, she had to be transferred by ambulance. Since admission, the Companion Aide has been working with this resident. At first, just to build a relationship then she took over her care. As of this time, her physical and verbal behaviors have

almost completely resolved. Her psychotropic medications have been decreased twice, she is accepting more care, and her family has been able to take her out of the facility without incident.

Success Story #2: A Companion Aide started a reading program for two residents with end stage dementia. Both of these residents were non-verbal except for a rare word a few times a month. Since she has been reading to these residents, both are more alert and talking almost daily. As a result of the Companion Aide reading to the above two residents, another resident has started reading herself. Her primary care physician stated she could not believe the change in her.

Success Story #3: One Companion Aide has been completing life stories and starting the Music and Memory program with residents. When meeting with one family along with the resident, the family expressed how elated they were with their loved one's response to the music.

Success Story #4: One facility noticed a decrease in all resident-resident incidents in their "Memory Care Neighborhood" for the time period since they started using companion aides. They have also experienced great family satisfaction with the individualized attention for residents involved.

Success Story #5: One facility described the entire atmosphere on their Dementia Care Unit as "quite remarkable". This facility said: "It's difficult to pin point exactly what it is other than the added attention and support provided by the companion aides. Being a secured unit the companion aides provide the ability to assist residents off the unit more frequently to other activities, walks, visits etc. The 1:1 attention continues to enrich the lives of those living on the Dementia Care unit as well as throughout the Center. Each neighborhood will frequently call and request a companion aid throughout the day for residents around the building with dementia who would benefit from some extra support."

Success Story #6: One facility reported that they have a long term care resident who often presents with challenging behaviors. With the support of the Companion Aides, this resident has had a decrease in her antidepressant medication and her behaviors have also decreased despite the reduction in medication. This person is described as "remarkably more pleasant and engaging with others". Though she has a history of only liking to sit in the recliner by the nurse's cart, she has recently participated in activities and stayed at the dining room table for lunch positively interacting with the other resident's. Prior to the companion aid project and med changes, this person was agitated every day primarily in the late afternoon and evening. Each day there would be a nurse's note in regards to her behaviors. Now the nurse's notes reflect a decrease in behaviors with the occasional agitation. Social Services, her primary care physician and nursing recently met with family. Family commented on how much of a change they've seen in their mother and how happy they are to see their mom doing so well.

Success Story #7: One gentleman has a history of increased anxiety and weeping. Since the Companion Aide program started, the facility has reported that his anxiety has decreased a great deal and he has begun to enjoy activities such as checkers.