

*State of Vermont*  
*Agency of Human Services*

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

**Annual Report**  
**for FFY 11**  
**October 1, 2010 to September 30, 2011**

**Submitted via email on**  
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## Attachments

Attachment 1: Summary of MCE Investments

## **I. Background and Introduction**

The Global Commitment to Health is a Demonstration Initiative is operated under a Section 1115(a) waiver granted by the Centers for Medicare and Medicaid Services, within the Department of Health and Human Services.

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

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

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

Implemented October 1, 2005, the Global Commitment converts the Office of Vermont Health Access (OVHA), the state's Medicaid organization, to a public Managed Care Entity (MCE). AHS will pay the MCE a lump sum premium payment for the provision of all Medicaid services in the state (with the exception of the Long-Term Care Waiver, managed separately). A Global Commitment to Health Waiver Amendment, approved October 31<sup>st</sup> 2007 by CMS, allows Vermont to implement the Catamount Health Premium Subsidy Program with the corresponding commercial Catamount Health Program (implemented by state statute October 1, 2007) up to 200 percent of the Federal Poverty Level. The Catamount Plan is a health insurance product offered in cooperation with Blue Cross Blue Shield of Vermont and MVP Health Care. It provides comprehensive, quality health coverage at a reasonable cost no matter how much an individual earns. The intent of this program is to reduce the number of uninsured citizens of Vermont. Subsidies are available to those who fall at or below 300 percent of the Federal Poverty Level (FPL). On December 23, 2009 a second amendment was approved that allowed Federal participation for subsidies up to 300 percent of the Federal Poverty Level. Additionally, this amendment also allowed for the inclusion of Vermont's supplemental pharmaceutical assistance programs in the Global Commitment to Health Waiver.

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

One of the Terms and Conditions of the Global Commitment Waiver requires the State "to submit an annual report. This is the report for the sixth waiver year, fiscal year 2011, which ended on September 30, 2011.

## II. Highlights and Accomplishments

### *MCE Work Plan & Requirements:*

As a Managed Care Entity (MCE), the DVHA must adhere to federal rules contained in 42 CFR 438 for Medicaid MCOs. During the first two waiver years the AHS and OVHA completed almost all activities in its initial work plan to ensure compliance with federal regulations. The Agency of Human Services (AHS) contracts with Health Services Advisory Group (HSAG) to conduct an external independent review of the quality outcomes and timeliness of, and access to, care furnished by the State's Managed Care Entity (MCE) to its Medicaid enrollees.

The scope of the external quality review in Year 6 consisted of the following activities:

- Review of DVHA's compliance with standards. The EQRO conducted a review to determine DVHA'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 AHS Intergovernmental Agreement (i.e., contract) with DVHA. The eight standards were provider selection, credentialing and recredentialing, enrollee information, enrollee rights, confidentiality, enrollee grievances, enrollee appeals and State fair hearings, and subcontractual relationships and delegation.
- Validation of DVHA's performance measures. The EQRO 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; and
- Validation of DVHA's performance improvement project (PIP). The EQRO reviewed DVHA's PIP to ensure that the MCE designed, conducted, and reported on the project in a methodologically sound manner, allowing real improvements in care and services and giving confidence in the reported improvements.

Summary of the external quality review findings are as follows:

- Review of compliance with standards. The EQRO reviewed DVHA's performance for 89 requirements across the eight standards. Of the 89 requirements, **DVHA** obtained a score of *Met* for 71 and *Partially Met* for 18. The EQRO did not score performance as *Not Met* for any of the requirements. As a result DVHA obtained a total percentage of compliance score of 90 percent across the 89 requirements. DVHA did not receive any scores of *Not Met*, and its overall performance of 90 percent represented generally strong performance.
- Validation of performance measures. The EQRO validated a set of nine AHS-required performance measures as calculated by DVHA. The nine measures included 18 clinical indicators (or rates). The EQRO determined that all nine measures were fully compliant with HEDIS specifications and were valid and accurate for reporting.
- *Validation of performance improvement projects:* The EQRO conducted a validation of the first annual submission of the **DVHA** PIP, *Increasing Adherence to Evidence-Based Pharmacy Guidelines for Members Diagnosed With Congestive Heart Failure*. The validation covered Activities I through VII. DVHA's 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*. Based on the validation of this PIP, the EQRO's assessment indicated high confidence in the results.

### III. Project Status

#### *Healthcare Reforms & Benefit Changes:*

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

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

However, approval was not given for the following requests:

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

In the amendment requests Vermont noted that an August 18, 2009 Joint Fiscal Committee decision rescinded the allocated funding to implement the depreciation allowance and the waiting period changes. DVHA submitted a report to the legislature in January of 2010 on the estimated costs of implementing the depreciation change and in February of 2010 on the estimated costs of changing the waiting period. The Budget Adjustment bill which was passed by the General Assembly deferred the implementation of the depreciation provision to July 1, 2011. During the 2011 session the legislature repealed the depreciation requirement in the SFY 12 budget act. The legislature did not move forward on the waiting period changes.

Enrollment in the Catamount Health premium assistance program continues to grow slowly. As of the end of September, 2011 there were 10,542 individuals enrolled in Catamount Health premium assistance; however, enrollment in the ESI component has decreased, with only 1561 individuals enrolled in the ESI component (including those eligible for VHAP-ESI) as of September 2011, as opposed to the 1641 enrolled in September 2010. Decreased enrollment in the Employer Sponsored Insurance (ESI) premium is at least partially due to the fact that employers continue to increase the deductibles in their plans in an effort to keep premiums down, and Vermont's ESI premium assistance program is not permitted by law to approve ESI plans if the deductible is more than \$500. An additional 2960 individuals were enrolled in Catamount Health with no premium assistance.

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

In August of 2010 Vermont applied for and received a \$1 million planning grant for the Exchange under ACA. Vermont requested and received permission from CCIIO for a no-cost extension to the first-year planning grant, and work under that grant is almost completed. Vermont submitted an application in September 2011 for a Level 1 Establishment grant.

As required by the Vermont appropriations act for State Fiscal Year 2011, Vermont submitted a waiver amendment request to implement a palliative care program that would allow Medicaid children with life-limiting illnesses to receive concurrent curative and palliative care.

