

From: [Frazer, Dylan](#)
To: [Frazer, Dylan](#)
Subject: FW: Response to Rep Konline
Date: Monday, October 20, 2014 9:12:30 AM
Attachments: [Optum VHC Operations Assessment Accepted Redacted.pdf](#)
[Communications with redactions.pdf](#)

From: DeLong, Danielle
Sent: Tuesday, August 12, 2014 4:33 PM
To: 'pkonline@gmail.com'
Cc: DeLong, Danielle
Subject: FW: Response to Rep Konline

Dear Rep Konline:

The Department of Vermont Health Access (DVHA) has conducted a search in response to your July 30, 2014 public records request regarding the contract the State entered into with OptumInsight on June 9th for \$5,690,000. The specific request included:

- 1) A copy of the "stabilization plan" that was contractually due on June 27th and the recommendations for technology improvements that was due on July 3rd.
 - Please find attached the final version of the Optum Operations Assessment, which provides both the stabilization plan and recommendations for technology improvements for Vermont Health Connect (VHC) Operations.
 - Please note that some information has been redacted from the Operations Assessment and the communications document. A chart detailing the redactions along with the reasoning for doing so can be found below.

- 2) All records and communications that pertain to this contract.
 - Attached are Mark Larson's communications regarding Optum.

Operations Assessment redactions:

Page 6	1 V.S.A. § 317(c)(1)	Confidential information regarding a non-State employee
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Communications document redactions:

Pages 1, 2, 3	1 V.S.A. § 317(c)(1)	Confidential information regarding a non-State employee
Pages 1, 2, 8, 47	1 V.S.A. § 317(c)(15)	Information pertaining to the negotiation of contracts

The stabilization plan and recommendations for technology improvements for VHC Information Technology is not yet ready to produce pursuant to 1 V.S.A. § 317 (c)(17), as the report and policy decisions therein are not yet finalized. Please be advised that, pursuant to 1 V.S.A. § 318(a)(2), you

have the right to appeal the denial of any part of your request to the Secretary of the Agency of Human Services.

If you have any questions please feel free to contact me.

Sincerely,

Dani

Dani Gokey Delong
Health Program Administrator, Policy Unit
Department of Vermont Health Access
Office: 802-879-5606
Fax: 802-879-8224
Danielle.delong@state.vt.us

[Redacted]

Amendment 2 - [Redacted]

[Redacted]

Amendment 3 - [Redacted]

Sonya, please let me know if the dollars for amendment 1 + amendment 2 work; as necessary, we will minimize the ops task orders included in amendment 1 with the notion of funding additional necessary ops work through amendment 3 down the road. I would also like to connect with you and/or Carrie to discuss next steps with CMS.

Thanks everyone, and please let me know what questions you have.

■

From: [Larson, Mark](#)
To: [Frazer, Dylan](#)
Subject: FW: Optum assessments - FW: Followup on SAO audit request
Date: Tuesday, August 05, 2014 12:25:15 PM

From: Tease, Justin
Sent: Tuesday, July 29, 2014 12:07 PM
To: Tucker, Lindsey; Nagelschmidt, Denise; [REDACTED]; Yahr, Emily
Cc: Stern, Sonya; Pallotta, Howard; Larson, Mark; Martini, David
Subject: RE: Optum assessments - FW: Followup on SAO audit request

As an FYI, Optum has said the IT assessments will be delivered no later than 8/8 and are expecting to beat that date.

Thanks,
Justin

From: Tucker, Lindsey
Sent: Monday, July 28, 2014 11:15 AM
To: Nagelschmidt, Denise; [REDACTED]; Tease, Justin; Yahr, Emily
Cc: Stern, Sonya; Pallotta, Howard; Larson, Mark; Martini, David
Subject: Optum assessments - FW: Followup on SAO audit request

Denise, when the Optum ops assessment is final and accepted this week, please work with Sonya to share with the State Auditor (request below).

Justin, when the Optum IT assessments are final and accepted this week, please work with Sonya to share with the State Auditor (request below).

I've had other requests (ex Rep Komline) for the reports and we should have plan for distributing when they are final. Emily, could you please help with that? Denise is working on a document to demonstrate how we are addressing the recommendations on the Ops side. I'll work with [REDACTED] to do the same on the IT side.

And please send me a file with all of the final assessments when they are complete.

Thank you.

Lindsey Tucker
Vermont Health Connect
802.363.2080
lindsey.tucker@state.vt.us

From: Tucker, Lindsey
Sent: Monday, July 28, 2014 11:09 AM
To: Lambert, Linda; Stern, Sonya
Cc: Petrow, Anne; Aylward, Irina; Morehouse, Tanya
Subject: RE: Followup on SAO audit request

Linda,

I apologize for the delay in getting back to you. The Optum reports will be finalized this week, and we will share as soon as they are.

Thank you.

Lindsey Tucker

Vermont Health Connect

802.363.2080

lindsey.tucker@state.vt.us

From: Lambert, Linda

Sent: Wednesday, July 23, 2014 1:53 PM

To: Tucker, Lindsey; Stern, Sonya

Cc: Petrow, Anne; Aylward, Irina; Morehouse, Tanya

Subject: Followup on SAO audit request

Lindsey & Sonya: Thank you very much for the documents you provided to Irina last Friday regarding premium payment operations. We are working our way through them now. However, the first two items (the first 2 Optum deliverables) were not sent because they are not final.

Lindsey—based on the conversation that you and I had a couple of weeks ago, I understood that at least the first deliverable was provided in draft form to DVHA as directed by the contract. With the understanding that the deliverables may still be draft, we would like a copy of what Optum provided. Please email this to us at your earliest convenience.

We also have a question about the last item in our request list—the amount that has been paid to Benaissance. The response was that the contract is with CGI. I apologize that our question was not specific, but what we are interested in is how much Benaissance has been paid to date for premium payment processing. We understand that the State is not paying for this directly, but assume that CGI provides this information to you or, if not, that they can.

Linda Lambert

Director, IT and Performance Audit

VT State Auditor's Office

From: [Larson, Mark](#)
To: [Frazer, Dylan](#)
Subject: FW: Urgent Action Required - Optum Task Order 004
Date: Tuesday, August 05, 2014 12:24:31 PM

-----Original Message-----

From: Tucker, Lindsey
Sent: Sunday, July 13, 2014 10:17 AM
To: Larson, Mark
Subject: FW: Urgent Action Required - Optum Task Order 004

FYI - he's had it since late Friday. Thanks.

Lindsey Tucker
Vermont Health Connect
802.363.2080
lindsey.tucker@state.vt.us

-----Original Message-----

From: Trantum, Emily
Sent: Sunday, July 13, 2014 10:16 AM
To: Clasen, Michael
Cc: Tucker, Lindsey; Wilder, Tiffany
Subject: Urgent Action Required - Optum Task Order 004

Hi Michael,

You should have a link to Optum TO 004 for signature. We would greatly appreciate if you could look at this today, as we need it signed in order to move forward with work on Monday and more importantly to avoid enacting a clause that would allow the contractor to do less work if the TO is not signed by 7/14.

You are the final signature required as a part of the review process, please let me know if you are having any issues.

Thank you,

Emily Trantum

Sent from my iPhone

From: [Larson, Mark](#)
To: [Frazer, Dylan](#)
Subject: FW: Optum Insight Task Order 002
Date: Tuesday, August 05, 2014 12:23:16 PM

From: Tucker, Lindsey
Sent: Thursday, June 26, 2014 6:09 PM
To: Trantum, Emily; Larson, Mark
Cc: Hathaway, Carrie; Jones, Kate
Subject: RE: Optum Insight Task Order 002

And apparently Jaye made some substantive changes that are of concern to them, so I'll need to work that through now.

Lindsey Tucker
Vermont Health Connect
802.363.2080
lindsey.tucker@state.vt.us

From: Trantum, Emily
Sent: Thursday, June 26, 2014 5:23 PM
To: Larson, Mark
Cc: Tucker, Lindsey; Hathaway, Carrie; Jones, Kate
Subject: RE: Optum Insight Task Order 002

Unfortunately, it will have to be first thing tomorrow. I have a hard stop right now - late to dinner with people I am hosting from Michigan (only in town tonight).

Emily Trantum
Contracts and Grants Administrator
Department of Vermont Health Access (DVHA)
312 Hurricane Lane
Williston, VT 05495-2087
emily.trantum@state.vt.us
office: 802.879.5946 | cell: 802.585.5328

From: Larson, Mark
Sent: Thursday, June 26, 2014 5:17 PM
To: Trantum, Emily
Cc: Tucker, Lindsey; Hathaway, Carrie; Jones, Kate
Subject: Re: Optum Insight Task Order 002

If they sign off, will we be able to upload tonight?

Mark Larson
Commissioner
Department of Vermont Health Access

Sent from my iPhone

On Jun 26, 2014, at 5:16 PM, "Trantum, Emily" <Emily.Trantum@state.vt.us> wrote:

Hi Mark,

We just finished addressing all of the changes reviewers requested. I just sent the final to Lindsey ready to go back to Optum.

Best,

Emily Trantum
Contracts and Grants Administrator
Department of Vermont Health Access (DVHA)
312 Hurricane Lane
Williston, VT 05495-2087
emily.trantum@state.vt.us
office: 802.879.5946 | cell: 802.585.5328

From: Larson, Mark
Sent: Thursday, June 26, 2014 5:15 PM
To: Trantum, Emily
Cc: Tucker, Lindsey; Hathaway, Carrie; Jones, Kate
Subject: Re: Optum Insight Task Order 002

Can I get an update on the status?

