

State of Vermont
Agency of Human Services

Global Commitment to Health
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Annual Report
for FFY 12
October 1, 2011 to September 30, 2012

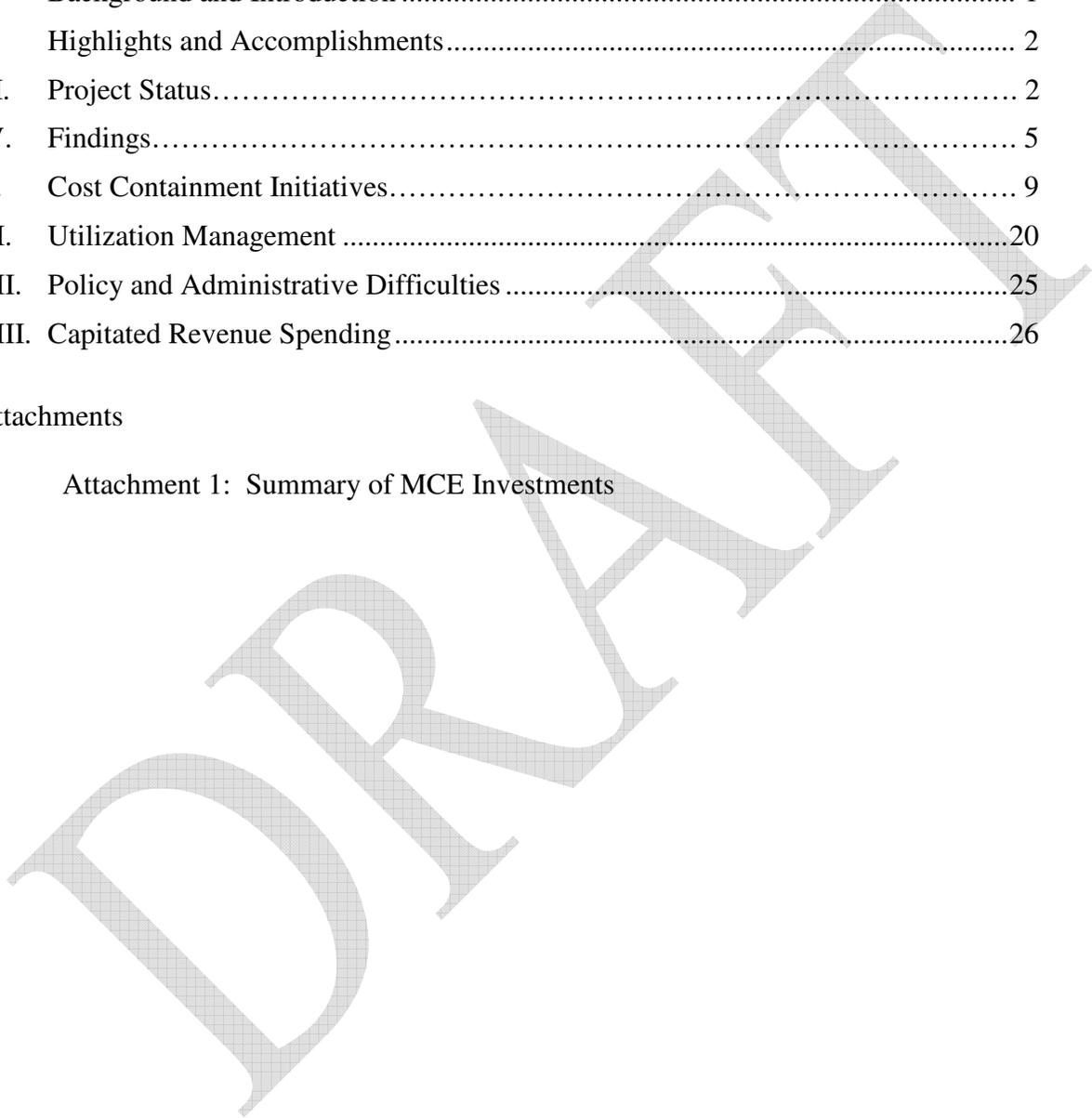
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Attachments

Attachment 1: Summary of MCE Investments



I. Background and Introduction

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

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 1989 implementation of the state-funded Dr. Dynasaur program. In 1992, Dr. Dynasaur became part of the state-federal Medicaid program.

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

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

Implemented October 1, 2005, the Global Commitment converted the (then Office) Department of Vermont Health Access (DVHA), the state's Medicaid organization, to a public managed care model. The Agency of Human Services (AHS) pays DVHA 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, 2007 by CMS, allowed Vermont to implement the Catamount Health Premium Subsidy Program with the corresponding commercial Catamount Health Plan (implemented by state statute October 1, 2007) for incomes up to 200 percent of the FPL to reduce the number of uninsured citizens in Vermont.

The Catamount Plan is a health insurance product offered in cooperation with Blue Cross Blue Shield of Vermont and MVP Health Care that provides comprehensive, quality health coverage at a reasonable cost regardless of how much an individual earns. Subsidies are available to those who fall at or below 300 percent of the FPL. On December 23, 2009 a second amendment was approved that allowed Federal participation for subsidies up to 300 percent of the FPL, and allowed for the inclusion of Vermont's supplemental pharmaceutical assistance programs in the Global Commitment to Health Waiver. Renewed January 1, 2011 the current waiver continues all of these goals.

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 reinforces 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 seventh waiver year, federal fiscal year 2012, which ended on September 30, 2012.

II. Highlights and Accomplishments

- CMS approved an amendment to Vermont's 1115 Demonstration, effective August 1, 2012, with a June 27, 2012 reissue date which provided Vermont with the authority to: 1) eliminate the \$75 inpatient admission co-pay; and 2) implement nominal co-payments for the Vermont Health Access Plan (VHAP) population as long as they do not exceed the co-payments charged to the state plan populations under the Medicaid State Plan. Premiums and co-payments for the Demonstration Populations were removed from the body of the Demonstration document and are now included as Attachment C.
- Pursuant to Item #39 of the Global Commitment's Special Terms and Conditions (STCs), the Agency of Human Services (AHS) submitted its preliminary Affordable Care Act (ACA) Transition Plan on June 28, 2012: *Global Commitment to Health (& Choices for Care) Preliminary Transition Plan*.
- Health Insurance Exchange - Awarded the Level 1 Establishment Grant in November 2011. Awarded the Level 2 Establishment Grant funding in August 2012. Named the Exchange – Vermont Health Connect with tag line: *Find the plan that is right for you*. The DVHA with its IGA partners was found to be 100% in compliance with the standards.
- External Quality Review - the DVHA with its IGA partners was found to be 100% in compliance with the external quality review standards.
- The Vermont Chronic Care Initiative (VCCI) was expanded to include the 1) Pediatric Palliative Care initiative, and 2) services to address high risk pregnancies.
- The DVHA established a Substance Abuse Unit in August 2012 to consolidate its substance abuse services into a single, unified structure. The Buprenorphine Practice Guidelines were submitted and approved by the Managed Care Medical Committee (MCMC) in November 2012.
- Implemented improved point-of-sale pharmacy claims processing which relies on health insurance enrollment information supplied by other insurers to identify and deny claims – at the point of sale – that should be billed to primary insurers before being billed to DVHA as the payer of last resort. DVHA enhanced its pharmacy edits to avoid waste in the 90-day supply requirement for select maintenance drugs by allowing two initial 30-day fills for physicians to titrate patients to desired doses.
- Investments in the community-based mental health services: expand and improve emergency room, crisis and residential supports; flexible outpatient services; housing subsidies; and peer supports.