*Vermont Chronic Care Initiative:*

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

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

The VCCI supports and aligns with other State health care reform efforts. VCCI has now expanded its services to all age groups and prioritize their outreach activities to target beneficiaries with the greatest need based on urgency and ability to impact their behavior. VCCI will continue to partner with providers, hospitals, community agencies and other Agency of Human Services (AHS) departments to support a patient-focused model of care committed to enhanced self-management skills, healthcare systems improvement, and efficient coordination of services in a climate of increasingly complex health care needs and scarce resources.

In July 2010, DVHA also expanded its direct care coordination capacity in two areas of the state through the Challenges for Change initiative. The two trial areas were selected based on, among other factors, high disease prevalence and high health system utilization. The initiative adds three additional DVHA care coordination staff (two RNs and 1 Licensed Clinical Social Worker) in each of the two areas (Rutland and Franklin Counties). The staff are co-located within doctors' offices and local hospitals, and are integrated with existing VCCI care coordination staff and lead the way for the Blueprint for Health Community Health Teams which now integrate with the VCCI efforts in these communities. In Franklin County, our VCCI team was named the 'Community Partner of the Year' at the annual meeting of Northwestern Counseling and Support Services (NCSS) a core partner serving individuals with mental health conditions, DVHA has also expanded its care coordination services which will include palliative care pending CMS approval of our waiver.

## Health Resources and Services Administration (HRSA) and VCCI in Franklin County

HRSA designates Health Professional Shortage Areas (HPSAs), which are designated based on requests that states and others submit that demonstrate these areas meet the criteria for having too few health professionals to meet the needs of the population. Franklin County is recognized as a HPSA.

The National Health Service Corps (NHSC) is a network of primary medical, dental and behavioral health care professionals and sites that serve the most medically underserved regions of the country. To support their service, NHSC clinicians receive financial support in the form of loan repayment and scholarships, as well as educational training and networking opportunities. As a result, VCCI was able to hire a Licensed Clinical Social Worker to our workforce in Franklin County who is a participant of NHSC. This type of support is and will be instrumental in our VCCI recruiting efforts in some rural areas.

### APS Contract

Since 2007, DVHA has contracted with APS Healthcare for assistance with providing disease management assessment and intervention services to Vermont Medicaid beneficiaries with chronic health conditions. DVHA currently is in the fourth year of its contract with APS and with the newest amendment has made a decision to move away from traditional disease management and instead is expanding its care coordination services provided by DVHA nurse case managers and social workers. DVHA has found this approach more effective with its highest cost/highest risk beneficiaries. As DVHA expands this approach, it requires a different kind of support than covered in the existing contract with APS. APS presented a cost neutral proposal to provide services to DVHA that are better aligned with DVHA's current needs. Specifically, APS proposed to provide an enhanced information technology and sophisticated decision-support system to assist DVHA's care coordinators target the most costly and complex beneficiaries, adjusted with new information as frequently as daily. This enhanced system builds upon the case management and tracking system DVHA staff have been using since 2007. In addition, APS will provide support to DVHA's care coordinators working within provider offices as part of the Blueprint Community Health Teams. APS has guaranteed a 2:1 return on investment by implementing these enhancements, which equates to roughly \$5 million dollars and will bear 100% of the investment for system enhancements if the agreed upon savings are not realized (i.e., full risk contract based upon agreed upon savings methodology). As a result, DVHA invoked its option to extend the contract with APS for two additional years, ending June 30, 2013.

The VCCI program now features key components of a statewide technology infrastructure to improve care coordination for Vermonters with chronic illness and high utilization of health care services, and to eliminate avoidable costs of care. This infrastructure solution is based on the following: innovative technology for care management; delivery of evidence-based interventions by Care Coordinators within the Department of Vermont Health Access (DVHA); pharmacy analysis and prescriber feedback; technical assistance/training on the use of the technology and information products; and collaborative support for provider and beneficiary interventions.

The chronic care case management system used by DVHA, APS Care Connection™, will continuously identify the highest cost/highest risk (HC/HR) beneficiaries to target for care coordination interventions. The APS Percolator™, which uses evidence-based algorithms to identify and stratify the Medicaid beneficiary population and their providers for interventions, includes indicators such as:

- Admissions for Ambulatory Care Sensitive Conditions.
- Visits to multiple physicians indicating lack of engagement in a medical home.
- Polypharmacy, low medication adherence ratios, and inappropriate prescribing.

- Emergency Department visits for non-emergent reasons, using the New York University algorithms to identify these services.
- Other visits to Emergency Departments.
- Acute admissions and readmissions.

APS will provide the technical and clinical staffing to maintain Care Connection and the Percolator. APS also will provide technical assistance, training, clinical and claims data advisory support to Care Coordinators employed by DVHA, and conduct interventions with providers delivering services to high cost, high risk beneficiaries. APS will provide extensive health informatics reporting, analysis and recommendations to DVHA.

The DVHA Care Coordinators with the support of APS will receive a list and/or receive referrals of high cost, high risk beneficiaries generated by the Percolator using data from a variety of sources (e.g., claims, pharmacy, self report, staff interactions, program goals, etc.). This listing will identify potential highest priority cases for that day and recommend evidence-based interventions to support Care Coordinator workflow. Care Coordinators will use the CareConnection™ system to document beneficiary assessments, interventions, and other aspects of the plan of care for each beneficiary.

APS also will generate diagnosis based Patient Health Registries for provider practices and individual Patient Health Briefs that identify urgent concerns and gaps in care for clinical staff to use in their work with providers. These tools were under development during FFY 2011 and the first Registry targeting asthma was disseminated to providers. VCCI will consult with the Clinical Pharmacist and they will also identify gaps in medication adherence and issues with poly-pharmacy, as well as promote best prescribing practices.

The DVHA has also contracted with the University of Vermont (UVM) for VCCI program evaluation, and for assistance with identifying and implementing quality improvement projects. A clinical performance improvement project (PIP) was developed and is being implemented through the VCCI, focusing on heart failure, one of the high cost, high risk chronic conditions that VCCI targets. The PIP was designed and is being implemented according to the CMS PIP requirements related to quality outcomes. The PIP topic addresses the appropriate treatment of heart failure (HF), a progressive chronic condition. An important component of outpatient management of HF is appropriate use of evidence-based pharmaceutical treatments. The study design and analysis of the baseline data were completed and submitted for validation to the external quality review organization hired by AHS. DVHA received a validation score of 100%. Interventions are being developed and implemented for Year 2 of the PIP.