Mark Larson
Commissioner
Department of Vermont Health Access

Sent from my iPhone

On Jun 26, 2014, at 3:44 PM, "Trantum, Emily" <Emily.Trantum@state.vt.us> wrote:

Jaye just sent her edits! I am in a meeting, but will move it forward as soon as I am out.

Emily Trantum
Contracts and Grants Administrator
Department of Vermont Health Access (DVHA)
312 Hurricane Lane
Williston, VT 05495-2087
emily.trantum@state.vt.us
office: 802.879.5946 | cell: 802.585.5328

From: Trantum, Emily
Sent: Thursday, June 26, 2014 3:42 PM

To: Tucker, Lindsey; Larson, Mark
Cc: Hathaway, Carrie
Subject: FW: Optum Insight Task Order 002

Hi All,

I received 3 more green lights from reviewers on TO 002. My main concern at this point is that Jaye Johnson has not sent conformation or edit indicating she's reviewed. She requested the word version earlier and we haven't heard anything back. We have tried to call, but have not had an answer. If we upload and route without any feedback from Jaye, she will likely reject it when it gets to her for signature in Silanis, which means we have to re-start the process.

So Far the only comment I have that requires an edit is from Jill:

- [REDACTED]

Please let me know if there is anything else we can do (besides continuing to call and email).

Thank you,

Emily Trantum
Contracts and Grants Administrator
Department of Vermont Health Access (DVHA)
312 Hurricane Lane
Williston, VT 05495-2087
emily.trantum@state.vt.us
office: 802.879.5946 | cell: 802.585.5328

From: Trantum, Emily
Sent: Thursday, June 26, 2014 2:35 PM
To: Wilder, Tiffany; Jones, Kate; Gould, Jill; Larson, Mark;
jjohnson@atg.state.vt.us; Prail, Darin; Nealy, Diane; Racine, Doug;
Thompson, Darwin; Byrne, Emily; Spaulding, Jeb
Cc: Boes, Richard; Clasen, Michael; Henry, Dixie; Holland, Tim; Kipp, Peter;
Morse, Linda; Tucker, Lindsey; Stern, Sonya
Subject: RE: Optum Insight Task Order 002

Hello Everyone,

We have only received comments back from 4 reviewers. If you are still planning to review the document and provide edits, please have your

comments or edits to me by 2:50pm. We are on an extremely tight timeline and would greatly appreciate your prompt attention.

Please let me know if you have any questions or concerns!

Best,

Emily Trantum
Contracts and Grants Administrator
Department of Vermont Health Access (DVHA)
312 Hurricane Lane
Williston, VT 05495-2087
emily.trantum@state.vt.us
office: 802.879.5946 | cell: 802.585.5328

From: Wilder, Tiffany
Sent: Wednesday, June 25, 2014 1:46 PM
To: Jones, Kate; Gould, Jill; Larson, Mark; jjohnson@atg.state.vt.us; Prail, Darin; Nealy, Diane; Racine, Doug; Thompson, Darwin; Byrne, Emily; Spaulding, Jeb
Cc: Boes, Richard; Clasen, Michael; Henry, Dixie; Trantum, Emily; Holland, Tim; Kipp, Peter; Morse, Linda; Tucker, Lindsey; Stern, Sonya
Subject: Optum Insight Task Order 002
Importance: High

Good afternoon,

Please review the OptumInsight Task Order 002 for Stream 4 User Acceptance Testing (UAT) oversight and test execution support for CGI's "package 2" release that includes automated change of circumstance functionality.

Please have comments to Emily Trantum by 10:00am tomorrow morning. It's anticipated that Task Order 002 will be uploaded for electronic signatures tomorrow.

Please click the following link to review:

[OptumInsight - TO 002](#)

Regards,

Tiffany Wilder
Financial Administrator I
Department of Vermont Health Access (DVHA)
312 Hurricane Lane
Williston, VT 05495-2087
Tiffany.Wilder@state.vt.us

802-879-5610

From: [Larson, Mark](#)
To: [Frazer, Dylan](#)
Subject: FW: Optum issue
Date: Tuesday, August 05, 2014 12:22:54 PM
Attachments: [image001.png](#)

From: Tucker, Lindsey
Sent: Monday, June 23, 2014 6:06 PM
To: Larson, Mark
Cc: JILL G FINNERTY
Subject: Optum issue

Mark,

Heads up: Optum won't move forward on the testing work without a signed task order.

Thanks.

Lindsey Tucker
Deputy Commissioner, Vermont Health Connect
Department of Vermont Health Access
802.363.2080
lindsey.tucker@state.vt.us



From: [Larson, Mark](#)
To: [Frazer, Dylan](#)
Subject: FW: Please advise regarding Optum-related requests from SAO
Date: Tuesday, August 05, 2014 12:20:43 PM

Hi Dylan: I'm sending correspondence to you for Rep Komline's public records request.

From: Tucker, Lindsey
Sent: Friday, July 18, 2014 8:32 AM
To: Larson, Mark
Subject: Fwd: Please advise regarding Optum-related requests from SAO

Ok to send Optum drafts to State Auditors Office?

Lindsey Tucker
Department of Vermont Health Access
Sent from my iPhone

Begin forwarded message:

From: "Stern, Sonya" <Sonya.Stern@state.vt.us>
Date: July 18, 2014 8:29:52 AM EDT
To: "Tucker, Lindsey" <Lindsey.Tucker@state.vt.us>
Cc: "Hathaway, Carrie" <Carrie.Hathaway@state.vt.us>, "Petrow, Anne" <Anne.Petrow@state.vt.us>
Subject: Please advise regarding Optum-related requests from SAO

Hi Lindsey,
As we are getting ready to submit our inputs pertaining to "Operational" (Premium Processing), I wanted to do one final check regarding the two lines related to Optum's report deliverables which SAO requested at the very top of the list.
Last week you replied to Anne that you prefer not to submit reports because they were still in draft form.

It is in our best interests to cooperate with SAO's document request, and since they asked for the latest available version, if the latest drafts we have are in decent shape, I recommend we include them with the submission.

If you feel strongly that these two items are not ready to go, please advise when you think they will be ready so we can let SAO know when to expect them. We need to demonstrate to SAO that we are responsive to their request.

	<i>Operational</i>
1	Optum – Stream 2 deliverable (Operations Stabilization Plan (due 6/27/2014) – the latest available version
2	Optum – Stream 1 deliverable (IT Plan (due 7/3/2014) – the latest available version

Thank you,

Sonya Stern
Finance Director, Vermont Health Connect
Department of Vermont Health Access
sonya.stern@state.vt.us
Cell: (802) 585-4994
[<image001.png>](#)

From: [Larson, Mark](#)
To: [Trantum, Emily](#)
Subject: Re: Optum Update
Date: Saturday, July 26, 2014 11:40:09 AM

Ok. Dixie said she may have limited cell access today. I will text her.

I do have Jeb's info.

Mark Larson
Commissioner
Department of Vermont Health Access

Sent from my iPhone

> On Jul 26, 2014, at 11:32 AM, "Trantum, Emily" <Emily.Trantum@state.vt.us> wrote:

>

> Hi Mark,

>

> It's now with Dixie for signature. Unfortunately I do not have a phone number for her. Her admin would not provide it to me.

>

> Jeb is the only other person I don't have a cell number for.

>

> Best,

>

> Emily

>

> Sent from my iPhone

>

>> On Jul 26, 2014, at 9:25 AM, "Trantum, Emily" <Emily.Trantum@state.vt.us> wrote:

>>

>> Jaye said she will review and sign in the next 30 minutes. I will try to keep it moving and let you know if I hit any barriers.

>>

>> Here's the remaining signature list in order:

>>

>> Diane Nealy

>> Darin Prail

>> Dixie Henry

>> Richard Boes

>> Emily Byrne

>> Jeb Spaulding

>> Sonya Stern

>> Myself

>>

>>

>> Sent from my iPhone

>>

>>> On Jul 26, 2014, at 7:50 AM, "Trantum, Emily" <Emily.Trantum@state.vt.us> wrote:

>>>

>>> Sure, I will drop LT from the updates.

>>>

>>> Only Jill and you. It's been with Jaye since you signed. She did mention on the call she'd be available, so I'm sure she'll check in this morning and I will call soon. I didn't want to bother people before 8am.

>>>
>>> Sent from my iPhone
>>>
>>>> On Jul 26, 2014, at 7:46 AM, "Larson, Mark" <Mark.Larson@state.vt.us> wrote:
>>>>
>>>> Thanks Emily. Who had signed so far?
>>>>
>>>> Also you can drop Lindsey. She's on vacation. I will help track people down.
>>>>
>>>> Mark Larson
>>>> Commissioner
>>>> Department of Vermont Health Access
>>>>
>>>> Sent from my iPhone
>>>>
>>>>> On Jul 26, 2014, at 7:44 AM, "Trantum, Emily" <Emily.Trantum@state.vt.us> wrote:
>>>>>
>>>>> Good Morning,
>>>>>
>>>>> The TO is with Jaye. I sent her an email and will call her after 8am.
>>>>>
>>>>> Best,
>>>>> Emily
>>>>>
>>>>>
>>>>> Sent from my iPhone

From: [Larson, Mark](#)
To: [Trantum, Emily](#)
Subject: Re: Optum Update
Date: Saturday, July 26, 2014 7:46:02 AM

Thanks Emily. Who had signed so far?