III. Project Status

Health Insurance Exchange

Vermont was awarded the Level 1 Establishment Grant in November, 2011 and has been making steady progress toward the successful development of the Exchange. The Medicaid and Exchange Advisory Board (MEAB), which formed from the merger of separate Exchange and Medicaid boards, met for the first time in July, and continued to meet on a monthly basis. The State established an Exchange division

within the Department of Vermont Health Access (DVHA) by creating and filling a new Exchange Deputy Commissioner position and beginning the creation, hiring, and recruitment process for other Exchange positions. The Exchange initiated contracts with a number of vendors who are providing expertise, assistance, and support.

Vermont enjoys a high level of collaboration among State agencies, and prioritizes community and stakeholder engagement in the development of the Exchange. State leaders and Exchange staff sought input from stakeholders in meetings, forums, and individual conversations, and also through a survey and structured interviews. A number of analyses were conducted on the Vermont insurance market, informing the State's eventual development of plan designs, determination of Essential Health Benefits (EHBs), and selection and certification of Qualified Health Plans (QHPs). Vermont conducted a preliminary assessment of its financial management system.

Recognizing the constraints of tight timelines and limited State resources, the Exchange moved toward engaging outside vendors to assist with the development of Information Technology (IT) requirements for the Exchange, and ensuring the integration and alignment of the Exchange build with the modernization of the State's integrated eligibility system. Exchange staff hosted numerous public forums on the Exchange, and held focus groups to develop a name and visual identity for the Exchange. The selected name for the Exchange is **Vermont Health Connect** with the tagline "Find the plan that is right for you".

Vermont selected its benchmark plan, finalized EHBs, and made significant progress toward issuing an RFP for QHPs to be offered on the Exchange. Vermont also decided to utilize federal services for risk adjustment and reinsurance. Numerous business requirements development sessions were held for both the Exchange and integrated eligibility, and progress was made on a contract with an Exchange systems integrator. A decision was made to include all health care eligibility into this contract, while a separate procurement process occurs for Vermont's integrated eligibility system. Vermont successfully hired a number of Exchange staff, and brought in additional contracted resources as necessary.

On June 28, 2012, Vermont submitted an application for Level 2 Establishment Grant funding, and in August received a Notice of Award for \$104.2M. Vermont also made a decision to seek an additional Level 1 grant for the primary purpose of seeking funding for an In-Person Assistance Program.

Legislative Activity

The Exchange benefits from a high level of support from Government leaders, State staff, and an overwhelming number of Vermonters for overall health reform and the development of the Exchange. In May 2012 the Governor signed Act 171 into law, which clarified the definition of small employer, defined the role of brokers in the Exchange, merged the individual and small group markets, and required individuals and small groups to purchase insurance through the Exchange.

Outreach & Education

Vermont tasked consultant GMMB with the creation of an outreach and education plan, to be informed by research, stakeholder outreach, previous experience, and legislative requirements. GMMB completed a telephone survey of typical Vermonters to identify their needs and preferences as well as targeted interviews with key stakeholders. In March 2012, the State received the results of the benchmark survey, based on telephone responses from 1004 Vermonters over the age of 18:

<http://dvha.vermont.gov/administration/hbe-benchmark-survey-results-04-30-12.pdf>

GMMB also completed 15 structured interviews in March 2012 with carriers, brokers, consumer advocacy and small business organizations, and providers:

<http://dvha.vermont.gov/administration/hbe-stakeholder-interview-findings-ltr-4-27-12.pdf>

Vermont has done extensive work to develop an outreach and education plan which includes a set of core strategies, and is guided by a defined set of target audiences, including primary and secondary audiences. The target audiences detailed in the plan address the populations identified in 45 CFR 155.130. The plan does not specifically address federally-recognized tribes since there are none in the State of Vermont. The plan does add sub-populations to the primary audiences list, including young adults (18-34), as they make up the largest portion of the uninsured population in Vermont, and Catamount Health beneficiaries, as they are currently in a State program and will transition to the Exchange in 2014. Additionally, the underinsured population is a priority for the State. The plan explores a variety of tactics for reaching these populations with the goal of engaging them and driving them to the Exchange website or a Navigator where they can learn more about the Exchange and get assistance enrolling. The plan includes the following components:

- Materials development
- Earned media
- Paid media (advertising)
- Social media
- Stakeholder engagement
- Partnerships and grassroots engagement
- State employee communications

GMMB conducted eight focus groups with individuals and small business owners to provide feedback on the name and visual identity for the Exchange. In July 2012, GMMB produced a summary of findings from the focus groups:

<http://dvha.vermont.gov/advisory-boards/vt-focus-groups-report-final.pdf>

GMMB used the findings to inform their recommendations for the name and identity, and that document can be found at:

<http://dvha.vermont.gov/advisory-boards/vt-visual-identity-recommendation.pdf>

The name that was recommended is **Vermont Health Connect** with the tagline “Find the plan that’s right for you” and both have been approved by the Exchange leadership team.

Catamount Health and Employer Sponsored Insurance:

Enrollment in the Catamount Health premium assistance program grew slightly throughout 2012 with an average monthly enrollment of 10,716 individuals enrolled in Catamount Health premium assistance. Enrollment in the Employer-Sponsored Insurance (ESI) program decreased with only 1553 individuals enrolled it (including those eligible for VHAP-ESI). On average 824 individuals enrolled in VHAP-ESI and on average 729 individuals enrolled in ESI. Decreased enrollment in the ESI program is partially due to the fact that employers continue to increase the deductibles in their plans in an effort to control the cost of premiums. Vermont’s ESI premium assistance program is not permitted, by law, to approve an ESI plan if the deductible is greater than \$500.

In early September 2012 MVP Health Care filed a request with the Department of Financial Regulation (DFR) and the Department of Vermont Health Access (DVHA) requesting departure from the Catamount Health product line to be effective December 31, 2012. This request was granted and the state embarked

on a joint effort to provide notice to beneficiaries regarding this departure. The state seamlessly transitioned the 317 subsidized MVP individuals to Blue Cross Blue Shield (Catamount Blue) to ensure that no one experienced a break in coverage.

IV. Findings

External Quality Review

As a Managed Care model, the Department of Vermont Health Access (DVHA) adheres to federal rules contained in 42 CFR 438. 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 DVHA to its Medicaid enrollees.

The AHS Quality Improvement Manager (QIM) worked with the External Quality Review Organization (EQRO) to prepare documents for the 2012 review activities. Before any activities could take place, a time line was reviewed and agreed upon. With this time line in place, a work plan was created for each of the three required activities. These documents included the following information: key task, due date, responsible party, and any applicable comments. These documents were shared with DVHA and its IGA partners and made final ahead of the on-site and desk reviews.

The Performance Improvement Project (PIP) summary form, compliance review tool, and performance measure review guide were developed by the EQRO with input from AHS QIM. These are the tools that are used by the EQRO to gather data that assesses DVHA's performance relative to quality assessment and improvement requirements as well as their ability to comply with State and Federal Medicaid managed care standards. In order to define the scope of the review, the AHS QIM finalized the performance measures subject to validation, identified the performance improvement expectations, and agreed upon the Medicaid managed care standards to be reviewed. This year's compliance review involved measurement & improvement standards. The performance measures subject to validation were the same as those validated in 2011. This allows for an opportunity to track and trend the measures over time. Performance improvement validation activities continued last year's project.