#### Future Directions:

The State of Vermont has an ambitious agenda for universal healthcare reform (Vermont's Blueprint for Health). This agenda includes disease specific clinical standards; IT support in practices for physician case planning, patient tracking and population profiling; payment reform; all payer claims database; and an outcomes evaluation plan. The VCCI care coordination teams work closely with the community health teams and provide case management services for those high-risk patients and is a fundamental strategy within DVHA for supporting primary care providers, as part of overall healthcare reform efforts.

#### Highlights of the Vermont Chronic Care Initiative for FFY 2011

- Baseline data for the clinical performance improvement project (PIP) on Heart Failure were collected and analyzed and work began developing evidence-based interventions to improve adherence to recommended drug therapy. Implementation of interventions began the end of SFY 2011 and will be evaluated mid-year.

- DVHA is transitioning away from traditional disease management and expanding its care coordination services provided by DVHA Nurse Case Managers and Medical Social Workers, Licensed Clinical Social Worker and Licensed Drug and Alcohol Counselor.
- DVHA has an enhanced information technology and sophisticated decision-support system through its contract with APS which targets the most costly and complex beneficiaries, adjusted with new information as frequently as daily.
- DVHA has enhanced its specialty services by adding a Licensed Clinical Social Worker and a Licensed Alcohol and Drug Counselor to the VCCI team; and has received NHSC recognition in Franklin County.
- DVHA care coordinators expanded meetings and electronic data exchange systems with hospital emergency departments (EDs) for increased collaboration regarding emergency room utilization among VCCI beneficiaries.
- DVHA care coordinators in the Challenges for Change Pilot for both Rutland and St. Albans have established high penetration in EDs and in various Primary Care Physician co-location sites in those counties.
- DVHA is expanding its VCCI scope to now include Palliative Care pending CMS waiver authorization.
- The data indicates that from July 1, 2011 through September 30, 2011 VCCI maintained an average monthly caseload of 747 beneficiaries and from October 1, 2010 through September 30<sup>th</sup>, 2011 a total of 2,189 beneficiaries received either face to face or telephonic case coordination/intervention support services.

Buprenorphine Program

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

(Figure 1)

Complexity Level	Complexity Assessment	Rated Capitation Payment			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			

On January 1, 2010, DVHA notified all buprenorphine providers and implemented an automated payment system for the CPTOD. All claims are now submitted directly to HP Enterprise Services and processed through the MMIS, enabling the DVHA to more accurately budget and track expenditures. The billing requirements are aligned with the treatment complexity levels outlined in the Buprenorphine Provider Agreements and the Buprenorphine Practice Guidelines. The total for all four quarters (October 2010-September 30, 2011) is \$215,741.62 (Figure 2).

(Figure 2)

<b>Buprenorphine Program Payment Summary FFY 2011</b>	
<b>FIRST QUARTER</b>	
<b>Oct-10</b>	<b>\$ 22,701.28</b>
<b>Nov-10</b>	<b>\$ 15,774.28</b>
<b>Dec-10</b>	<b>\$ 17,233.56</b>
<b>Total</b>	<b>\$ 55,709.12</b>
<b>SECOND QUARTER</b>	
<b>Jan-11</b>	<b>\$13,263.03</b>
<b>Feb-11</b>	<b>\$20,099.69</b>
<b>Mar-11</b>	<b>\$17,382.60</b>
<b>Total</b>	<b>\$50,745.32</b>
<b>THIRD QUARTER</b>	
<b>April-11</b>	<b>\$27,828.34</b>
<b>May-11</b>	<b>\$23,079.54</b>
<b>June-11</b>	<b>\$14,258.14</b>
<b>Total</b>	<b>\$65,166.02</b>
<b>FOURTH QUARTER</b>	
<b>July-11</b>	<b>\$23,135.76</b>
<b>Aug-11</b>	<b>\$16,117.24</b>
<b>Sept-11</b>	<b>4,868.16</b>
<b>Total</b>	<b>\$44,121.16</b>
<b>Grand Total</b>	<b>\$215,741.62</b>

### FFY 2012 Strategic Planning

The Department of Vermont Health Access will continue collaboration with its partners (VDH/ADAP, DOC, and others) to ensure infrastructure stability and enhanced program development through system integration, science to service implementation, data collection, and evaluation. Ongoing strategic planning and discussions will continue with ADAP on Medication Assisted Therapy and issues around capacity.

The development of the Vermont *Buprenorphine Practice Guidelines* has been a collaborative effort with the Vermont Department of Health, Division of Alcohol and Drug Abuse Programs (VDH/ADAP) and other community partners. The Guidelines are reviewed and updated every two years and DVHA will be revising these guidelines in 2012. With the assistance of VDH/ADAP, local treatment providers and other experts, the DVHA will continue to conduct thorough reviews of complex and difficult buprenorphine cases and provide ongoing Technical Assistance and Education to providers as needed to maintain and enhance service delivery and integrity.

## **Mental Health – Vermont State Hospital – Replacement Planning**

The Department of Mental Health replacement plans for the service capacities of the Vermont State Hospital (VSH) underwent transformation in response to man-made and natural events during this reporting period. The incoming administration closely scrutinized and suspended further planning for a 15-bed secure adult psychiatric treatment and recovery residential program proposed on the grounds of the state office complex in Waterbury. While approved for a Certificate of Need (CON) in December 2010, the ongoing physical space needs for quality patient care at VSH, as well as, the less than optimal inpatient service milieu resulting from such environmental limitations compelled a different direction for the department and the VSH staff and patients. Replacement of the VSH inpatient services became the priority of the new administration and the focus of planning in the months that followed.

Initial planning anticipated development of a 40 -54 bed hospital proximate to an acute medical care hospital, likely located in central Vermont, through much of this reporting period. DMH continued its development work with the Brattleboro Retreat to identify a number of VSH replacement beds that could be developed in the southern part of the state (in the range of 16-24 inpatient beds). In the midst of this planning, the emergent evacuation of the Vermont State Hospital due to flooding from Tropical Storm Irene in August 2011 presented new challenges to development plans.