Also you can drop Lindsey. She's on vacation. I will help track people down.

Mark Larson
Commissioner
Department of Vermont Health Access

Sent from my iPhone

> On Jul 26, 2014, at 7:44 AM, "Trantum, Emily" <Emily.Trantum@state.vt.us> wrote:
>
> Good Morning,
>
> The TO is with Jaye. I sent her an email and will call her after 8am.
>
> Best,
> Emily
>
>
> Sent from my iPhone

From: [Tucker, Lindsey](#)
To: [Wilder, Tiffany](#); [Jones, Kate](#); [Gould, Jill](#); [Larson, Mark](#); [Johnson, Jaye](#); [Prail, Darin](#); [Nealy, Diane](#); [Henry, Dixie](#); [Boes, Richard](#); [Byrne, Emily](#); [Clasen, Michael](#)
Cc: [Trantum, Emily](#); [Holland, Tim](#); [Kipp, Peter](#); [Morse, Linda](#); [Stern, Sonya](#); [Miller, Lawrence](#)
Subject: RE: Optum TO 005 - expedited review
Date: Tuesday, July 01, 2014 2:01:42 PM

Thank you so much, Emily!

I'd actually suggest giving folks a bit more time to review. Perhaps if people could send any edits or comments by [7:45am tomorrow](#) (Wednesday), that would still give us time first thing in the morning to consolidate and send out for routing by mid-morning. Our goal is signature by EOD Thursday, in advance of the long weekend, so the work can start on Monday.

Could you all please cc me on your comments so I can begin to respond this evening as they come in? I look forward to seeing your thoughts and questions.

Thank you very much!

Lindsey Tucker
Vermont Health Connect
802.363.2080
lindsey.tucker@state.vt.us

From: Wilder, Tiffany
Sent: Tuesday, July 01, 2014 1:57 PM
To: Jones, Kate; Gould, Jill; Larson, Mark; Johnson, Jaye; Prail, Darin; Nealy, Diane; Henry, Dixie; Boes, Richard; Byrne, Emily; Clasen, Michael
Cc: Trantum, Emily; Tucker, Lindsey; Holland, Tim; Kipp, Peter; Morse, Linda; Stern, Sonya
Subject: Optum TO 005 - expedited review
Importance: High

Good afternoon,

Please review the OptumInsight Task Order 005 to provide detailed enrollment transaction process documentation and oversight for enrollment transaction transmissions to enable VHC to reduce current and avoid future backlog.

Please have comments to myself and Emily Trantum by [4:30pm this afternoon](#).

Click the link below to review:

[Optum TO 005](#)

Best,

Tiffany Wilder
Financial Administrator I
Department of Vermont Health Access (DVHA)

312 Hurricane Lane
Williston, VT 05495-2087
Tiffany.Wilder@state.vt.us
802-879-5610

From: [Larson, Mark](#)
To: [Trantum, Emily](#)
Subject: Re: Optum Insight Task Order 002
Date: Thursday, June 26, 2014 3:33:49 PM

Emily,

Any additional comments? Does it need additional optum review?

Mark Larson
Commissioner
Department of Vermont Health Access

Sent from my iPhone

On Jun 26, 2014, at 2:34 PM, "Trantum, Emily" <Emily.Trantum@state.vt.us> wrote:

Hello Everyone,

We have only received comments back from 4 reviewers. If you are still planning to review the document and provide edits, please have your comments or edits to me by 2:50pm. We are on an extremely tight timeline and would greatly appreciate your prompt attention.

Please let me know if you have any questions or concerns!

Best,

Emily Trantum
Contracts and Grants Administrator
Department of Vermont Health Access (DVHA)
312 Hurricane Lane
Williston, VT 05495-2087
emily.trantum@state.vt.us
office: 802.879.5946 | cell: 802.585.5328

From: Wilder, Tiffany
Sent: Wednesday, June 25, 2014 1:46 PM
To: Jones, Kate; Gould, Jill; Larson, Mark; jjohnson@atg.state.vt.us; Prail, Darin; Nealy, Diane; Racine, Doug; Thompson, Darwin; Byrne, Emily; Spaulding, Jeb
Cc: Boes, Richard; Clasen, Michael; Henry, Dixie; Trantum, Emily; Holland, Tim; Kipp, Peter; Morse, Linda; Tucker, Lindsey; Stern, Sonya
Subject: Optum Insight Task Order 002
Importance: High

Good afternoon,

Please review the OptumInsight Task Order 002 for Stream 4 User Acceptance Testing (UAT) oversight and test execution support for CGI's "package 2" release that includes

automated change of circumstance functionality.

Please have comments to Emily Trantum by 10:00am tomorrow morning. It's anticipated that Task Order 002 will be uploaded for electronic signatures tomorrow.

Please click the following link to review:

[OptumInsight - TO 002](#)

Regards,

Tiffany Wilder
Financial Administrator I
Department of Vermont Health Access (DVHA)
312 Hurricane Lane
Williston, VT 05495-2087
Tiffany.Wilder@state.vt.us
802-879-5610

State of Vermont
Agency of Human Services

Global Commitment to Health
11-W-00194/1

Section 1115
Demonstration Year: 9
(10/1/2013 – 9/30/2014)

Quarterly Report for the period
April 1, 2014 – June 30, 2014

Submitted Via Email on

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I. Background and Introduction

AHS to insert

i. Global Commitment to Health Waiver: Renewal

AHS to insert

II. Enrollment Information and Counts

Comment [FD1]: Not new. Just updated to reflect Q3 numbers

Key updates from Q3 2014:

- Significant decreases in enrollment seen in Demonstration Populations 3, 6, 7, and 11;
- Significant increases seen in Demonstration Populations 1 and 5.

Table 1 presents point-in-time enrollment information and counts for Demonstration Populations for the Global Commitment to Health Waiver during the third quarter of FFY 2014. Due to the nature of the Medicaid program, beneficiaries may become retroactively eligible and may move between eligibility groups within a given quarter or after the end of a quarter. Additionally, since the Global Commitment to Health Waiver involves most of the State's Medicaid program, Medicaid eligibility and enrollment in Global Commitment are synonymous, with the exceptions of the Choices for Care Waiver and CHIP.

Table 1 is populated based on reports run the Monday after the last day of the quarter, in this case on July 7, 2014. Results yielding $\leq 5\%$ fluctuation quarter to quarter are considered as illustrating normal deviations reflecting retroactive eligibility determinations and expected terminations. Results reflecting $>5\%$ fluctuation between quarters are reviewed by staff from DVHA and AHS to provide further detail and explanation of the changes in enrollment. For explanation on substantial fluctuations observed in several Demonstration Populations during the third quarter (Q3) of FFY 2014, please see Section VII: Member Month Reporting.

Table 1. Enrollment Information and Counts for Demonstration Populations*, Q3 FFY 2014

Demonstration Population	Current Enrollees Last Day of Qtr 6/30/2014	Previously Reported Enrollees Last Day of Qtr 3/31/2014	Variance 3/31/2014 to 6/30/2014
Demonstration Population 1:	278,325	263,544	5.61%
Demonstration Population 2:	143,188	138,633	3.29%
Demonstration Population 3:	34,252	40,892	-16.24%
Demonstration Population 4:	0	N/A	N/A
Demonstration Population 5:	5,049	3,466	45.67%
Demonstration Population 6:	0	5,617	-100.00%
Demonstration Population 7:	12	6,143	-99.80%
Demonstration Population 8:	29,976	30,501	-1.72%
Demonstration Population 9:	7,613	7,776	-2.10%
Demonstration Population 10:	0	N/A	N/A
Demonstration Population 11:	6	25,264	-99.98%

* Demonstration Population counts are person counts, not member months.

III. Outreach Activities

i. Member Relations

Comment [FD2]: Two middle paragraphs are new

Key updates from Q3 2014:

- The annual Green Mountain Care Member Newsletter project is underway with an early summer publication and mailing timeline.
- The Medicaid and Exchange Advisory Board (MEAB) held three monthly meetings during this quarter.
- The annual provider timely access survey was mailed in May.

The Provider and Member Relations (PMR) Unit is responsible for member relations, outreach and communication, including the GreenMountainCare.org member web site. The PMR Unit ensures an adequate network of providers for covered services, enrolls and manages the provider network, and has responsibility for the Medicaid Non-Emergency Medical Transportation Program.

PMR solicited ideas and articles for the annual Green Mountain Care Member Newsletter from the DVHA Management Team during this quarter in anticipation of a publication date in July. Information on plans and benefit changes resulting from the current legislative session are typically included along with articles on preventative and other health issues to encourage members to be proactive in their personal health outcomes.

The annual Provider Timely Access Survey resulted in only 4 providers being required to complete a Corrective Action Plan (CAP). Based on a random sample of primary care providers (PCPs) who see at least 25 unique individuals per year, PMR mailed 315 surveys on May 15. By May 29, we received 116 responses, resulting in a return rate of 37%. This number was down a bit from last year but is still seen as a success beyond the initial expectation of 12%-20% return rate. A banner regarding timely access for members will be communicated to all providers in October, making it about a year since the previous banner on this topic.

The Medicaid and Exchange Advisory Board (MEAB) held meetings on April 14, May 12, and June 9. Agendas and minutes are publicly posted at <http://gmcboard.vermont.gov/meetings>.