This year, the EQRO evaluated the technical methods of the PIP up to and including step nine (i.e., assess for real improvement). In addition to preparing physical documents, the AHS QIM worked with DVHA staff to help them prepare for the upcoming EQRO review activities. This included participating in conference calls between DVHA and the EQRO to determine how best to report PIP activities undertaken during the past year on the newly approved PIP Summary Form, clarifying requirements on the ISCAT document, as well as, clarifying the requirements associated with the measurement and improvement compliance standards.

The AHS QIM worked with the EQRO to provide technical assistance to DVHA and its IGA partners re: the three required review activities. While responsibility for completion of the PIP Summary Form, the Performance Measure Validation documents, and the compliance review tool belongs to DVHA and its partners, the AHS QIM supported their efforts via phone, and face-to-face meetings. All tools and supporting documents were posted to the EQRO FTP site by the due date.

The AHS QIM attended both on-site EQRO reviews (i.e., compliance and performance measure validation) and participated in the desk review of the performance improvement project. The PIP work group submitted the initial PIP summary form to the EQRO for review. The PIP validation evaluated the technical methods of the PIP (i.e., the study design, implementation/evaluation and outcomes) associated with the Re-measurement 1 data reported. 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 EQRO conducted their performance measure validation via an on-site review. 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 MCE 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 2011 (i.e., January 1, 2011 through December 31, 2011). During the compliance review, 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.

After the desk and onsite reviews were conducted, the AHS QIM worked with the EQRO to develop final reports for each. The PIP received an overall *Met* validation status when originally submitted and DVHA had the opportunity to incorporate HSAG's recommendations from the PIP Validation Tool, and resubmit the PIP, at which time the plan improved its overall evaluation element score and maintained the *Met* validation status. Overall, 96 percent of all applicable evaluation elements received a score of *Met*. DVHA progressed to reporting Re-measurement 1 data. With the progression, the overall evaluation elements score declined when compared to the 2010–2011 validation due to the lack of statistically significant improvement. All 9 performance measures were assigned a validation finding of fully compliant with AHS specifications. DVHA received an overall compliance score of 100 percent.

Finally, the AHS QIM worked with the EQRO to develop the Annual Technical Report. This document 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 DVHA. The performance of this PIP suggests a thorough application of the PIP design. DVHA's documentation provided evidence that the plan appropriately conducted the data collection activities of the Implementation stage. These activities ensured that the study properly defined and collected the necessary data to produce accurate study indicator rates. Additionally, DVHA documented appropriate improvement strategies that were targeted to overcome barriers identified by the plan. Targeted interventions are critical for bringing about improvement in performance improvement studies and should be developed to specifically address and overcome barriers.

The identification of barriers through barrier analysis and the subsequent selection of appropriate interventions to address these barriers are necessary steps to improve outcomes. DVHA's choice of interventions, the combination of intervention types, and the sequence of implementing the interventions are essential to the PIP's overall success. The study indicator did not achieve statistically significant improvement. To increase the measurable effects of its quality improvement activities, DVHA should conduct further drilldown analysis to ensure that the barriers identified are specific to its population and that targeted interventions are implemented which directly address the barriers.

As the study progresses, HSAG recommends that DVHA do the following: 1) Continue to review interim evaluations of results in addition to the annual evaluation. DVHA should determine if the interventions are having the desired effect or if modifying current interventions or implementing new interventions are necessary to improve results based on the interim evaluation results; 2) Continue to conduct a drill-down type of analysis before and after the implementation of any intervention to determine if any subgroup

within the population has a disproportionately lower rate that negatively affected the overall rate. DVHA should target the identified subgroups with the lowest study indicator rates for interventions, allowing the implementation of more precise, concentrated interventions.

DVHA staff demonstrated their commitment to performance measure reporting in many ways this year. The team worked to submit a thoroughly completed ISCAT and all supporting documentation prior to the on-site visit. In addition, appropriate staff was available during the audit to answer questions and provide demonstrations.

The final rates were submitted prior to the on-site visit for review and benchmarking that allowed for discussion during the on-site visit on how the plan performed. DVHA operates in a highly electronic environment, and providers are all paid using a fee for service model. Both of these factors enhance the accuracy and completeness of submitted claims data. The use of certified software to generate HEDIS rates allowed for consistent interpretation of reporting requirements and specifications, and led to reliable and accurate rates.

DVHA made great strides in preparing for the performance measure validation activities this year. The submitted documentation and on-site discussion demonstrated that DVHA had a good grasp on the process. In reviewing the performance measure rates, specifically for the diabetes measure, it was evident that there are missing lab data that if received could help to improve performance. It is recommended that DVHA consider working with one or two large local laboratories to see if a process could be built to receive a lab results data file feed on a regular basis. These lab results data would greatly improve performance on the diabetes indicators. Also, as DVHA prepares to report the diabetes measure through hybrid reporting, it should be prepared to provide documentation of the entire process for next year's audit.

Finally, DVHA staff demonstrated a strong ability to comply with Federal and State Measurement and Improvement standards this year. In its examination of DVHA's documents and DVHA staff responses to the interview questions and discussions during the interview, HSAG identified and was impressed with the significant continued improvements DVHA had implemented in its processes, documentation, and performance results since the previous review. This was clearly evident and impressive, notwithstanding the challenges experienced during the past year (e.g., loss and relocation of staff and resources from the severe flooding and increased budget restraints and limitations).

As in prior years, HSAG continued to experience AHS' and DVHA's strong commitment to building care and services and designing policies and processes that meet the applicable CMS and State requirements, but always with the goal of embracing enrollee-focused decisions, processes, and services. DVHA's commitment to taking care of enrollees' health care needs and providing quality, timely, and accessible services and easy-to-navigate processes for the enrollee was evident during the on-site interviews and in the documentation reviewed. While not a required corrective action, HSAG found the content of DVHA's provider manual to be largely focused on administrative processes such as provider enrollment, billing, coding, and claims payment. In comparison to provider manuals of other Medicaid managed care organizations with which HSAG is familiar, DVHA's provider manual was significantly and substantively more limited in terms of information and requirements for the providers' clinical practice, patient engagement, quality of care provided, and performance results. HSAG encouraged DVHA to consider expanding and strengthening its provider manual.

Quality Assurance and Performance Improvement Activities (QAPI)

During FFY 2012, the Quality Assessment and Performance Improvement (QAPI) Committee continued its monitoring and oversight of the managed care activities to ensure compliance with state and federal

regulations. The following activities were reviewed 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 QAPI Committee reviewed specific items associated with these requirements. The items included:

- HEDIS Measures;
- CAHPS Survey;
- IGA Partner specific client satisfaction surveys;
- Performance Improvement Project: *Increasing Adherence to Evidence-Based Pharmacy Guidelines in Members with Chronic Heart Failure*;
- Provider Mapping;
- Member services call logs and Ombudsman reports;
- Utilization data reports;
- 2012 HIPAA Event Report;
- Practice Guidelines for prescribing Buprenorphine and practice guidelines for the management of diabetes; and
- *Toolkit for Monitoring Delegated Administrative Activities* summary.

The QAPI Committee performed the annual review of the Quality Plan and developed a Quality Work Plan. The QAPI Committee assisted in the preparation for the July 2012 external quality review focusing on the measurement and improvement standards. The DVHA with its IGA partners was found to be 100% in compliance with the standards. Representatives from each IGA partner, the Department of Vermont Health Access (DVHA) and the Agency of Human Services (AHS) participated in a training on the quality improvement model adopted by AHS. Each participant completed a performance improvement project.