The Vermont State Hospital was licensed for 54 beds at the time of the flood. Patients were emergently transferred with VSH staffing to regional partner hospitals, intensive residential recovery programs, and a secure facility on a temporary basis while damage assessments were completed. In the days and weeks following the flooding, the closure of the VSH facility, as well as, the state office complex which existed in the regional flood plan has led to ongoing relocation planning needs. Long-term planning for psychiatric inpatient service capacity now needs to incorporate the new challenge of 54 fewer inpatient beds in its planning and development needs. Given this current acute need, as well as overall continuity of operations demands, other non-essential development work has been assigned reduced priority.

### *Outreach/Innovative Activities:*

Due to state and federal health care reforms, the DVHA felt it important to outreach to Vermonters with information about where health care was going while reminding them of their coverage options under Green Mountain Care. Given the importance of small community newspapers and public access television in a rural state, they played an important part in our outreach strategy. Papers published short articles and letters to the editor by satisfied customers of Green Mountain Care. A program featuring DVHA's Commissioner and the BISHCA's Deputy Commissioner covered topics relative to federal reform, while reminding viewers to check out their health insurance options under Green Mountain Care. This program played for two months on at least nine public access stations statewide.

The Director of Outreach and Enrollment, co-chaired the health committee of the Military Family and Community Network, an effort to ensure that returning soldiers and their family members have access to health insurance. Not all soldiers have access to TRICARE, or can afford their portion of the premiums. Statewide outreach to military personnel and their family was part of the information that returning veterans received following their tour of duty. Additionally, we were present at a "welcome home" event for 500 returning veterans and their families to inform them of the availability of health insurance under Green Mountain Care. This is relevant to those veterans who do not have access to TRICARE.

During FFY 11, Green Mountain Care partnered with the Vermont Department of Labor to conduct outreach at one job fair and 15 lay offs reaching a total of 643 people about Green Mountain Care.

The DVHA also began to look at systems that cause churn. During the month of March we tracked 127 premium checks that were mailed to incorrect addresses, which is a significant number for our small state and ultimately result in delays that cause a drop in coverage. As a result we added payment information to the Green Mountain Care website. We also made improvements to the website to allow applicants to apply for health care on-line.

*Quality Assurance and Performance Improvement Activities:*

During this year, the Quality Assessment and Performance Improvement (QAPI) Committee modified the structure/format to best address the monitoring/oversight needs of the Agency, as well as, the quality assessment and performance improvement needs of the MCE. It was decided that DVHA would convene MCE staff four times per year to discuss specific delegated QAPI activities. A schedule was distributed which identified which specific activity would be discussed during each meeting. The Committee approved a revised purpose statement that included a description of the Committee's structure and responsibilities as well as the revised *Toolkit for Monitoring Delegated Administrative Activities*.

The Committee continued its monitoring/oversight of the QAPI activities to ensure compliance with state and federal standards. The following activities were reviewed/discussed during this year: Health Information System, Enrollee Experience of Care, Performance Measures, Performance Improvement Projects, Availability of Services, Confidentiality, Practice Guidelines, Utilization Management, Provider Selection, Grievance & Appeal, Authorization of Services, and Coordination & Continuity of Care. The Committee reviewed the specific items associated with these requirements. The items included:

- HEDIS Measures;
- CAHPS Survey;
- IGA Partner specific client satisfaction surveys;
- Performance Improvement Project description: *Increasing Adherence to Evidence-Based Pharmacy Guidelines in Members with Chronic Heart Failure*;
- Provider Mapping;
- 2011 HIPAA Event Report;
- Practice Guidelines; and
- *Toolkit for Monitoring Delegated Administrative Activities* summary.

A new quality initiative focusing on the quality of care for psychiatric inpatient services was presented to the Committee. A team of representatives from the Agency is performing the activities of the initiative and reporting back to the QAPI Committee. The Committee will provide an oversight role for this initiative.

The Committee also reviewed the grievances and appeals data and the usefulness of the current information that is being reported out through the DVHA's quarterly reports. The Committee approved a new form that was distributed to all of the IGA partners that provides the Committee with more details on trends and interventions made by each of the IGA partners. The Committee looks for trends and concerns including in the areas of access standards and compliance with patient rights.

The Committee assisted in the preparation for the July 2011 external quality review focusing on the Structure and Operations standards. The results of the review were presented to the Committee and the Corrective Action Plan was approved.

Throughout the year the Committee reported on their activities to the AHS Quality Improvement Manager. Meetings were held with all Committee members as well as with the DVHA Quality

Director. Evidence of the MCE's compliance activities were posted to an electronic folder for review by the AHS Quality Improvement Manager.

### External Quality Review

During this year, the Performance Improvement Project (PIP) work group continued to prepare for this year's External Quality Review Organization (EQRO) PIP validation. Baseline data collection was completed at the beginning of the year and a technical assistance call was held with the EQRO to discuss this year's reporting requirements. During the year, the Managed Care Entity's (MCE) Performance Improvement Project (PIP) work group submitted the initial PIP summary form to the External Quality Review Organization (EQRO) for review. This year's document included information associated with Activities I through VII of the protocol and focused on analysis of baseline data and interpretation of results. After an initial review, the EQRO provided the group with two points of clarification. The PIP work group decided to address these points of clarification, modify their initial submission, and resubmit the modified document to the EQRO for final review. Once this was done, the External Quality Review Organization (EQRO) reviewed the MCE's modified Performance Improvement Project (PIP) submission form and produced a final report detailing the findings of their Performance Improvement Project validation activities. The validation covered steps I through VII, which involved review of the selected study topic, study questions, and study indicators, and identification of the study population, and data collection procedures. The EQRO conducted their validation consistent with the CMS protocol, *Validating Performance Improvement Projects: a Protocol for Use in Conducting Medicaid External Quality Review Activities*, final protocol, Version 1.0, May 1, 2002. The validation finding for DVHA's PIP showed an overall score of 100 percent, a critical element score of 100 percent, and a *Met* validation status indicating high confidence in the results of the PIP for steps I-VII.