IV. Operational/Policy Developments/Issues

i. Vermont Health Connect

Comment [FD3]: All new

Key updates from Q3 2014:

- To date, VHC has enrolled 42,853 individuals in Medicaid and 30,691 in the Qualified Health Plan (QHP) of their choice.
- VHC is now focused on successfully transitioning Medicaid renewals to the Marketplace and preparation for 2015 open enrollment.
- VHC continues to face challenges in processing its change of circumstance backlog. To address this issue, it has engaged an additional contractor, OptumInsight, to provide staff augmentation and to assist in the development of operational efficiencies as VHC prepares for open enrollment.

Vermont Health Connect (VHC), a state-based health insurance marketplace, launched on October 1, 2013. Between October 1, 2013 and March 31, 2014, nearly 88,000 individuals in Vermont applied for coverage through VHC. To date, VHC has enrolled 42,853 individuals in Medicaid and 30,691 in the Qualified Health Plan (QHP) of their choice. In November of 2013, Vermont launched premium processing

functionality for individuals and worked with insurance carriers to effectuate coverage for January 1, 2014. This functionality was expanded to include credit card processing in March, 2014. Delays in system functionality prompted Governor Shumlin to issue an order allowing individuals to extend their 2013 insurance coverage for three months and for small businesses to directly enroll through insurance carriers through 2015. Many of these individuals in Vermont transitioned to VHC by March 31, enrolling in QHPs with financial assistance. The State continued to work with members of the transition population throughout April and May to ensure that they had the opportunity to take advantage of a special enrollment period for which they were eligible and avoid gaps in coverage. Vermont Health Connect is now focused on successfully transitioning the 80,000 Medicaid individuals who need to transition from the State's legacy Access eligibility system to the Marketplace upon renewal of their coverage.

VHC's Customer Support Center, operated by Maximus, went live on September 3, 2013 and continues to assist customers in navigating the website, processing phone applications, and responding to requests for updates on changes of circumstances that have been delayed due to system functionality shortcomings. The high volume of interest in Vermont Health Connect, combined with operational challenges, resulted in extended wait times at the call center from October to December. In January, the State worked with Maximus to expand its staff of Customer Service Representatives (CSRs) to include additional workers trained specifically to process phone applications. Specializing the work of CSRs has allowed the State to train other staff to answer the most common pre- and post-application questions. Based on the information gleaned during the grant period, the State worked with the Maximus call center to expand staffing by an additional 70 CSRs in Chicago beginning in January of 2014, almost doubling the available staff to answer VHC phone calls.

The State continues to work with its contracting partners to expand marketplace functionality, with a current focus on implementing an automated change of circumstance process. This will allow enrollees to themselves modify the information contained in their application, support eligibility for special enrollment periods, and facilitate plan selection change when allowable. VHC continues to face challenges in processing its change of circumstance backlog. To address this issue, it has engaged an additional contractor, OptumInsight, to provide staff augmentation and to assist in the development of operational efficiencies as VHC prepares for open enrollment for 2015.

At the close of 2014 open enrollment, VHC concluded its ambitious outreach and education campaign for year one but continues to actively collaborate with key stakeholders, including insurance carriers, brokers, small business owners, and community partners. The Outreach and Education team is now focused on successfully transitioning Medicaid renewals and preparation for 2015 open enrollment. Vermont continues to deploy its comprehensive training plan and continues to work with agencies and departments to ensure that roles and responsibilities are clearly defined, business processes are fully mapped, and adequate resources are in place to support daily operations. VHC plans to expand its functionality to include enrollment for small businesses during the open enrollment period for 2016.

V. Expenditure Containment Initiatives

i. Vermont Chronic Care Initiative (VCCI)

Comment [FD4]: All but first two paragraphs is mostly new

Key updates from Q3 2014:

- The MMIS/CM procurement process generated 4 responses, with 2 vendors unable to meet minimum State requirements. DVHA will revise and repost the RFP based on the inability of the remaining vendors to meet established thresholds and related timelines for implementation. A new RFP will be released mid-July and will reflect feedback from vendors who submitted a 'letter of intent' but who did not submit a proposal. VCCI supplemental support services have been removed from the updated RFP.
- The APS Healthcare contract for the VCCI analytical and clinical support services has been renegotiated with a new expiration date of June 30, 2015 in anticipation of full 'on-boarding' of the new CM solution for the VCCI in June, 2015.
- Two targeted consumer mailings were completed, including one in April to 2,800 members in high risk communities on 'pain killer safety,' covering security and disposal. A second mailing was sent in June to over 2,000 women of child bearing age with complex health histories on the importance of pre-conception counseling and planning.
- The VCCI leadership has been invited to speak at the NASHP conference in October on the VCCI model and the positive results it's garnered for high risk populations.

The goal of the VCCI is to improve health outcomes of Medicaid beneficiaries by addressing the increasing prevalence of chronic illness through various support and care management strategies. Specifically, the program is designed to identify and assist Medicaid members with chronic health conditions in accessing clinically appropriate health care information and services; coordinate the efficient delivery of health care to this population by attempting to remove barriers, bridge gaps, and avoid duplication of services; and educate, encourage and empower this population to eventually self-manage their chronic conditions.

The VCCI uses a holistic approach of evaluating and supporting improvement in medical and behavioral health, as well as socioeconomic issues that are often barriers to sustained health improvement. Medicaid members that are eligible for the VCCI account for the top 5% of service utilization, or who are on a trajectory to become 'super-utilizers' of services. The VCCI's strategy of embedding staff in high-volume hospitals and primary care sites continues to support population engagement at the point-of-need in areas of high service utilization. By targeting predicted high-cost members, resources can be allocated to areas representing the greatest opportunities for clinical improvement and cost savings.

The VCCI had expanded the embedded staffing model with licensed staff in high volume Medicaid primary care sites and hospitals that experience high rates of ambulatory care sensitive (ACS) Emergency Department (ED) visits and inpatient admissions/readmissions. Due to challenges at some provider sites concurrent with staff attrition last quarter, the VCCI partner footprint has been reduced to only six locations (4 PCP's and 2 hospitals). This has been augmented with a 'liaison' role while looking at longer term strategies and opportunities as new staff is brought on and as Accountable Care Organization (ACO) partnerships begin to take form.

The embedded approach continues to offer several advantages. First, it fosters strong provider relationships and direct referral for high-risk populations. Second, it encourages 'real time' case findings at the point-of-service within primary care physician (PCP) and hospital sites to assist in reducing hospital readmission rates in high-risk populations. The VCCI has access to hospital data on inpatient and ED admissions through data exchanges from partner hospitals (via secure FTP site transfers). The VCCI aims

to eventually secure data from all 14 hospitals in Vermont. While some hospitals have not supported these strategies in the past, the advent of Medicaid ACOs may help facilitate new relationships based on common goals. Third, the embedded staffing model provides an opportunity for enhanced coordination and care transitions with hospital partners and primary care sites, as well as with home health agencies that may be delivering skilled nursing care post-discharge. This enhanced service coordination is a goal of the Vermont Health Care Innovation Project care management and care models (CMCM) workgroup which is currently working on a learning collaborative to be piloted in 3 locations.

The VCCI continues to experience challenges related to both timely recruitment and retention of skilled nurse care managers. Due to their Medicaid knowledge and experience, nurse care managers have been frequently hired by partners of the VCCI, and at a higher pay scale than provided by the State. The VCCI is continuing to work with senior DVHA leadership on methods to incentivize nurses to work for DVHA, and an AHS leadership team has been assigned to this work.

In Q3, the VCCI had turnover in all of the medical social worker positions. This change has offered the VCCI the opportunity to reevaluate staffing structure and licensure requirements to support the most efficient, effective and holistic approach to case management based on member needs. Subsequently, several existing positions are being converted to RN positions that have more versatility in practice than non-licensed social workers.

The VCCI remains strategically aligned with the Blueprint for Health, which is further described in *Section V.ii*.

Pediatric Palliative Care Program

Comment [FD5]: Mostly new

The Pediatric Palliative Care Program (PPCP) is a statewide program that maintains active enrollment of approximately 35-40 children and families at any time. The VCCI is engaged with home health agencies for quality monitoring. However, due to very low volumes and/or less than one year of program operation, this is not yet a highly robust effort with measurable data. The VCCI likely needs to redesign the audit tool based on early testing and will continue to advocate for DVHA PPCP staff to have access to the partner data system for more efficient quality monitoring. Consumer satisfaction surveys are now being disseminated concurrent with the six-month reassessment for program eligibility and service authorization process. A follow-up clinical training session for pediatric palliative care nurses is scheduled for September, 2014 in partnership with the Vermont Assembly of Home Health Agencies (VAHHA) and the Vermont Department of Health (VDH).