The DVHA developed a new position, Managed Care Compliance Director, prompting a review of the current reporting structure and the role of the QAPI Committee. The QAPI Committee reviewed its current structure and purpose, and identified the need to focus more on quality improvement which would align with the changes being made throughout the AHS. New staff was hired to focus on quality improvement resulting in the change in membership of the QAPI Committee. As part of the restructuring the DVHA Quality Improvement Director and the AHS Quality Improvement Manager (QIM) met with each of the IGA partners individually to focus on identifying any changes in compliance activities, ongoing performance improvement efforts and how activities can be aligned throughout the AHS.

Throughout the year the QAPI Committee reported on their activities to the AHS QIM. Evidence of DVHA's compliance activities were posted to an electronic folder for review by the QIM. One recommendation was made to the AHS Quality Manager for a corrective action plan related to one IGA partner's compliance with standards for coordination/continuity of care and appropriateness of care for special health needs populations. Through a collaborative effort a plan was developed to bring the IGA partner into compliance with no formal corrective plan being necessary.

Quality Strategy

During this year, no issues with the Quality Strategy were identified by members of the QAPI committee. As a result, no action was taken on the strategy. However, the AHS QIM spent time reviewing the National Strategy for Quality Improvement in Health Care (National Quality Strategy). The QIM will look to engage members of the QAPI committee in a discussion regarding the National Quality Strategy to determine where Global Commitment and national

quality assessment and improvement efforts might align for maximum results.

Evaluation Activities

During this year, the AHS Quality Improvement Manager (QIM) worked with evaluation staff at the Pacific Health Policy Group (PHPG) to initiate the demonstration evaluation. The initial evaluation work plan was modified to correspond with the time-period agreed upon in CMS's response to the request. The document will determine the Demonstration's progress toward accomplishing its three goals of increasing access, improving quality, and controlling costs and will include both quantitative and qualitative analyses of enrollment statistics, quality of health care measurement information, and beneficiary survey results. A full evaluation report will accompany Vermont's waiver renewal application.

V. Cost Containment Initiatives

Vermont Chronic Care Initiative (VCCI)

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

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

The VCCI supports and aligns with other State health care reform efforts, including the Blueprint for Health advance practice medical homes and local Community Health Teams (CHTs). The VCCI has expanded services to include all age groups accounting for the top 5% of expenses; and those with ambulatory sensitive conditions which are adversely impact utilization trends, such as ED and inpatient admissions and readmissions. The VCCI has expanded both its service scope as well as partners who support these new focus areas, as outlined in segments below.

The VCCI continues to expand upon the 2010 strategy to embed licensed staff within high volume Medicaid primary care sites and hospitals experiencing high volume ambulatory sensitive Emergency Department (ED) visits and inpatient admissions/readmissions. At the end of FY 2012, the VCCI had staff in 16 locations including 2 hospitals and 7 primary care provider (PCP) sites, with expansion to new sites scheduled for FY 2013, pending new hires. This approach fosters provider relationships as well as direct referral for high risk populations; and availability of 'real time' case findings at the point service within the PCP site; as well as within the hospital for ED and/or inpatient admission with a goal of reducing readmissions to (93% of all hospital readmissions are for the top 5% of the Medicaid population). This also provided an opportunity for enhanced coordination and planned transitions in care with hospital

partners and primary care sites, as well as with home health agencies who may be delivering skilled nursing care.

Pediatric Palliative Care

The VCCI expanded to include a Pediatric Palliative Care Program (PPCP), which was approved by CMS in December 2011 as part of the Global Commitment waiver renewal. The PPCP was officially launched in September of 2012 in Chittenden County as the first pilot community due to size as well as infrastructure available to support implementation. The intention of offering the PPCP was to address the unique needs of children who are living with a serious and potentially life threatening illness. As stated in the waiver, children who are medically eligible must be under age 21, have Vermont Medicaid, and be living with a life limiting or life threatening diagnosis from which they may not live into adulthood. Services may include Care Coordination, Family Training, Expressive Therapy, Respite, and Counseling (including Bereavement if necessary).

The PPCP includes participation from Agency of Human Services (AHS) leads for Integrated Family Services (IFS) and Children's Integrated Services (CIS) within the Department of Children and Families (DCF) and Children with Special Health Needs (CSHN) within the Department of Health (VDH). An extensive network of pediatric palliative care providers at Fletcher Allen Health Care (FAHC) and Dartmouth Hitchcock Children's Hospital, as well as primary care pediatric practitioners and pediatric oncologists are among new provider partners engaged in the PPCP. Community partners include Home Health Agencies (hospice and palliative care units), the Vermont Ethics Network and the Vermont Family Network.

The PPCP nurse case manager was able to attend a program at Harvard University to support this work which included 2 one week sessions with the ability to interact with academic and clinical experts locally and nationally to help inform this body of work. A progressive statewide rollout of the PPCP is planned for FY 2013.

High Risk Pregnancy

The VCCI expansion included the addition of High Risk Pregnancy Case Management at the onset of the state fiscal year – July 2012. Unfortunately due to our inability to recruit skilled staff the program has not as yet been launched. However plans remain in place to collaborate with partners at VDH/MCH as well as offer pilot level services to high risk populations in Franklin County in calendar year 2013. These efforts align with the ACA funding in the community for health homes for individuals with Substance Abuse (SA) disorders, including pregnant women. The High Risk Pregnancy case management addition will be centrally administered and focus on the system of care and coordination of services for the identified population; and supportive telephone case management and care coordination services by the high risk pregnancy nurse. Field based VCCI staff will provide supportive services as indicated. The state remains challenged in our recruitment efforts by the competitive salaries nurses can receive from hospitals – including for community based work. While positions were upgraded in summer of 2012, challenges persist in both and recruitment and retention.

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 is in the final year of its contract with APS and with the newest amendment had made a decision to move away from traditional telephonic disease management

and instead to expand 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 staff are able to communicate directly at the local level with provider, partners, patients and their families. As DVHA transitions to the new approach, it required a different level of support from APS. APS presented a cost neutral proposal to provide services to DVHA that are better aligned with DVHA's current needs. Specifically, APS is providing enhanced information technology and more sophisticated decision-support tools to assist DVHA's care coordinators to outreach the most costly and complex beneficiaries based on risk and ability to positively impact results. APS continues to provide supplemental population based supports to the DVHA's care coordinators working within provider offices; as well as to support the work of the Blueprint Community Health Teams addressing NCQA priorities. APS also has embedded evidence based treatment guidelines for this population.

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 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 the two additional years with a scheduled end date of June 30, 2013.

University of Vermont

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, focusing on heart failure which is 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. HF patients are managed through both APS and DVHA's VCCI. 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 (EQRO) hired by AHS. DVHA received a validation score of 100%. Interventions are being developed and implemented for Year 2 of the PIP.

Highlights of the Vermont Chronic Care Initiative for FFY 2012 include the following:

- Staff expansion to support further development of the integrated nursing model within hospital and primary care practice sites. DVHA now has 27 FTE's including 2 regional managers and an administrative support staff member.
- DVHA developed and trained field based partners and launched a new Pediatric Palliative Care Program in one pilot community; with expansion planned for FY 2013 with statewide implementation completed by early spring 2013.
- A high risk pregnancy nurse case management program was approved by the legislature with budget authorization for 2 nurse case managers, which are under recruitment; the positions will support development of a system of care including leveraging the current infrastructure and expanding and assuring coordination among service providers. This initiative will be supported by the emerging ACA funds for Substance Abuse case management as well.
- Nursing recruitment and retention challenges required a rewriting all nursing positions within DVHA. Pay grade adjustments were approved in July for all positions within the VCCI. A Market

Factor has also been recommended and will require budget review to further supplement the nursing salary structure within DVHA as salaries remain significantly below the regional norms.