AHS staff also met with DVHA staff responsible for calculating and reporting the set of measures that will be used to monitor performance during this year. The performance measure specifications identified by AHS were HEDIS 2010. At the beginning of the year, a conference call between the EQRO and the DVHA was convened to determine how the use of a certified software vendor will impact this year's Performance Measure Validation Review. Also during this year, the MCE submitted Performance Measure (PM) source code and supporting documentation to help inform the EQRO PM Validation activities. After reviewing the documents, the EQRO conducted an on-site review of the DVHA. During their visit, the EQRO completed the following: opening meeting, evaluation of system compliance, review of ISCAT and supporting documentation, overview of data integration and control procedures, primary source verification, and a closing conference. During their review, the EQRO validated a set of 9 performance measures calculated by the DVHA as outlined in the CMS publication, *Validating Performance Measures: a Protocol for Use in Conducting External Quality Review Activities*, final protocol, Version 1.0, May 1, 2002. The performance measures were reported and validated for the measurement period of calendar year 2010 (i.e., January 1, 2010 through December 31, 2010). AHS selected the nine measures from the 2011 Healthcare Effectiveness Data and Information Set (HEDIS ). The data systems used to process and collect claims and encounters, provider data, and membership data were assessed and determined to meet all applicable audit standards. All measures were reported using the administrative method. No medical record review was conducted. DVHA was able to include denied claims this year (as per HEDIS specifications), which allowed it to capture more accurate data and see improvement in some of the rates. DVHA contracted with an NCQA-Certified software vendor (Verisk) to produce the measures, which further supported the validity of the measure results. All 9 measures were assigned a validation finding of fully compliant with AHS specifications.

Additionally, the AHS worked with the DVHA to help them prepare for this year's compliance review. During this year, the MCE submitted documents demonstrating its ability to comply with Federal

Medicaid Managed Care Structure and Operations standards. After reviewing the document, the EQRO conducted an on-site review. The EQRO conducted a review of compliance with federal Medicaid managed care regulations and their associated AHS IGA/contract requirements in eight performance categories (i.e., standards). During the visit, the EQRO conducted the following activities: opening conference, review of documents, interviews with key staff, and a closing conference. The EQRO followed the guidelines in the February 11, 2003, CMS protocol, *Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs): A Protocol for Determining Compliance With Medicaid Managed Care Proposed Regulations* at 42 CFR Parts 400, 430, et al, for the pre-on-site and on-site review activities. The DVHA received an overall compliance score of 90 percent. While the total percentage of compliance scores for each of the standards are meaningful, the scores should be considered in relationship to the total number of requirements evaluated within each standard. The number of requirements varied significantly, from 2 requirements for Standard V—Confidentiality to 29 requirements for Standard VII—Grievance System, Enrollee Appeals and State Fair Hearings. For standards scored as less than 100 percent compliant, the number of requirements in each standard had a direct impact on the overall percentage of compliance scores for the standard. For three of the eight standards (Provider Selection, Confidentiality, and Subcontractual Relationships and Delegation), DVHA’s performance was fully compliant with the requirements, resulting in scores of 100 percent. For the remaining five standards, DVHA’s scores ranged from a high of 93 percent for Standard VIII, Grievance System—Enrollee Appeals and State Fair Hearings to a low of 81 percent for Standard VII, Grievance System—Enrollee Grievances.

Finally, the EQRO produced a final Technical Report that combines the results of all three external quality review activities and identifies strengths and challenges associated with the three activities as well as making recommendations to improve the timeliness, access, and quality of services provided by the MCE. This document was forwarded to CMS.

#### Quality Strategy:

The AHS Quality Improvement Manager and the members of the QAPI committee review the Quality Strategy on a regular basis and recommend any necessary modifications. During this year, no issues with the Quality Strategy were identified. As a result, there were no changes made to the Quality Strategy during this year.

#### Evaluation Activities:

At the end of FFY09, the interim evaluation report of the Global Commitment to Health 1115 Waiver prepared by Pacific Health Policy Group (PHPG) accompanied the State’s formal waiver extension request to CMS. During last year, VT was granted a waiver extension. During the next year, the AHS Quality Improvement Manager will meet with the PHPG project manager to modify the current evaluation work plan to correspond with the time period agreed upon in CMS’s response to the request. The State must submit to CMS a draft of the evaluation report within 120 days after the expiration of the Demonstration. CMS must provide comments within 60 days after receipt of the report. The State must submit the final evaluation report within 60 days after receipt of CMS comments.

## **IV. Utilization Management**

Utilization Management is a systematic evaluation of the necessity, appropriateness, and efficiency of MCE 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/eliminate inappropriate care. The MCE must have in effect a mechanism to detect both under/over utilization of services and to assess the quality and appropriateness of care furnished to enrollees with special health care needs.

## A. MCE Activities

### Over/Under Utilization

#### Clinical Utilization Review Board (CURB)

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. The Department of Vermont Health Access (DVHA) was tasked to create the CURB to examine existing medical services, emerging technologies, and relevant evidence-based clinical practice guidelines and make recommendations to DVHA regarding coverage, unit limitations, place of service, and appropriate medical necessity of services in the state's Medicaid programs.

The CURB is comprised of 10 Members with diverse medical experience, appointed by the Governor upon recommendation of the Commissioner of the Department of Vermont Health Access (Commissioner). The CURB will solicit additional input as needed from individuals with expertise in areas of relevance to the Board's deliberations. The Medical Director of DVHA serves as the State's liaison to CURB.

The CURB has the following duties and responsibilities:

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

## Drug Utilization Review (DUR) Board

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

The Act required the establishment of a Drug Utilization Review Board which would:

- review and approve drug use criteria and standards for both retrospective and prospective drug use reviews (DURs)
- apply these criteria and standards in the application of DUR activities
- review and report the results of DURs, and
- recommend and evaluate educational intervention programs.

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

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

Implementation of this pharmaceutical initiative required that either the DUR Board or a Pharmacy and Therapeutics Committee be established that would provide guidance on the development of a Preferred Drug List for Medicaid patients. The Department of Vermont Health Access (DVHA) elected to utilize the already established DUR Board to obtain current clinical advice on the use of pharmaceuticals.

Meetings of the DUR Board occur either every month or every other month depending upon the numbers of drugs and issues to be reviewed.

The DUR Board typically includes 10-12 members who are appointed to two-year terms. At least one-third, but not more than half, of the Board's members are licensed and actively practicing physicians, and at least one-third of its members are licensed and actively practicing pharmacists. Other interested and qualified people also may be appointed. Board members are recommended by the Commissioner of the Department of Vermont Health Access and must be approved by the Governor. For additional information about the Board, or to be considered for a future appointment, please contact the Commissioner's office at the Department of Vermont Health Access.