Pregnancy Care Connection

Comment [FD6]: Mostly new

The VCCI launched a pilot program for the High Risk Pregnancy (HRP) Case Management service in October 2013. The service, recently renamed Pregnancy Care Connection (PCC), focuses on direct case management as well as the system of care for at-risk/vulnerable pregnant women and their unborn child(ren). PCC was able to complete a consumer mailing targeting 2000 at risk women of child bearing age to advise of pre-conception counseling (One Key Question/ State of Oregon approved). This is consistent with Vermont Maternal and Child Health data, which demonstrates a high rate of unplanned pregnancies, especially in women under 24. The mailing has generated some early referrals to the VCCI, including women who had already become pregnant. DVHA is also moving forward to assure alignment between the VCCI/ HRP nurses and the Medicaid Health Homes Initiative for substance abuse treatment services (Hub and Spoke, as described in the following section). This was deemed important given the prevalence; risk factors and related cost of care for mothers and infants with substance use/abuse and/or treatment history; and associated prematurity/low birth weight and/or neonatal intensive care unit stays for withdrawal. Early data suggests a need for service targeted at this cohort as well as those with mental

health diagnoses. The VCCI will continue to review the data, model, and feedback provided by field workers to assess the efficacy of PCC, and will work in partnership with DVHA leadership to allow for a strategic approach to program development and resource allocation.

APS Contract

Since 2007, DVHA has contracted with APS Healthcare for assistance in providing disease management assessment and intervention services to Vermont Medicaid beneficiaries with chronic health conditions. In SFY 2012, the contract migrated to a focus on the top 5% of Medicaid utilizers. APS Healthcare provides several services to support the VCCI, including supplemental professional staffing and data analytics. APS Healthcare delivers enhanced information technology and sophisticated decision-support tools to assist case management staff outreach to the most costly and complex beneficiaries based on risk factors. Additionally, APS Healthcare provides supplemental reports on population-based gaps in care to the VCCI field-based staff, which support ACO providers working with patients who are considered high utilizers.

In 2011, the VCCI implemented a combination of individual- and population-based strategies for disease management, with a primary focus on the top 5% of beneficiaries accounting for the highest service utilization. That same year, DVHA's contract with APS Healthcare was 100% risk-based with a guaranteed 2:1 return on investment (ROI). In SFY 2012, the VCCI delivered a net \$11.5 million ROI, which included both the APS and DVHA staff efforts. In SFY 2013, the VCCI significantly exceeded its 2012 results, with a \$23.5 million net savings over anticipated expense for this population. Consistent with these results, the VCCI demonstrated a 17% reduction in ACS ED usage, a 37 % reduction in ACS hospitalizations, and a 34% reduction in 30-day readmission rates among the top 5% of members. SFY 2013 was the first year that it was feasible to conduct a comparative analysis on the top 5% of members.

To assure continuity of the VCCI business operations during the MMIS/CM procurement process, the DVHA has extended its contract with APS Healthcare through June 30, 2015. This will allow for a thoughtful procurement, contracting and onboarding process, without interruption of the VCCI services, should APS not be the selected vendor.

Activities supported by APS in Q3 include:

- Completed the VCCI/APSMITA self-assessment for case/care management
- Contract renegotiated for 1 year extension through June 30, 2015
- Recruitment for RN (2 FTE) and analyst vacancies (.6 FTE)
- Average VCCI case load (DVHA/APS): 513; unique members: 1003
- Data secured on hypertensive members eligible for VDH/ASTHO grant activities
- Provider Health Registry development and dissemination for diabetes gaps in care
- PDSA for case load development initiated
- Action Plans updated consistent with NCQA requirements to foster adoption by APMCs
- Updated VCCI Brochures and Referral Forms
- Drug therapy overviews for COPD and diabetes completed

Comment [FD7]: First two paragraphs are the same. After that is mostly new

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

Comment [FD8]: Same as before, except last paragraph and data tables.

Key updates from Q3 2014:

- In June, the Vermont Supreme Court issued a ruling finding in favor of the Chittenden Center’s zoning permit to operate an Opioid Treatment Program (Hub) in a South Burlington neighborhood zoned for commercial/medical. The South Burlington School Board opposed the zoning permit. The program has been open at the South Burlington location for almost a year without any incidents.
- The Hub programs are now statewide and continue to see significant caseload growth; serving just under 2,400 Vermonters.
- In addition to providing methadone MAT, as they have traditionally done, Hubs now provide buprenorphine MAT to complex patients. The use of buprenorphine in these programs continues to grow, now representing 33% of the total caseload of Hubs.
- Blueprint practice facilitators are working extensively with Hub and Spoke providers on common measurement, practice-level quality improvement, and implementation of evidence-based care. In addition, the practice facilitators are working with the Hub programs on preparing to meet the NCQA Patient-Centered Specialty Practice standards. This will further align these specialty addictions programs with the patient-centered medical home primary care providers.
- Completed three learning collaboratives with the Hub programs and “Spoke” practices. These were extremely well attended (more than 17 different practices/programs) and physicians led multi-disciplinary teams in common measurement and intensive quality improvement activities.
- The Green Mountain Care Board is requiring a quarterly report on progress to increase the participation of other payers in this initiative. The CMS policy of Medicare not reimbursing for services in an Opioid Treatment Program presents as a difficulty in integrating all payers.

The Blueprint for Health (Blueprint) is Vermont’s state-led initiative charged with guiding a process that results in sustainable health care delivery reform. The Blueprint uses multi-insurer payment reforms to improve infrastructure and care provided by PCPs. It includes advanced primary care practices that are recognized as patient-centered medical homes, multi-disciplinary core Community Health Teams (CHTs), and specialized care coordinators. The Blueprint supports the State’s National Committee for Quality Assurance (NCQA) certification and performance-based payments. In 2013, the Blueprint continued to grow and strengthen the underlying model in all geographic regions, or Health Service Areas, in the state. The Blueprint for Health 2013 Annual Report to the Vermont Legislature was published online in January, 2014 and is available via:

<http://hcr.vermont.gov/sites/hcr/files/pdfs/VTBlueprintforHealthAnnualReport2013.pdf>

As part of the Blueprint, the Hub and Spoke Initiative creates a framework for integrating treatment services for opioid addiction. This Initiative represents AHS and DVHA’s efforts to collaborate with community providers to create a coordinated, systemic response to the complex issues of opioid addictions in Vermont. The Hub and Spoke 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. The two primary medications used to treat opioid dependence are methadone and buprenorphine. Buprenorphine is typically prescribed by specially licensed physicians in a medical office setting and methadone is provided only in specialty opioid treatment programs. Both of these treatment regimens are associated with substantial service fragmentation as providers are not well integrated into the larger health care and mental health care systems.

To address this service fragmentation and better serve a patient population with high overall health care costs, Vermont has developed State Plan Amendments (SPAs) in partnership with CMS to provide Health Home services to the MAT population under section 2703 of the ACA. The SPAs supported geographically staggered MAT Health Home implementation throughout Vermont. 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.

As part of the Initiative, DVHA established five regional Hubs, which build upon the existing methadone opioid treatment programs, and provide buprenorphine treatment to a subset of clinically complex patients (Table 2). These Hubs serve as the regional consultants and subject matter experts on opioid dependence and treatment. Hubs are replacing episodic care based exclusively on addiction illness with comprehensive health care and continuity of services. Three Hubs were implemented under the first Health Home SPA, effective on July 1, 2013. Two additional regional Hubs were implemented through the second SPA beginning in January 1, 2014.

In addition to Hubs, Spoke staff is embedded directly in the prescribing practices to allow more direct access for patients to mental health and addiction services, promote continuity of care, and support the provision of multidisciplinary team care. Spoke staff provide service free of cost to patients receiving MAT. Spokes include a physician prescribing buprenorphine in office-based opioid treatment 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. Registered nurses and licensed addictions/mental health clinicians, who are part of the Blueprint CHTs, also provide support to the Spoke providers and their patients receiving MAT.

For updates from Q3 of FFY 2014, please see the above “key updates.” During this quarter, Hub and Spoke Health Homes were implemented statewide and over three-fourths (83%) of the Spoke staff for the statewide program is now hired. These Spoke staff work with 60 buprenorphine providers serving 1,972 Medicaid beneficiaries receiving MAT. Spoke staffing is scaled at 1 registered nurse and 1 licensed clinician for every 100 patients receiving MAT. The following tables present the caseloads of regional Hubs and Spoke staffing as of June, 2014.

Table 2. Hub Caseload

Region (Counties in Vermont)	Start Date (Month/Year)	Total Number of Clients (Buprenorphine and Methadone)	Number of Clients Receiving Buprenorphine	Number of Clients Receiving Methadone
Chittenden, Franklin, Grand Isle & Addison	1/2013	862	300	562
Washington, Lamoille, Orange	7/2013	251	116	135
Windsor, Windham	7/2013	547	137	410
Rutland, Bennington	11/2013	345	138	207
Essex, Orleans, Caledonia	1/2014	380	104	276

Total	2385	795	1590
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Table 3. Spoke Staffing: June 2014

Region	Providers	Staff FTE Funding	Staff FTE Hired	Medicaid Beneficiaries
Bennington	6	3.5	3.5	173
St. Albans	6	5.5	2.8	262
Rutland	5	5.0	2.1	253
Chittenden	13	7.5	7.85	357
Brattleboro	6	5.0	5	230
Springfield	1	1.0	1.0	41
Windsor	2	2.0	2.0	82
Randolph	4	2.5	2.0	110
Barre	7	4.5	4.5	212
Lamoille	4	3.0	2.0	135
Newport & St Johnsbury	5	2.0	2.0	100
Addison	1	.5	0	17
Total	60	42	34.75	1,972

iii. Managed Substance Abuse Services

Comment [FD9]: All new with the exception of some of the first paragraph

Key updates from Q3 2014:

- The DVHA Managed Substance Abuse Services and Mental Health Services have been consolidated into one unit to provide integrated Behavioral Health Services.
- The Behavioral Health Team adopted the McKesson/Interqual tool for authorizing mental health and substance abuse services.