- The VCCI continues to implement the Heart Failure (HF) PIP with assignment of cases with this condition to VCCI staff on a priority basis; along with PCP and Cardiology outreach on gaps in care. The VCCI also implemented a population based approach to identifying gaps in care via 'patient health registries' for primary care and cardiology providers on cases in management that are not receiving evidence based care. This effort will continue in FY 2013 to assure improvements are maintained. The VCCI is also partnering with the Blueprint for Health and the statewide efforts to also address HF via their Community Health Teams locally.
- Completed two (2) Heart Failure registries in June and September for providers whose patients had gaps in care (June - 36 providers / 39 patients; September- 42 providers / 47 patients).
- Completed a coronary artery disease registry (CAD) identifying gaps in care for PCPs with 42 'registries' disseminated on 122 beneficiaries with gaps in treatment.
- Expansion of the hospital data sharing via FTP site and/or excel reports to support and augment risk data and point in time outreach to vulnerable individuals with patterns of high risk, cost and utilization. Currently VCCI has arrangements with five hospitals.
- Annualized data on engagement in the VCCI during 2012 as provided by APS Healthcare; indicates that the VCCI maintained an average monthly caseload of 627 beneficiaries with a yearly total of 1775 unique members served. Unique members are beneficiaries who have been assigned to VCCI staff and have had a Social Needs, Behavioral Risk or Transitions of Care Assessment completed.
- Three (3) VCCI staff was enrolled in a one year training to become a 'trained trainer' for Motivational Interviewing. This skill set will allow ongoing support by the VCCI staff with their colleagues to enhance skills.
- DVHA authorized training for 4 senior nurse case managers to become Certified Case Managers (CCM) with anticipated testing and certification prior to calendar year end.

Substance Abuse Unit

DVHA established a Substance Abuse Unit in August 2012 to consolidate its substance abuse services into a single, unified structure and point of contact for prescribers, pharmacists, and beneficiaries. This unit provides seamless and integrated care to beneficiaries receiving Medication Assisted Therapy (MAT) and/or those participating in the *Team Care* program or who have a *Pharmacy Home*. The Substance Abuse Unit coordinates with the *Hub and Spoke* initiative, the Vermont Chronic Care Initiative (VCCI) and the DVHA Pharmacy Unit to provide beneficiary oversight and outreach.

Team Care (formerly called the lock-in program) designates one prescribing physician and one pharmacy (the *Pharmacy Home*) to improve coordination of care and decrease over-utilization and misuse of services by beneficiaries. Beneficiaries who exceed certain thresholds for opiates and other controlled substances or who utilize multiple prescribers and pharmacies to obtain controlled substance prescriptions are identified for *Team Care*. All beneficiaries receiving MAT with buprenorphine/Suboxone[®] have a *Pharmacy Home* that dispenses all their prescriptions. In addition to overseeing these programs, the Substance Abuse Unit coordinates and facilitates prescriber reconsideration requests and appeals when prior authorizations for controlled substances are denied.

Cost savings associated with the Substance Abuse Unit are expected through improved coordination of care and through reductions in over-utilization, misuse of medications, duplicative pharmacy payments, non-emergency health care services, unnecessary emergency room use, and inpatient detoxification.

Buprenorphine Program

The development of the Vermont *Buprenorphine Practice Guidelines* continues to be a collaborative effort with the Vermont Department of Health, Division of Alcohol and Drug Abuse Programs (VDH/ADAP) and other community partners. The Buprenorphine Practice guidelines are also reviewed and updated every two years. DVHA has revised the guidelines and they were submitted and approved by the Managed Care Medical Committee (MCMC) in November 2012.

The DVHA, in collaboration with the Vermont Department of Health’s (VDH) 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		

The total for the 4 quarters (October 2011- June, 2012) is \$232,516.4 (Figure 2).

(Figure 2)

Buprenorphine Program Payment Summary FFY 2012	
FIRST QUARTER	
Oct-11	\$14,415.76
Nov-11	\$ 15,136.66
Dec-11	\$ 15,255.38
1st Quarter Total	\$44,807.80
SECOND QUARTER	
Jan – 2012	\$11,626.56
Feb – 2012	\$16,199.22
March- 2012	\$11,473.18
2nd Quarter Total	\$39,298.96
THIRD QUARTER	
April - 2012	\$12,678.38
May - 2012	\$27,532.72
June - 2012	\$19,685.84
3rd Quarter Total	\$59,896.94
FOURTH QUARTER	

July - 2012	\$28,282.08
August - 2012	\$30,257.50
September - 2012	29,973.12
4th Quarter Total	\$88,512.70
Grand Total	\$232,516.4

Pharmacy Program

The DVHA Pharmacy Unit is responsible for managing all aspects of the publicly funded pharmacy benefits program: responsibilities include but are not limited to pharmacy claims processing, drug coverage determinations, drug reconsiderations and appeals, oversight of federal, state, and supplemental drug rebate programs, resolving drug-related pharmacy and medical provider issues, overseeing the contract with the prescription benefit management (PBM) contractor, oversight and management of the Drug Utilization Review (DUR) Board, management of the Preferred Drug List (PDL), assuring compliance with state and federal pharmacy and pharmacy benefits regulations, managing a \$140 million drug budget, and analyzing trends and seeking innovative cost and quality initiatives. The goal is to ensure that beneficiaries receive clinically appropriate medications in the most efficient and cost-effective manner, to deliver the best outcomes at the lowest overall cost to the health care system.

Use of Atypical Antipsychotics

DVHA's Pharmacy Unit continues to be highly engaged in promoting clinically appropriate prescribing of atypical antipsychotics and psychotherapeutic drugs in general. DVHA has addressed the overuse of low doses of quetiapine (Seroquel®) for insomnia and anxiety with prescribers, and is currently participating in a Center for Health Care Strategies technical assistance grant to support other initiatives such as creating evidence-based prior authorization criteria for the use of anti-psychotics in children, improving the informed consent process for foster families, and providing psychiatric consultations for primary care providers and pediatricians caring for children in custody. In addition, DVHA continues to focus on psychotherapeutic drug use in adults. For example, the Vermont Academic Detailing Program, which promotes high-quality, evidence-based treatment decisions by healthcare professionals through interactive visits between prescribers and pharmacists, presented an educational module on the appropriate use of antipsychotics in adults that was met with much enthusiasm by the provider community.

Pediatric Antipsychotic Criteria/Survey

DVHA's Pharmacy Unit participated in a work group to assess and reduce the use of antipsychotics in children in Vermont. One of the key outcomes of the workgroup was an analysis of pediatric Medicaid patients being prescribed antipsychotics. The analysis was made possible through data obtained from prescribers, who were required to fill out a survey for each of their Medicaid pediatric patients being prescribed an antipsychotic.

The form shared a dual purpose of informing the work group of prescribing practices in Vermont, as well as acting as a medical necessity review for each pediatric beneficiary being prescribed an antipsychotic.

The information obtained on the survey also informed the Drug Utilization Review (DUR) Board in the development of new criteria around target symptoms and/or diagnosis. Prior authorization

approval criteria for new pediatric (< 18 years old) starts for all Atypical (second generation) Antipsychotic medications was approved by the DUR Board and based on target symptom and/or diagnosis. A new prior authorization will be required annually to give prescribers an opportunity to re-evaluate the need for ongoing therapy.