### Appropriateness of Services

The MCE delegates, to its IGA partners who provide care to the four identified special health care needs populations, the responsibility to develop mechanisms to assess the quality and appropriateness of care furnished to enrollees with special health care needs. The Department of Mental Health monitors the quality and appropriateness of care to enrollees in the CRT Program through the biennial Minimum Standards Review; and for children identified with severe emotional disturbance through Program Reviews. The Department of Disability, Aging and Independent Living monitors the quality and appropriateness of care to enrollees in the DS Program and the TBI Program through Quality Service

Reviews. (For further descriptions of the delegated activities see the individual departments' quality plans.)

### *Program Integrity Unit*

The Single State Agency for Medicaid has delegated the responsibility for Program Integrity to the Department of Vermont Health Access (DVHA), Program Integrity (PI). The PI Unit strives to ensure that Medicaid funds are utilized appropriately by identifying and ultimately reducing fraud, waste and abuse.

Extensive collaboration exists between other DVHA units as well as with external stakeholders for the investigation of fraud, waste and abuse. Cases of suspected provider fraud are referred to the Medicaid Fraud and Residential Abuse Unit (MFRAU) located in the Vermont Attorney General's Office. Beneficiary eligibility fraud is referred to the Department of Children and Family Services (DCF). Identified quality or process improvement needs are brought to the attention of other AHS Departments at the Quality Assurance Performance Improvement (QAPI) Committee meetings.

The PI unit uses claims analysis to detect aberrant billing practices, identify potential findings and perform preliminary investigations. Potential findings are selected for validation through a variety of investigative approaches. The results of more extensive reviews help to determine if the findings are:

- Suspected provider fraud, which results in a referral to MFRAU
- Suspected beneficiary eligibility fraud, which is referred to the DCF
- An unintentional error by the billing entity
- Errors that indicate a need for education/training and/or clarification of rules, procedures and policy; or
- Determined to be without findings.

The PI unit employs several methods to identify fraud, waste and abuse including:

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

### *Medicaid Management Information System*

The Medicaid Management Information System (MMIS) is an integral component of the PI unit's utilization review activities. It is a tool that allows scrutiny of claims data and includes, but is not limited, to the following:

- Provider review by provider type
- Beneficiary utilization (e.g., pharmacy utilization)
- Specific codes/services
- Emergency department utilization
- Utilization by type of service (e.g., inpatient, outpatient, surgical, mental health, chiropractic services)
- Selected hospital admissions.

### *Claims Data Analysis and Post Payment Review*

The PI unit has contracted with OptumInsight to provide claims data analysis and post payment review. OptumInsight utilizes data mining techniques and has developed a variety of algorithms to detect aberrant utilization. Over sixty provider type code descriptions are reviewed using MMIS claims data. Reports generated from these reviews identify specific claims data and facilitate PI investigations.

### *Ad Hoc Queries*

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

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

### *Decision Support System (DSS)/Profiler*

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

### Inpatient, Outpatient, and Emergency Department Utilization

*Methods.* Utilization statistics for inpatient, outpatient, and emergency department services provided under Global Commitment during FFY 2011 were compiled by DVHA's Data & Reimbursement Unit in February, 2012, using paid claims data. The scope of analysis included institutional services provided under the Medicaid program between 10/1/2010 and 9/30/2011, excluding crossover claims.<sup>1</sup> The following areas of utilization were the focus of this analysis:

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

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

*Findings.* The following table presents discharge counts and average length-of-stay by age for inpatient services provided in FFY 2011.

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

Table 1. Inpatient Utilization.

Utilization	Age	Discharges	Sum LOS Days	Avg LOS Days
TOTAL INPATIENT (IP)	<1	3,209	12,062.00	3.76
TOTAL INPATIENT (IP)	1-9	559	2,046.00	3.66
TOTAL INPATIENT (IP)	10-19	1,176	7,280.00	6.19
TOTAL INPATIENT (IP)	20-44	5,957	25,784.00	4.33
TOTAL INPATIENT (IP)	45-64	3,204	19,037.00	5.94
TOTAL INPATIENT (IP)	65-74	67	486.00	7.25
TOTAL INPATIENT (IP)	75-84	28	163.00	5.82
TOTAL INPATIENT (IP)	85+	8	21.00	2.63
TOTAL INPATIENT (IP)	Total	14,208	66,879.00	4.71
IP MEDICINE	<1	3,173	11,606.00	3.66
IP MEDICINE	1-9	462	1,633.00	3.53
IP MEDICINE	10-19	971	6,224.00	6.41
IP MEDICINE	20-44	4,589	20,071.00	4.37
IP MEDICINE	45-64	2,289	13,335.00	5.83
IP MEDICINE	65-74	49	252.00	5.14
IP MEDICINE	75-84	22	131.00	5.95
IP MEDICINE	85+	8	21.00	2.63
IP MEDICINE	Total	11,563	53,273.00	4.61
IP MED ALCOH/SUBST	<1	0	0.00	0.00
IP MED ALCOH/SUBST	1-9	0	0.00	0.00
IP MED ALCOH/SUBST	10-19	13	60.00	4.62
IP MED ALCOH/SUBST	20-44	427	2,313.00	5.42
IP MED ALCOH/SUBST	45-64	175	849.00	4.85
IP MED ALCOH/SUBST	65-74	1	1.00	1.00
IP MED ALCOH/SUBST	75-84	0	0.00	0.00
IP MED ALCOH/SUBST	85+	0	0.00	0.00
IP MED ALCOH/SUBST	Total	616	3,223.00	5.23
IP MED PSYCHIATRIC	<1	0	0.00	0.00
IP MED PSYCHIATRIC	1-9	39	545.00	13.97
IP MED PSYCHIATRIC	10-19	385	4,385.00	11.39
IP MED PSYCHIATRIC	20-44	980	8,217.00	8.38
IP MED PSYCHIATRIC	45-64	319	3,131.00	9.82
IP MED PSYCHIATRIC	65-74	4	23.00	5.75
IP MED PSYCHIATRIC	75-84	2	53.00	26.50
IP MED PSYCHIATRIC	85+	0	0.00	0.00
IP MED PSYCHIATRIC	Total	1,729	16,354.00	9.46
IP MED OTHER	<1	3,173	11,606.00	3.66
IP MED OTHER	1-9	423	1,088.00	2.57
IP MED OTHER	10-19	573	1,779.00	3.10
IP MED OTHER	20-44	3,182	9,541.00	3.00
IP MED OTHER	45-64	1,795	9,355.00	5.21
IP MED OTHER	65-74	44	228.00	5.18
IP MED OTHER	75-84	20	78.00	3.90
IP MED OTHER	85+	8	21.00	2.63
IP MED OTHER	Total	9,218	33,696.00	3.66
IP SURGERY	<1	36	456.00	12.67
IP SURGERY	1-9	93	393.00	4.23
IP SURGERY	10-19	205	1,056.00	5.15

IP SURGERY	20-44	1,366	5,690.00	4.17
IP SURGERY	45-64	913	5,668.00	6.21
IP SURGERY	65-74	18	234.00	13.00
IP SURGERY	75-84	6	32.00	5.33
IP SURGERY	85+	0	0.00	0.00
IP SURGERY	Total	2,637	13,529.00	5.13

The following table presents visit counts by age for outpatient services provided in FFY 2011, first for all outpatient services, and then for emergency department services.