In March 2014, Managed Substance Abuse Services and Mental Health Services have been consolidated into one unit to provide integrated Behavioral Health Services. This collaboration will offer a more comprehensive approach for behavioral health care coordination and will utilize combined staff's expertise in substance abuse, mental health, and quality improvement services. The consolidation of the two teams will allow beneficiaries with co-occurring mental health and substance abuse conditions to receive coordinated services from DVHA, as well as provide DVHA with additional resources to work on improving access to care from achieved efficiencies. 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 MAT efforts with the Hub and Spoke Initiative, the VCCI, and the Pharmacy Unit to provide beneficiary oversight and outreach. All beneficiaries receiving MAT services and who are prescribed buprenorphine will continue to have a Pharmacy Home that dispenses all of their prescriptions.

During this quarter, the Behavioral Health Team participated in the AHS Substance Abuse Treatment

Coordination Workgroup. This workgroup is a coordinated effort to standardize substance abuse screening and referral processes throughout AHS. The workgroup was developing an AHS-wide training for screening. Team members also participated in monthly meetings with 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 quarter the Behavioral Health Team adopted the McKession/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. Implementation of the tool is planned for July, 2014.

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, which will allow for improved coordination of services.

Buprenorphine Program

The Department of Vermont Health Access, in collaboration with VDH's Alcohol and Drug Abuse Programs, maintains a capitated program for treatment of opiate dependency (CPTOD). The CPTOD provides an enhanced remuneration for physicians in a step-wise manner depending on the number of beneficiaries treated by a physician enrolled in the program. The Capitated Payment Methodology is depicted in the following table (Table 4).

Table 4. Capitated Program for Treatment of Opiate Dependency

Complexity Level	Complexity Assessment	Rated Capitation Payment				Final Capitated Rate (depends on the number of patients per level, per provider)
III.	Induction	\$366.42	+	<u>BONUS</u>	=	
II.	Stabilization/Transfer	\$248.14				
I.	Maintenance Only	\$106.34				

The total payment for the Buprenorphine Program for all three quarters of FFY 2014—with the exception June, since data is not yet available—is \$123,168.32 (Table 5).

Table 5. Buprenorphine Program Payment Summary FFY 2014

FIRST QUARTER, FFY 2014	
October 2013	\$12,041.22
November 2013	\$17,688.50
December	\$19,508.14
1st Quarter Total	\$49,237.86
SECOND QUARTER, FFY 2014	
January 2014	\$10,988.52
February 2014	\$18,857.68
March 2014	\$11,319.48
2nd Quarter Total	\$41,165.68

THIRD QUARTER, FFY 2014	
April 2014	18,479.72
May 2014	\$14,285.60
June 2014	(No data at this time)
3rd Quarter Total	\$32,764.78
Grand Total	\$123,168.32

iv. 340B Drug Discount Program

Comment [FD10]: All the same except for updated numbers

Key updates from Q3 2014:

- The Notch Pharmacy began participating in the 340B Program this quarter.
- Vermont has realized \$202,499.62 net cost savings this quarter and year-to-date net cost savings of \$327,962.54 through Medicaid participation of a relatively small number of eligible covered entities.

The 340B Drug Pricing Program resulted from enactment of the Veterans Health Care Act of 1992, which is codified as Section 340B of the Public Health Service Act. The 340B Drug Pricing Program is a federal program managed by the Health Resources and Services Administration (HRSA), Office of Pharmacy Affairs. Section 340B requires drug manufacturers to provide outpatient drugs to eligible health care centers, clinics and hospitals (termed “covered entities”) at a significantly reduced price. The 340B price is a “ceiling price,” meaning it is the highest price that the covered entity would have to pay for select outpatient and over-the-counter drugs and the minimum savings that the manufacturer must provide to covered entities. The 340B ceiling price is at least as low as the price that state Medicaid agencies currently pay for select drugs. Participation in the program results in significant savings estimated to be 20% to 50% on the cost of outpatient drug purchases for 340B covered entities. The purpose of the 340B Program is to enable these entities to stretch scarce federal resources, reach more eligible patients, and provide more comprehensive services.

Only federally designated covered entities are eligible to purchase at 340B pricing, and only patients of record of those covered entities may have prescriptions filled by a 340B pharmacy.

Covered entities can utilize contract pharmacy services under a “ship to-bill to” arrangement where the covered entity retains legal title of the drugs purchased under 340B and has their drugs shipped to the contract pharmacy. The covered entity retains legal title to all drugs purchased under 340B and must pay for all 340B drugs. The contract pharmacy is subject to audits to identify and prevent diversion and/or duplicate discounts (accessing the 340B discount and Medicaid rebate on the same drug).

Vermont has made substantial progress in expanding 340B availability since 2005. This expansion was aided by federal approval of the statewide 340B network infrastructure, which is operated by five federally qualified health centers (FQHCs) in Vermont. In 2010, DVHA aggressively pursued enrollment of 340B covered entities made newly eligible by the ACA and as a result of the Challenges for Change legislation passed in Vermont. As of October 2011, all but two Vermont hospitals and some of their owned practices were eligible for participation in 340B as covered entities.

DVHA expanded its 340B program to encourage enrollment of both existing and newly eligible entities within Vermont and to encourage covered entities to include Medicaid in their 340B programs. In 2012, the DVHA received federal approval for a Medicaid pricing 340B

methodology. To encourage participation in the Vermont Medicaid 340B program, providers receive an incentive payment (described below). The methodology for the 340B incentive payment is the lesser of 10% of the total Medicaid savings or \$3 per claim for non-compound drugs and \$30 per claim for compound drugs. Claims are paid at the regular rates, and a monthly true-up process calculates the 340B acquisition cost, dispensing fees, savings, and what is owed back to the State with payments due 30 days after the invoices are mailed. DVHA continues to encourage Medicaid enrollment with the goal of enrolling all eligible and HRSA-enrolled covered entities in Vermont.

In Vermont, the following entities participate in the 340B Program. **Boldfaced** entities also participate in Medicaid's 340B initiative (although this is not an exhaustive list of entities enrolled in Medicaid's 340B initiative):

- Vermont Department of Health, for the AIDS Medication Assistance Program, Sexually-Transmitted Disease Drugs Programs, and Tuberculosis Program; all of these programs are specifically allowed under federal law.
- **Planned Parenthood of Northern New England's Vermont clinics**
- **Vermont's FQHCs**, operating 41 health center sites statewide
- **Central Vermont Medical Center**
- Copley Hospital
- **Fletcher Allen Health Care and its outpatient pharmacies**
- Gifford Hospital
- Grace Cottage Hospital
- **Indian Stream Health Center (New Hampshire)**
- North Country Hospital
- Northeastern Vermont Regional Hospital
- *Notch Pharmacy (new as of FFY Q3)*
- Porter Hospital
- Rutland Regional Medical Center
- **Springfield Hospital**

340B Reimbursement and Calculation of Incentive Payment

DVHA identified the following goals in establishing its proposed 340B reimbursement methodology:

- Reduce Medicaid program expenditures;
- Encourage broad participation in the 340B program, thereby increasing potential savings to the Medicaid program;
- Acknowledge that 340B pharmacies will be covering their operating costs solely through the dispensing fee, since acquisition cost savings essentially are "passed through" to the Medicaid program; and
- Recognize pharmacies' additional administrative costs related to 340B inventory management and reporting.

Vermont researched available resources regarding pharmacy dispensing costs, which included consultation with local pharmacists. Vermont determined that a reasonable estimate of pharmacy dispensing costs falls in the range of \$12.00 to \$15.00 per prescription. DVHA also determined that pharmacies' additional costs associated with 340B program management would equal \$3.00 per prescription. Therefore, Vermont determined that a reasonable 340B dispensing fee would range from

\$15.00 to \$18.00 per prescription. Vermont’s proposed reimbursement methodology established a flat rate payment at the low end of this range (\$15.00) and presents the opportunity, subject to demonstrated Medicaid program savings, for entities to share in Medicaid savings.

Because of federal laws prohibiting “duplicate discounts” on Medicaid drug pricing related to the interaction of 340B and manufacturer rebate programs, Medicaid participation in 340B has been limited both in Vermont and nationally. Vermont put in place an innovative, first in the nation, methodology to maximize Medicaid participation in 340B pricing for Medicaid beneficiaries served by eligible prescribers at 340B-enrolled covered entities. Using the Global Commitment authority, the DVHA provides incentive payments to providers for their 340B participation that recognizes the additional administrative burden of the program. Because of the beneficial 340B pricing, both Vermont and CMS benefit from higher rates of 340B covered entity-employed prescribers and Medicaid beneficiary participation in the program.

For the reporting period, Vermont has realized \$202,499.62 net cost savings for FFY Q3 and year-to-date net cost savings of \$327,962.54 through Medicaid participation of a relatively small number of eligible covered entities.

v. Utilization Management

Comment [FD11]: Same

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

Safeguards for Overprescribing

Comment [FD12]: Same

While DVHA is confident that prescribers, covered entities, and pharmacies will continue to operate in an ethical and medically-appropriate fashion, DVHA has many controls and processes in place to monitor and prevent overprescribing. These controls include monitoring features of our Program Integrity Unit (PIU) and the Drug Utilization Review (DUR) program, both of which are vetted through the State’s Drug Utilization Review Board (DURB).