Federal 340B Drug Discount Program

DVHA's Pharmacy Unit has been able to further control drug costs with the continued expansion of the 340B drug discount program. Vermont has put in place an innovative methodology to maximize Medicaid participation in 340B pricing for Medicaid beneficiaries served by eligible prescribers at 340B-enrolled covered entities. This methodology has enabled growth in the 340B program participation by covered entities, and has demonstrated proven savings to the Vermont Medicaid programs.

Drug Utilization Review Board

The Vermont pharmacy best practices and cost control program was authorized in 2000 and established in SFY 2002 by Act 127. This program, as the Vermont Health Access Pharmacy Benefits Management (PBM) Program, is administered by DVHA. Central to this program is the Drug Utilization Review Board (composed of physicians and pharmacists), which also serves as the program's Pharmacy and Therapeutics (P&T) Committee. The goal of the program and the DUR Board is to ensure that clinically appropriate, cost-effective drug therapy is provided to beneficiaries. During FFY 2012, the DUR Board focused on high-cost, high volume medications and was once again particularly active in the areas of buprenorphine and antipsychotic prescribing (see above). The Drug Utilization Review Board met eight times in FFY2012.

Increase "Pay & Chase" Receipts due to New Pharmacy Data Matching

On November 1, 2012, DVHA implemented an improvement in the way it processes point-of-sale pharmacy claims that reduces the need for manual post-payment coordination-of-benefits intervention. This initiative is a new component of the State's contract with its pharmacy benefits manager (PBM). It relies on health insurance enrollment information supplied by insurers to identify and deny claims – at the point of sale – that should be billed to primary insurers before being billed to DVHA, the payer of last resort. In addition to denying the claim, DVHA's return messaging on the denied claim provides the pharmacy with the correct insurance billing information. Gross savings were estimated to be approximately \$2,725,000 annually with an increase in administrative costs of \$725,000.

While the initiative was expected to be implemented October 1, 2012, it was implemented November 1, 2012, due to a delay in the execution of a contract amendment with the PBM. For the first two months Third Party Liability (TPL) cost-avoidance savings was approximately \$595,000, with administrative costs of approximately \$27,000, for a net savings of \$568,000. This savings includes both annualized and monthly savings figures, and is the result of both operational savings, and updates and improvements to the eligibility feed to the PBM, resulting in better identification of third party liability information.

Results are based on limited operational data; as the initiative matures DVHA will continue to monitor and evaluate ways to improve it. However, one major insurer has been unwilling to share TPL data on its members with DVHA, which may impact savings because DVHA has been unable to effectively identify and deny claims at the point of sale for those beneficiaries. DVHA

continues to explore alternative ways for the insurer to share this data in a manner the insurer finds acceptable.

Contract for Nutritional Supplements

Through its participation in the Sovereign States Drug Consortium (SSDC), DVHA attempted to secure preferred pricing on oral nutritional supplements to achieve a projected savings of \$25,000. After completing research, analyzing data, and discussing supplemental rebates with the SSDC, DVHA determined this was not a viable approach at this time. One reason for this decision is limited choice of products and manufacturers, particularly for children, who comprise a significant amount of nutritional supplement use; it is important to find supplements for children with an acceptable taste and texture. Also, of the limited number of generics available, many are “store brands,” which would limit access within DVHA’s network. In addition, for many specialty products such as those used for protein mal-digestion, there are no alternatives and therefore they are only available from a single manufacturer. When DVHA polled the SSDC states, none were interested in pursuing a separate bid process for these products; several states had unsuccessfully attempted this approach in the past. DVHA will continue to monitor the availability of nutritional products in the marketplace and apply clinical criteria through prior authorization to assure appropriate use of these products

Enhance Pharmacy Edits

This initiative focuses on avoiding excessive waste in the mandatory 90-day supply (90DS) program for select maintenance drugs. Effective July 1, 2012, DVHA modified the program to allow two initial 30-day fills of maintenance medications, thereby allowing additional time for physicians to titrate patients to desired doses before a 90-day supply is required. This change was expected to save the State \$125,000 annually. A limited analysis was performed to evaluate the cost-effectiveness of the 90DS program. For one medication analyzed, a common oral inhaler used to treat asthma and chronic obstructive pulmonary disease (COPD), the net savings of the program was \$13,375 annually. Despite occasional changes in therapy and some beneficiaries losing eligibility during a 90 day period, the initiative still achieves substantial cost savings and a savings to waste ratio exceeding 2:1. Allowing an additional 30 day fill will further reduce waste. DVHA continues to review and analyze the cost-effectiveness of this initiative, and another large class analysis is planned.

Vermont State Hospital – Replacement Planning

Given the abrupt closure of Vermont’s only state-run psychiatric hospital due to flooding from Tropical Storm Irene just before the start of FFY 12, Vermont had the unique opportunity to reduce its reliance on institutional care and further build its community based system of care for persons with mental health conditions. The Department of Mental Health (DMH), consistent with the plan advanced by Governor Peter Shumlin and available Medicaid and Medicare funding resources, had a unique opportunity to take significant steps forward in promoting a more person-centered, flexible and community based system with all the elements for a comprehensive and integrated system of care. Proposed major mental health reform legislation was formally passed as Act 79 during the Vermont 2012 legislative session.

Access to acute, psychiatric inpatient care remains a critical part of the overall mental health system reform efforts. Act 79 authorized up to 25 acute hospital beds to be developed at a new state-run hospital to be built in Berlin, Vermont. Pending construction, 28 inpatient beds, to serve individuals who would otherwise have been treated at the former 54-bed state-run hospital, were authorized at the Brattleboro Retreat (14 beds), Rutland Regional Medical Center (6 beds), and Morrisville (8 temporary beds).

Renovations at Rutland Regional Medical Center and the Brattleboro Retreat were necessary during this period to accommodate this population and will be completed in early spring 2013. Long term agreements with these hospitals will include provisions for a “no-refusal” system, reimbursement based on acuity and enhanced programming/staffing, and access to peer supports. One favorable element is that in these settings, care can be covered in part by Medicare, and even more so by Medicaid.

The renovations of a former nursing home facility in Morrisville, VT into a temporary eight bed hospital will also be completed by January, 2013. These additional temporary beds will further alleviate demand in an already stretched psychiatric inpatient system of care. DMH continued to contract with Fletcher Allen Health Care (FAHC) for additional psychiatric inpatient beds for patients who would have been served by the former state-run hospital. “Level 1” patients, psychiatrically complex and/or other complicated needs individuals who would otherwise have been hospitalized at the former state-run hospital, were codified through formal payment agreements with each of these facilities to assure that individuals needing inpatient mental health care would not be waiting for excessive periods in emergency rooms awaiting a hospital admission. Other existing psychiatric inpatient service capacity provided by Central Vermont Medical Center and the Windham Center remains part of the ongoing continuum of inpatient care service options. This geographic distribution of acute inpatient services will provide individuals with inpatient options closer to home which can be very important to their recovery and discharge planning needs.

A care management system to support patient access and flow into acute care hospitalization, or diversion when clinically appropriate and step-down transition from inpatient care, has also been in development. This centralized departmental function will traverse the inpatient and community treatment settings to promote timely access to the most acute levels of care. Care management staff is being expanded to follow all individuals proposed for involuntary mental health inpatient services and facilitate coordination of treatment services between the community and inpatient provider. Availability of centralized resources to address systemic issues or barriers that might arise as an individual moves through the continuum of care will maximize access to available inpatient beds. Global Commitment resources are being brought to bear to support this clinical management function, as well as, implement the statutory directives outlined in Act 79. Opportunities to care manage other publicly funded mental health inpatient admissions for individuals receiving community designated agency mental health services is also evolving for care management services. This capacity is being developed in tandem with comparable initiatives being undertaken by the DVHA.