Table 2. Outpatient Utilization.

Age	TOTAL OUTPATIENT (OP) Visits	OP EMERG DEPT Visits
<1	5,959	2,814
1-9	33,569	15,012
10-19	42,956	15,100
20-44	142,314	40,117
45-64	89,147	12,270
65-74	879	85
75-84	206	19
85+	107	13
Total	315,137	85,430

*Discussion.* In FFY 2011, Global Commitment, Medicaid, paid for 14,208 inpatient stays and 315,137 outpatient visits for Vermonters. Of the inpatient stays, 81% were for inpatient medicine, and 19% were for inpatient surgery. Drilling down further, psychiatric services constituted 15% of the inpatient medicine stays, and treatment for alcohol and substance abuse services constituted .05% of inpatient medicine stays. Compared to other inpatient stays, alcohol/substance-abuse stays were moderately longer in average duration (similar to that for inpatient surgery), and psychiatric stays were substantially longer. Among outpatient visits, emergency department visits constituted roughly 27%.

## V. Policy and Administrative Difficulties

### *Fiscal & Operational Management:*

FFY10, GC waiver year five, was the final year of the original Global Commitment to Health Section 1115 Demonstration. AHS and DVHA spent a considerable amount of time discussing the GC waiver renewal terms with CMS throughout FFY10 and beyond. We received three one-month extensions (October, November, December 2010) while the details for the waiver renewal were being finalized. The GC waiver extension was approved for January 1, 2011, and is scheduled to end on December 31, 2013. AHS and DVHA have worked together to implement new procedures and processes that support accurate expenditure reporting in accordance with the requirements outlined in the new GC Special Terms & Conditions. AHS paid DVHA a prospective PMPM capitation payment on the first business day of every month during FFY11. The PMPM payments included retroactive changes in enrollment with a 12-month runout period, per our PMPM payment process. In accordance with the amended Standard Terms and Conditions, effective with the waiver renewal on January 1, 2011, this PMPM payment served as the proxy by which to draw down Federal funds for Global Commitment. Effective with the filing of the QE0311 CMS-64 report, the State began claiming based upon actual allowable Medicaid expenditures

(administrative, program, and MCE Investments), versus the previous practice of claiming Federal Medicaid dollars based upon the PMPM calculation.

AHS submitted its FFY11 IGA with DVHA to CMS on August 27, 2010. AHS has not yet received approval from CMS for its FFY11 IGA pending resolution of several issues, discussions of which have been ongoing, and the State anticipates resolution shortly.

The ARRA period ended on June 30, 2011; AHS does not anticipate any additional prior quarter adjustments for ARRA claims at this time.

AHS worked with DVHA and HP throughout FFY11 to ensure that the State's reporting system supports all MBES requirements; we continue to work with HP to support all ACA reporting requirements, including identification of those services reimbursed at a different Federal match rate.

AHS worked with Aon Hewitt during waiver year six for development of the FFY11 and FFY12 actuarial rate range certifications. In accordance with the State's contracting requirements, AHS posted a request for proposals in July, 2011 for the Global Commitment actuarial vendor contract, as the agreement with Aon Hewitt is due to expire on March 31, 2012. Two vendors submitted bids for this engagement – Aon Hewitt and Milliman, Inc.; the State has selected Milliman, Inc. as the vendor to produce the per-member-per-month capitation rates as required under the Global Commitment Waiver Special Terms and Conditions for the FFY13 and FFY14 periods. The State had previously worked with Milliman, Inc. for the Global Commitment PMPM Rate Range Development for the FFY06, FFY07 and FFY08 periods, and we anticipate that we will once again have a successful working relationship with this firm. AHS is currently in the final stages of contract negotiations and anticipates entering into the agreement with Milliman, Inc. effective April 1, 2012.

Monica Light, Financial Director, and Connie Harrison, Financial Manager are the key staff responsible for preparing and submitting the quarterly CMS-64 reports; in October 2011, Monica and Connie attended a training, "CMS-64 and Program Integrity Accounting Seminar", that was facilitated by the Medicaid Integrity Institute at the National Advocacy Center in Columbia, South Carolina. Subsequent to this training, Monica and Connie have been working with DVHA and HP to implement required changes to our reporting processes.

#### *Operational Challenges:*

Challenges experienced in waiver year six continued to be related to the areas of data and fiscal reporting that were reported last year. For example, ensuring key fiscal and policy staff understand the rate setting methodology and its impact on the state budget process and information technology systems.

The State has made significant progress in reconciling the differences in fiscal years, while operating the Global Commitment waiver on a Federal fiscal year basis, and managing the budget in accordance with the State's fiscal year cycle (July-June).

Issues confounding the reporting problems include the interplay and reconciliation of the State's two 1115 waivers, the Long Term Care and the Global Commitment to Health mentioned above. This causes considerable complexity in reconciliations between GC and LTC waivers. The LTC waiver was renewed effective October 1, 2010, and clarified the exclusion of individuals under the age of 18, which must be covered under the GC waiver. Adding to the complexity of this reporting is the structure of Vermont's IT system. The IT structure supporting the AHS Healthcare programs was established in 1983 for eligibility and 1992 for the MMIS.

The Agency's financial staff participated a great deal in the extensive MITA self assessment and RFP development process during 2011, relative to modernizing the healthcare information technology.