The goal of DVHA’s DUR programs is to promote appropriate prescribing and use of medications. We identify prescribing, dispensing, and consumption patterns which are clinically and therapeutically inappropriate and do not meet the established clinical practice guidelines. A variety of interventions are then employed to correct these situations. Drug Utilization Review programs take a multilevel approach to identifying, filtering, and communicating important information pertaining to the prescribing and/or consumption of medications. It is an approach that analyzes patterns of utilization at a patient-specific level, as well as the unique prescribing habits and pharmaceutical care provided by the physician. The criteria, research and compilation of data, and recommended actions are reviewed and approved by consensus of the DURB.

In addition, DVHA’s PIU performs data-mining activities, which identify potential overpayments and problem claims in all spending categories, including pharmacy claims. For example, one algorithm looked at possible pharmacy errors in the billing of drugs dispensed in a kit. A common error occurs when the pharmacist enters a drug quantity (units billed to Medicaid) as the number of items in the kit instead of a quantity of “one” kit, resulting in overpayments to the pharmacy.

The DUR and PIU programs continue to develop and run data-mining queries to detect improper prescribing, dispensing, and reimbursement. Findings are discussed, as deemed necessary and appropriate, with various other departments in the DVHA and agencies including, but not limited to, the Pharmacy Unit, Clinical Utilization Review Board (CURB), DURB, and the Clinical Unit. If potential fraud is detected, the PIU may refer cases to the Attorney General's Medicaid Fraud and Residential Abuse Unit (MFRAU), the Vermont Medical Practice Board, and/or the Secretary of State's Office of Professional Regulations (OPR). Any Program Integrity investigation may also run parallel to or in conjunction with any other investigation initiated by MFRAU, Vermont Medical Practice Board and/or OPR. Standard Program Integrity guidelines and protocols are utilized to ensure appropriate steps are taken.

Clinical Utilization Review Board

Comment [FD13]: Same except for key updates, obviously.

Key updates from Q3 2014:

- The CURB held one meeting this quarter on May 21.
 - A University of Vermont Professor of Psychiatry presented on one current model of co-locating psychiatric providers in Medical Homes. DVHA will explore potential for support and further deployment of this model.
 - Requests for genetic testing are received for analytic validity, clinical utility, budget impact and ethical implications. DVHA determines clinical utility based on many resources including:
 - Peer-review literature
 - Technology assessments
 - Professional association opinions and guidelines
 - Direct discussion with providers
 - Other medical and commercial policies
- DVHA is currently pursuing an evidence based and clinically focused tool for creating sound policy, which will enable appropriate coverage decisions.

The Clinical Utilization Review Board (CURB) was established by Act 146 Sec. C34, 33 V.S.A. Chapter 19, Subchapter 6 during the 2010 legislative session. DVHA was tasked to create the CURB to examine existing medical services, emerging technologies, and relevant evidence-based clinical practice guidelines and make recommendations regarding coverage, unit limitations, place of service, and appropriate medical necessity of services in the State's Medicaid programs.

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

Additional information on these guiding principles and upcoming clinical projects considered by the CURB members are available in the CURB's 2013 annual report submitted to the Vermont Legislature in January 2014, and available via: <http://www.leg.state.vt.us/reports/2014ExternalReports/295874.pdf>.

In Q3 FFY 2014, the CURB held one meeting. Information on the CURB meetings, including agendas and minutes, is available via: <http://dvha.vermont.gov/advisory-boards>.

Drug Utilization Review Board

Comment [FD14]: Same

Key updates from Q3 2014:

- The DURB held two meetings this quarter on April 15 and June 3.

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

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

Additionally, per State statute requiring the DVHA Commissioner establish a pharmacy best practice and cost control program, the DURB was designated as the entity to provide clinical guidance on the development of a Preferred Drug List for Medicaid beneficiaries. The DURB typically includes 10-12 members, who are appointed to two-year terms. At least one-third, but not more than half, of the Board's members are licensed and actively practicing physicians, and at least one-third of its members are licensed and actively practicing pharmacists. Other interested and qualified people also may be appointed to the DURB. Board members are recommended by the DVHA Commissioner and approved by the Governor.

Meetings of the DURB occur monthly or bimonthly depending upon the number of drugs and issues to be reviewed. In Q3 FFY 2014, the DURB held two meetings. Information on the DURB and its activities in 2014 is available via: <http://dvha.vermont.gov/advisory-boards>.

vi. Mental Health System of Care

AHS to insert

VI. Financial/Budget Neutrality Development/Issues

AHS to insert

VII. Member Month Reporting

Key updates from Q3 2014:

- In Q3 FFY 2014, there were several fluctuations in enrollment, which led to an overall decrease in enrollment of -4.49%.
- Substantial decreases in enrollment were seen in Demonstration Populations 6, 7 and 11 due to coverage under VHAP and Vermont's Employer-Sponsored Insurance Premium Assistance Program (ESIA and Catamount-ESIA) ending on April 1, 2014.
- Increased enrollment was seen in Demonstration Populations 1, 2, and 5. The largest increase in enrollment (45.67%, or by 1,583 recipients) was in Demonstration Population 5, mostly due to the reclassifying of several aid category codes that target the ABD population.

Demonstration Populations are not synonymous with Medicaid Eligibility Group (MEG) reporting in Table 7. The numbers presented in the following table may represent duplicated population counts. For example,

Comment [FD15]: First two paragraphs are the same. Last two are all new.

an individual in Demonstration Population 4, which is home- and community-based services, and Demonstration Population 10 may in fact be in MEG 1 or 2.

This report is run the first Monday following the close of the month for all persons eligible as of the 15th day of the preceding month. Data reported in Table 6 are not used in Budget Neutrality Calculations or Capitation Payments, as information will change at the end of the quarter. The information in this table cannot be summed across quarters. All payments are adjusted at the end of the year to reconcile expected population movement between eligibility groups.

Table 6. Demonstration Populations, by FFY Quarter, for the last year

Demonstration Population	Total for Quarter Ending			
	3rd Qtr FFY '14	2nd Qtr FFY '14	1st Qtr FFY '14	4th Qtr FFY '13
Demonstration Population 1:	278,325	263,544	145,498	145,446
Demonstration Population 2:	143,188	138,633	130,263	131,481
Demonstration Population 3:	34,252	40,892	28,998	29,618
Demonstration Population 4:	0	N/A	N/A	N/A
Demonstration Population 5:	5,049	3,466	2,598	2,657
Demonstration Population 6:	0	5,617	8,322	8,826
Demonstration Population 7:	12	6,143	105,494	107,354
Demonstration Population 8:	29,976	30,501	30,620	30,505
Demonstration Population 9:	7,613	7,776	7,783	7,794
Demonstration Population 10:	0	N/A	N/A	N/A
Demonstration Population 11:	6	25,264	41,962	40,093

Table 7. Number of Recipients, by Month for FFY 2014, Q2 and Q3

	FFY 2014 Q2			FFY 2014 Q3		
	January 31, 2014	February 28, 2014	March 31, 2014	April 30, 2014	May 31, 2014	June 30, 2014
Demonstration Population 1	86,074	87,603	89,867	95,507	92,966	89,852
Demonstration Population 3	13,485	13,627	13,780	12,280	11,466	10,506
Demonstration Population 5	1,103	1,155	1,208	1,639	1,716	1,694
Demonstration Population 6	2,175	1,857	1,585	0	0	0
Demonstration Population 7	2,379	2,021	1,743	11	1	0
Demonstration Population 11	9,759	8,327	7,178	6	0	0

Substantial decreases in enrollment were seen in several populations due to changes in coverage as programs closed. Demonstration Population 6 now has no beneficiaries currently enrolled, which is a

reduction of 5,617 recipients from the last day of FFY 2014 Q2 and Demonstration Population 7 saw coverage drop of 6,131 recipient (or 99.80%). With coverage under VHAP ending on April 1, 2014 these reductions in enrollment were expected by DVHA. There was a similar decrease of 99.98% (a reduction by 25,258 recipients) in enrollment for Demonstration Population 11. This decrease also was anticipated, as coverage under Vermont's Employer-Sponsored Insurance Premium Assistance Program (ESIA and Catamount-ESIA) ended on April 1, 2014. These decreases in enrollment due to program closures and coverage changes also will be reflected in the Q4 FFY 2014 report.

Increased enrollment was seen for Demonstration Populations 1, 2, 3, and 5. The largest percent increase in enrollment was in Demonstration Population 5, with an increase of 45.67% (or 1,583 beneficiaries) this increase is largely due to the change in the MEG rate group from 'optional' to 'underinsured,' which went into effect on January 1, 2014. The largest recipient variance was in Demonstration Population 1 with an increase of 14,781 recipients since the second quarter of FFY 2014. Most of this increase is due to the reclassifying of several aid category codes that target the Aged, Blind, and Disabled (ABD) population that occurred on January 1, 2014.

In Q3 of FFY 2014, the overall fluctuations led to a change in enrollment of -4.49%.

VIII. Consumer Issues

AHS to insert

IX. Quality Improvement

Key updates from Q3 2014:

- Utilizing resources from the Adult Medicaid Quality (AMQ) Grant, DVHA continued to develop staff capacity to analyze and utilize performance measure data for monitoring and improving access and the quality of care in Medicaid.
- The Breast Cancer Screening Performance Improvement Project intervention period ran from January 1, 2014 through June 30, 2014. Results will be analyzed in Q4 2014.
- Baseline data gathered and intervention chosen for the Follow-up After Hospitalization for Mental Illness performance improvement project.