Community System Development

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

Expand and Improve Emergency, Crisis, and Residential Support

There has been broad consensus that emergency services and supports needed to be more consistent, flexible and mobile. Services needed to be able to respond to people in supportive ways, where they are, and be available 24/7 every day. Services also needed to integrate with local law enforcement, hospital emergency rooms and peer services where they exist. Given the

anticipated and growing demand for mental health support services in a state experiencing a smaller capacity of acute psychiatric inpatient care, access to evaluation has been an essential cornerstone of mental health service reform. Designated Agencies (DA's) were provided resources to develop and enhance emergency outreach and crisis support services at the local level. Mobile response capability and improved collaborations with local law enforcement are emphasized to better meet the challenges of providing effective engagement in a rural state.

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

The realities of a rural state, with remote or geographic distance between points of service, require that transportation be a consideration for access of any crisis stabilization, residential, or inpatient treatment capacities established. In addition to inpatient resources, more residential programs and crisis bed capacity, intended to prevent or divert hospitalization when appropriate, was also a component of Act 79. The crisis bed programs are designed to be immediately available to individuals who are experiencing an emergency mental health crisis, who can be successfully served in an alternative treatment setting to hospitalization.

Three regions of the state are developing crisis bed stabilization capabilities where limited or no capacity existed before. Act 79 also supported the investment of Global Commitment resources into intensive residential recovery support programs. These facilities are intended to serve people who no longer need acute inpatient care but are not yet ready for full independent living. These program environments will assist individuals in their recovery by providing a safe and secure setting and therapeutic services aimed at returning persons served to their communities. During this FFY, a new 8-bed program was established in Westminster, VT and quickly offered some relief to the inpatient care system and individuals ready to step-down to a lesser level of care. An additional 8-bed program is in development for the northern part of the state. A 7-bed secure residential program will also be a component within the continuum of care and be sited in Middlesex, VT. All of these new resources are adding to a system of care that promotes better and timelier movement across various residential programs created to address individual support and service needs.

Flexible Outpatient Services

Developing a stronger outpatient service in the DA's, with a strong emphasis on identifying and responding to people at risk, was also a key component of the mental health system reform efforts. Services must be flexible and person-centered to respond to the real needs and choices of the individuals. Having available case management to meet the needs of people who do not meet other eligibility criteria was often identified as a "gap" service. Inroads for the outpatient services population were made via the expansion of "service planning and coordination supports" or case management services that extended beyond the severe and persistently mentally ill population. More responsive, hands-on case management support services to stabilize individuals who might otherwise further decompensate from mental health stressors or exhaust existing coping mechanisms were supported through Act 79. What has been called "non-categorical" case management is an expanded service capacity that is no longer reserved for the most incapacitated

individuals served in community-based programs. Earlier supportive intervention available to individuals struggling with mental health issues will further reduce potential need for limited acute inpatient resources. A population targeted for these support services, which are at risk for higher cost public and health care resource utilization, are individuals transitioning between periods of incarceration and re-entry to the community. Individuals at risk for recidivism, law enforcement involvement and incarceration, are a continuing priority group for expanded mental health and community support services. DMH expects that this service capacity will meet the needs of an expanded group of persons served and will continue to grow in the upcoming year.

Housing Subsidies

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

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

Peer Services

Act 79 also supported investments in peer services to broaden the array and options for recovery supports to individuals with mental illness. Alyssum, Vermont’s first peer-run crisis alternative program, has operated during this FFY and is a solid addition to the state’s continuum of mental health service options. In keeping with its longstanding commitment to stakeholder inclusion in the development of new services, DMH also established a peer services workgroup with a task of recommending growth and development of peer support. DMH will continue its work with peers to implement recommendations put forward:

- Added funding to existing peer services organizations to expand their capacity and strengthen their organizations;
- Funding a state wide “warm line” run by peers to provide support and help people obtain services they need and choose;
- Develop a coordinating entity, preferably within an existing organization, to coordinate peer efforts at training, organizing, transportation alternatives and other activities

The state’s peer community is also working collaboratively with the DMH to further develop a proposal for a peer supported residential program, also supported by Act 79, for individuals seeking an alternative course of recovery that minimizes reliance on medications.

Act 79 also called for independent external consultant review of Vermont's new plan for mental health services and to make recommendations for changes, data collections, and financing methodology. This report was completed in late summer 2012 and codified in recommendations the many initiatives undertaken by DMH as outlined earlier in this section. The benefits of an overall work plan, communication strategy for quality oversight, and establishment of system performance measures were identified for development. All of the initiatives that are under way are formalizing data collection and reporting capabilities consistent with Act 79 provisions regarding: access to emergency room and inpatient services, mobile outreach supports, crisis bed and intensive residential recovery bed utilization, alternative transportation availability, housing stability, and adverse event and emergency involuntary procedures. Baseline data, trends, outcomes, and cost impacts to the service system will be analyzed and reported back to the legislature as outlined within Act 79 beginning in early 2013.

VI. Utilization Management

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

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 DVHA Commissioner. The CURB solicits additional input as needed from individuals with expertise in areas of relevance to the CURB's deliberations. The Medical Director of DVHA serves as the State's liaison to CURB.

The CURB has the following duties and responsibilities:

- 1) Identify and recommend to the Commissioner opportunities to improve quality, efficiencies, and adherence to relevant evidence-based clinical practice guidelines in the Department's medical programs by:
 - a) examining high-cost and high-use services identified through the programs' current medical claims data;
 - b) reviewing existing utilization controls to identify areas in which improved utilization review might be indicated, including use of elective, nonemergency, out-of-state outpatient and hospital services;
 - c) reviewing medical literature on current best practices and areas in which services lack sufficient evidence to support their effectiveness;

- d) conferring with commissioners, directors, and councils within the Agency of Human Services and the Department of Financial Regulation, as appropriate, to identify specific opportunities for exploration and to solicit recommendations;
 - e) identifying appropriate but underutilized services and recommending new services for addition to Medicaid coverage;
 - f) determining whether it would be clinically and fiscally appropriate for 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 DUR Board to:

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

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

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

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

The DUR Board typically includes 10-12 members who are appointed to two-year terms. At least one-third, but not more than half, of the Board's members are licensed and actively practicing physicians, and at least one-third of its members are licensed and actively practicing pharmacists. Other interested and

qualified people also may be appointed. Board members are recommended by the DVHA Commissioner and approved by the Governor.

Appropriateness of Services

The DVHA delegates to its IGA partners who provide care to the four identified special health care needs populations, the responsibility to develop mechanisms to assess the quality and appropriateness of care furnished to enrollees with special health care needs. The Department of Mental Health (DMH) 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 (DAIL) 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 AHS has delegated responsibility for program integrity to the DVHA's Program Integrity (PI) Unit. The PI Unit strives to ensure that Medicaid funds are utilized appropriately by identifying and ultimately reducing fraud, waste and abuse.

Extensive collaboration exists between other DVHA units as well as with external stakeholders for the prevention, detection and investigation of fraud, waste and abuse. Review exists to identify both over and under payments. 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 for Children and Families (DCF). Identified quality or process improvement needs are brought to the Managed Care Medical Committee (MCMC).