*Cost Incurred But Not Reported (IBNR):*

The Global Commitment financial model relies on managed care capitation payments as the vehicle for funding Medicaid-covered services. Under a traditional managed care approach, the MCE receives prospective capitation payments in exchange for assuming the financial risk for payment of services rendered during the contract period. Services rendered prior to the start of the contract period would not be the responsibility of the MCE. Therefore, the MCE would accumulate a reserve in order to pay for claims incurred during the contract period, but paid after the contract period (i.e., “run out claims”). Capitation payments under Global Commitment began on October 1, 2005.

However, the State used the capitation revenues to pay for claims incurred prior to October 1<sup>st</sup> and did not request Federal Financial Participation for the claims incurred prior to October 1, 2005. In theory, the MCE was not obligated to use capitation revenues to pay for services rendered prior to the contract period and would have built a reserve to cover any claims tail at the end of the contract period. This approach would have required the State to appropriate more than twelve months worth of funds for a twelve month period to pay for previously incurred claims as well as the prospective capitation payments. The STCs of the GC waiver renewal, effective January 1, 2011, clarified how the State and CMS would handle the IBNR at the conclusion of the waiver.

## VI. Capitated Revenue Spending

The PMPM rates as set for waiver years five and six are listed below

### FFY10

<b>Medicaid Eligibility Group</b>	<b>Monthly Premium PMPM per IGA</b>
ABD - Non-Medicare - Adult	\$ 1,104.49
ABD - Non-Medicare - Child	\$ 2,174.99
ABD - Dual	\$ 1,186.21
ANFC - Non-Medicare - Adult	\$ 574.25
ANFC - Non-Medicare - Child	\$ 364.88
GlobalExp	\$ 413.60
GlobalRx - Dual	\$ 9.78
GlobalRx - Non-Medicare	\$ 177.98
OptionalExp	\$ 173.62
VHAP ESI	\$ 224.86
ESI Premium Assistance	\$ 176.95
Catamount Premium Assistance	\$ 428.84

### FFY11

<b>Medicaid Eligibility Group</b>	<b>Monthly Premium PMPM per IGA</b>
ABD - Non-Medicare - Adult	\$ 1,107.54
ABD - Non-Medicare - Child	\$ 2,288.86
ABD - Dual	\$ 1,227.84
ANFC - Non-Medicare - Adult	\$ 616.56
ANFC - Non-Medicare - Child	\$ 370.94
GlobalExp	\$ 425.33
GlobalRx - Dual	\$ 10.00
GlobalRx - Non-Medicare	\$ 117.46
OptionalExp	\$ 152.85
VHAP ESI	\$ 197.82
ESI Premium Assistance	\$ 125.10
Catamount Premium Assistance	\$ 455.47

Investments made by the MCE for State fiscal year 2011 totaled \$56,275,877. Areas of capitated spending and the associated categories are outlined in Attachment 1.

# Attachments

Investment Criteria #	Rationale
1	Reduce the rate of uninsured and/or underinsured in Vermont
2	Increase the access of quality health care to uninsured, underinsured, and Medicaid beneficiaries
3	Provide public health approaches and other innovative programs to improve the health outcomes, health status and quality of life for uninsured, underinsured, and Medicaid-eligible individuals in Vermont
4	Encourage the formation and maintenance of public-private partnerships in health care, including initiatives to

## SFY11 Final MCO Investments

8/23/11

Investment Criteria #	Department	Investment Description
2	DOE	School Health Services
2	BISHCA	Health Care Administration
2	VVH	Vermont Veterans Home
2	VSC	Health Professional Training
2	UVM	Vermont Physician Training
2	AHSCO	Designated Agency Underinsured Services
4	AHSCO	Vermont 2-1-1 Service
2	VDH	Emergency Medical Services
2	VDH	TB Medical Services
3	VDH	Epidemiology
3	VDH	Health Research and Statistics
2	VDH	Health Laboratory
4	VDH	Tobacco Cessation: Community Coalitions
3	VDH	Statewide Tobacco Cessation
2	VDH	Family Planning
4	VDH	Physician/Dentist Loan Repayment Program
2	VDH	Renal Disease
2	VDH	WIC Coverage
4	VDH	Vermont Blueprint for Health
4	VDH	Area Health Education Centers (AHEC)
4	VDH	Community Clinics
4	VDH	FQHC Lookalike
4	VDH	Patient Safety - Adverse Events
4	VDH	Coordinated Health Activity, Motivation & Prevention Programs (CHAMPPS)
2	VDH	Substance Abuse Treatment
4	VDH	Recovery Centers
2	VDH	DMH Investment Cost in CAP
4	VDH	Poison Control
2	DMH	Special Payments for Treatment Plan Services
2	DMH	MH Outpatient Services for Adults
4	DMH	Mental Health Consumer Support Programs
2	DMH	Mental Health CRT Community Support Services
2	DMH	Mental Health Children's Community Services
2	DMH	Emergency Mental Health for Children and Adults
2	DMH	Respite Services for Youth with SED and their Families
2	DMH	Recovery Housing
4	DMH	Challenges for Change: DMH
2	DMH	Seriously Functionally Impaired
4	DVHA	Vermont Information Technology Leaders/HIT/HIE
4	DVHA	Vermont Blueprint for Health
1	DVHA	Buy-In
1	DVHA	HIV Drug Coverage
1	DVHA	Civil Union
2	DVHA	Patient Safety Net Services
2	DCF	Family Infant Toddler Program
2	DCF	Medical Services
2	DCF	Residential Care for Youth/Substitute Care
2	DCF	Aid to the Aged, Blind and Disabled CCL Level III
2	DCF	Aid to the Aged, Blind and Disabled Res Care Level III
2	DCF	Aid to the Aged, Blind and Disabled Res Care Level IV
2	DCF	Essential Person Program
2	DCF	GA Medical Expenses
2	DCF	CUPS/Early Childhood Family Mental Health
2	DCF	Therapeutic Child Care
2	DCF	Lund Home
2	DCF	GA Community Action
3	DCF	Prevent Child Abuse Vermont
4	DCF	Challenges for Change: DCF
2	DAIL	Mobility Training/Other Svcs.-Elderly Visually Impaired
2	DAIL	DS Special Payments for Medical Services
2	DAIL	Flexible Family/Respite Funding
4	DAIL	Quality Review of Home Health Agencies
2	DOC	Intensive Substance Abuse Program (ISAP)
2	DOC	Intensive Sexual Abuse Program
2	DOC	Intensive Domestic Violence Program
2	DOC	Community Rehabilitative Care
2	DOC	Northern Lights