Comment [FD16]: All new, and this is a new(ish) section. Quality Improvement was separated from Compliance, as they are distinct units and functions.

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

Quality Committee Updates

DVHA's Medical Director and Quality Improvement (QI) Administrator continue to coordinate the monthly Quality Committee (DQC) meetings. In Q3, the DQC focused on a review of Intra-Governmental Agreement (IGA) partners' quality management plans. The DQC is collaborating with its IGA Partners' Commissioners to solidify their Departments' representation on the DQC, as well as to re-establish performance measures that they will routinely report on for the Medicaid population(s) they serve.

The DQC also tasked a joint AHS-DVHA work group with an in-depth analysis of the current *Global Commitment for Health* investment expenditures. The review is expected to determine whether the investment expenditures are realizing optimal outcomes, as well as identify whether existing investments could become programmatic or administrative claims instead.

Formal (Validated) Performance Improvement Project

Comment [FD17]: New

DVHA's QI Administrator continues to lead an AHS-wide Performance Improvement Project (PIP) on Follow-up After Hospitalization (FUH) for Mental Illness, the study indicator for which is the Healthcare Effectiveness Data and Information Set (HEDIS) measure of the same name (FUH HEDIS). During Q3, the FUH PIP Implementation Team solidified our final baseline data, performed deeper demographic data analysis, conducted a cause and effect exercise, prioritized, and chose a study intervention.

Implementation of the study intervention is planned for the end of June, 2014. The intervention includes educating local designated hospitals (the hospitals in Vermont with inpatient psychiatric floors and accept involuntary admissions) on Medicaid's discharge planning and discharge policies and procedures. The intervention will include face-to-face meeting time between the hospital staff and PIP team members, distribution of updated materials, and regular performance reports from DVHA to the designated hospitals.

Consumer Assessment of Healthcare Providers and Systems Survey

Comment [FD18]: New

The DVHA Quality Unit's QI Administrator continued to coordinate the Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys during this quarter. DVHA's contracted vendor, WBA Research, distributed and collated both the Adult and Children's Medicaid CAHPS 5.0H surveys.

Also during this quarter, the QI Administrator registered Vermont Medicaid with the CAHPS data warehouse for the first time. This will allow DVHA access to national comparative reports in the future.

AHS Performance Accountability Committee

Comment [FD19]: New

DVHA's Quality Unit Director and QI Administrator continued to represent Vermont Medicaid's *Global Commitment for Health* activities at the monthly AHS-lead Performance Accountability Committee (PAC) meetings. Quality representatives from the other AHS Departments (Department of Health, Department of Mental Health, Department of Corrections, Department of Aging and Independent Living and the Department of Children and Families), as well as other AHS operations managers make up this committee. DVHA reported out to the PAC on FUH PIP progress and added input to a revision of the Vermont Quality Strategy document.

Additionally, S.293 "The Outcomes Bill" was signed into Vermont law during Q2 FFY 2014. Members of the PAC, including DVHA staff, will be working in the months to come on the requirements of this new legislation. In particular, performance accountability liaisons (PALs) have been appointed from each AHS Department to work with the State legislature. DVHA has also already named our Quality Improvement Administrator as the owner of a results-based scorecard that will become available for initial development starting in Q4 FFY 2014.

Adult Quality Measures Grant

Comment [FD20]: New

In Q3 FFY 2014, DVHA staff engaged in six hours of training through the Adult Quality Measures (AQM) Grant.

- The Lewin Group is providing a seven hour series of trainings on how to complete Performance Improvement Projects per CMS protocols. Staff completed trainings three and four this quarter on Creating a Sampling Plan and Developing a PIP Data Management/Analysis Plan.
- The Lewin Group also provided two hours of training on performance measurement to the Managed Care Medical Committee (MCMC). The module introduced the process of performance measurement and explored its applications within the health care field and beyond.
- One element of the AQM grant is for DVHA staff to develop the capacity to complete chart reviews in order to report on hybrid HEDIS measures. In June of 2014, the Vermont Child Health Improvement Program (VCHIP) provided a committee of DVHA staff with two hours of training on best practices in developing a chart review process. In Q4 2014, the committee will draft internal policy and procedures on completing hybrid measure chart reviews, and then will train selected DVHA staff on the new policy and procedures.

X. Compliance

Comment [FD21]: All new

Key updates from Q3 2014:

- Updated Inter-Governmental Agreements (IGAs) are now in circulation with management at partnering AHS departments.
- In June, DVHA and AHS completed the annual External Quality Review Organization (EQRO) audit.

The Managed Care Compliance program is responsible for ensuring that managed care operations are in compliance with all governing policies, regulations, agreements and statutes. This is accomplished through audits and corrective actions coordinated by the Managed Care Compliance Committee. This work is coordinated across AHS through Inter-Governmental Agreements (IGAs) with the departments involved in managed care programs.

Our updated IGAs are now in circulation with management at partnering AHS departments. These new IGAs further clarify roles and responsibilities related to managed care activities as described in the Global Commitment waiver. After implementation of these new agreements, DVHA and IGA partners will establish two new committees: a Managed Care Compliance Committee and a Global Commitment to Health Leadership Committee. The Managed Care Compliance Committee will include members from each IGA department, which will provide a wider range of expertise and experience when managing compliance concerns and projects. The Global Commitment to Health Leadership Committee will comprise of Commissioners from each of the IGA departments (as well as an AHS Central Office representative). This committee will be responsible for executive-level leadership of managed care responsibilities.

In June, DVHA and AHS completed the annual External Quality Review Organization (EQRO) audit. The EQRO audits are designed to cover different topics each year, with a complete cycle repeating every three years. This year, the EQRO audit evaluated the following standards:

- 1) Provider Selection
- 2) Provider Credentialing/Re-Credentialing
- 3) Member Information and Communication

- 4) Member Rights
- 5) Confidentiality
- 6) Member Grievances, Appeals and Fair Hearings
- 7) Subcontracts and Delegations

During the audit closing session, the auditors provided a few suggestions for improving some processes. DVHA expects to see a few audit findings, but the feedback we received from the auditors was very good overall. The auditors made several remarks that positively compared DVHA to Managed Care Organizations/Entities across the country and stated that Vermont continues to lead the way by setting and meeting very high standards for the delivery of services to Medicaid members. The final audit report will be available next quarter, and another report with specific information about findings and corrective actions will be provided.

XI. Demonstration Evaluation

AHS to insert

XII. Reported Purposes for Capitated Revenue Expenditures

AHS to insert

XIII. Enclosures/Attachments

Identify by title any attachments along with a brief description of what information the document contains.

- Attachment 1: Budget Neutrality Workbook
- Attachment 2: Enrollment and Expenditures Report
- Attachment 3: Complaints Received by Health Access Member Services
- Attachment 4: Medicaid Managed Care Entity Grievance and Appeal Reports
- Attachment 5: Office of the Health Care Advocate Report

ASH to review/add to attachments list

XIV. State Contact(s)

Fiscal:	Jim Giffin, CFO VT Agency of Human Services 208 Hurricane Lane Williston, VT 05495	802-871-3005 (P) 802-871-3001 (F) jim.giffin@state.vt.us
Policy/Program:	Monica Light, Director AHS Health Care Operations, Compliance, and Improvement VT Agency of Human Services 208 Hurricane Lane Williston, VT 05495	802-871-3254 (P) 802-871-3001 (F) monica.light@state.vt.us
Managed Care Entity:	Mark Larson, Commissioner Department of VT Health Access 312 Hurricane Lane, Suite 201 Williston, VT 05495	802-879-5901 (P) 802-879-5952 (F) mark.larson@state.vt.us

Date Submitted to CMS:

ATTACHMENTS

Optum Work Projection

Original Contract Amount > \$ 5,690,242.00

Projected Month by Month for NON-IT - Streams 1, 2, 3 & 4

Task Order Number	Status	Urgency	Title	Effective Date Start	Effective Date End	Funding Source	Stream 3	Stream 4	DOI Stream 5	Stream 1 & 2	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	
			Contract Amount				(\$2,463,779)	(\$2,610,925)		(\$615,538)														
Stream 1	executed	Executed	IT Analysis and Revised Plan	9-Jun	3-Jul					\$ 497,663	497,663													
Stream 2	executed	Executed	Operations Analysis and Revised Plan	9-Jun	3-Jul					\$ 117,875	117,875													
001	executed	Executed	Change of Circumstance Backlog - CoC Service Requests Month 1	16-Jun	14-Jul 93.525/41764		\$ 822,816					822,816												
002	executed	Executed	User Acceptance Testing support for package 2	27-Jun	31-Aug 93.525/41764			\$ 357,888				170,423	170,423											
003	executed	Executed	834 Backlog - Process Documentation and Oversight	7-Jul	31-Aug 93.525/41764		\$ 58,240				\$ 30,653	\$ 30,653												
004	executed	Executed	Change of Circumstance Backlog - CoC Service Requests Month 2	14-Jul	4-Aug 93.525/41764		\$ 592,532				\$ 592,532													
005	executed	Executed	Program Management Support and Knowledge Transfer	22-Jul	30-Sep 93.525/41764			\$ 771,060					\$ 321,275	\$ 321,275										
006	pending	Executed	Change of Circumstance Backlog - CoC Service Requests Month 3	4-Aug	29-Aug		\$ 824,157					\$ 824,157												

Note [Redacted]