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

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

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

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

Medicaid Management Information System

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

Claims Data Analysis and Post Payment Review

The PI Unit contracted with OptumInsight until 2013 to provide claims data analysis and post payment review. OptumInsight utilized data mining techniques and developed a variety of algorithms to detect aberrant utilization. OptumInsight used Medicaid policies, guidelines and claims data in the development of these algorithms. Reports generated from these reviews identified specific claims data and facilitated PI investigations.

Ad Hoc Queries

The PI Unit also utilizes the Enhanced Vermont Ad Hoc (EVAH) system. The EVAH system is a Business Objects application that enables the PI Unit to mine data and create varied and comprehensive ad hoc reports from the MMIS. EVAH is an invaluable tool employed by the PI Unit Medical Health care Data & Statistical Analyst, Fiscal Analyst and Programs and Operations Auditors to advance investigations that enables them to focus on individual elements within each claim.

Data gleaned from EVAH allows the PI Unit to compare claims information submitted by providers. The data can be reported and analyzed using any of the claim details to allow the PI unit to compare individuals, evaluate adherence to policy, etc. This is a valuable tool in detecting under and over utilization on a global scale.

Inpatient, Outpatient, and Emergency Department Utilization

Methods

Utilization statistics for inpatient, outpatient, and emergency department services provided under Global Commitment during FFY 2012 were compiled by DVHA's Data & Reimbursement Unit in February, 2013, using paid claims data. The scope of analysis included institutional services provided under the Medicaid program between 10/1/2011 and 9/30/2012, excluding crossover claims.¹ 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 2012.

¹ 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.

Utilization	Age	Discharges	Sum LOS Days	Avg. LOS Days
TOTAL INPATIENT (IP)	<1	3,284	11,813	3.60
TOTAL INPATIENT (IP)	1-9	490	1,681	3.43
TOTAL INPATIENT (IP)	10-19	1,156	7,273	6.29
TOTAL INPATIENT (IP)	20-44	5,865	26,307	4.49
TOTAL INPATIENT (IP)	45-64	3,032	18,092	5.97
TOTAL INPATIENT (IP)	65-74	33	202	6.12
TOTAL INPATIENT (IP)	75-84	12	94	7.83
TOTAL INPATIENT (IP)	85+	16	76	4.75
TOTAL INPATIENT (IP)	Total	13,888	65,538	4.72
IP MEDICINE	<1	3,255	11,630	3.57
IP MEDICINE	1-9	414	1,424	3.44
IP MEDICINE	10-19	941	6,384	6.78
IP MEDICINE	20-44	4,529	20,292	4.48
IP MEDICINE	45-64	2,160	12,927	5.98
IP MEDICINE	65-74	22	134	6.09
IP MEDICINE	75-84	11	78	7.09
IP MEDICINE	85+	14	62	4.43
IP MEDICINE	Total	11,346	52,931	4.67
IP MED ALCOH/SUBST	<1	2	11	5.50
IP MED ALCOH/SUBST	1-9	0	0	0.00
IP MED ALCOH/SUBST	10-19	15	70	4.67
IP MED ALCOH/SUBST	20-44	464	2,009	4.33
IP MED ALCOH/SUBST	45-64	183	928	5.07
IP MED ALCOH/SUBST	65-74	0	0	0.00
IP MED ALCOH/SUBST	75-84	0	0	0.00
IP MED ALCOH/SUBST	85+	0	0	0.00
IP MED ALCOH/SUBST	Total	664	3,018	4.55
IP MED PSYCHIATRIC	<1	0	0	0.00
IP MED PSYCHIATRIC	1-9	42	492	11.71
IP MED PSYCHIATRIC	10-19	347	4,373	12.60
IP MED PSYCHIATRIC	20-44	850	8,964	10.55
IP MED PSYCHIATRIC	45-64	315	3,886	12.34
IP MED PSYCHIATRIC	65-74	0	0	0.00
IP MED PSYCHIATRIC	75-84	0	0	0.00
IP MED PSYCHIATRIC	85+	0	0	0.00
IP MED PSYCHIATRIC	Total	1,554	17,715	11.40
IP MED OTHER	<1	3,253	11,619	3.57
IP MED OTHER	1-9	372	932	2.51
IP MED OTHER	10-19	579	1,941	3.35
IP MED OTHER	20-44	3,215	9,319	2.90
IP MED OTHER	45-64	1,662	8,113	4.88
IP MED OTHER	65-74	22	134	6.09
IP MED OTHER	75-84	11	78	7.09
IP MED OTHER	85+	14	62	4.43
IP MED OTHER	Total	9,128	32,198	3.53
IP SURGERY	<1	29	183	6.31
IP SURGERY	1-9	76	257	3.38
IP SURGERY	10-19	215	889	4.13
IP SURGERY	20-44	1,336	6,015	4.50

IP SURGERY	45-64	872	5,165	5.92
IP SURGERY	65-74	11	68	6.18
IP SURGERY	75-84	1	16	16.00
IP SURGERY	85+	2	14	7.00
IP SURGERY	Total	2,542	12,607	4.96

The following table presents visit counts by age for outpatient services provided in FFY 2012, first for all outpatient services, and then for emergency department services.

Age	TOTAL OUTPATIENT (OP) Visits	OP EMERG DEPT Visits
<1	6,249	3,088
1-9	33,620	15,191
10-19	43,986	15,445
20-44	144,466	40,749
45-64	92,460	12,834
65-74	873	63
75-84	271	26
85+	186	17
Total	322,111	87,413

Discussion

In FFY 2012, Global Commitment, Medicaid, paid for 13,888 inpatient stays and 322,111 outpatient visits for Vermonters. Of the inpatient stays, 82% were for medicine, and 18% were for surgery. Psychiatric services constituted 14% of the inpatient medicine stays, and treatment for alcohol and substance abuse services constituted 6% of inpatient medicine stays. Compared to other inpatient stays, alcohol/substance-abuse stays were moderately longer in average duration (similar to that for inpatient surgery), and psychiatric stays were substantially longer. Among outpatient visits, emergency department visits constituted roughly 27%.

VII. Policy and Administrative Difficulties

Fiscal & Operational Management

The GC waiver extension was approved for January 1, 2011, and is scheduled to end on December 31, 2013. AHS and DVHA have been working diligently on preparing for waiver renewal, including a proposal to include the current Long Term Care (i.e., Choices for Care Waiver) and CHIP populations under the Global Commitment demonstration authority, effective January 1, 2014. AHS and DVHA are also in negotiations with CMS with regard to a Demonstration waiver for the Dual Eligible population, to become effective on or after January 1, 2014.

AHS paid DVHA a prospective PMPM capitation payment on the first business day of every month during FFY12. 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 began working with its then-current actuarial consultant, Aon, in April 2011, to develop actuarially sound capitation rate ranges for the FFY12 period, and delivered the selected FFY12 rates to CMS on August 23, 2011 (one week prior to the required September 1 due date). AHS began utilizing the FFY12 rates in calculating the monthly PMPM payments on October 1, 2012. AHS posted an actuarial consultant RFP in July 2011 in accordance with State contracting guidelines that required this contract to be rebid. The agreement with Aon expired on March 31, 2012, and AHS selected Milliman, Inc. as its actuarial services vendor, effective April 1, 2012 for the FFY13 and FFY14 periods.

AHS selected PMPM rates and sent an IGA for the FFY13 period to CMS on October 4, 2012. AHS worked with CMS throughout QE1212 and into QE0313, toward continued resolution of issues pertaining to approval of the FFY11 and FFY12 IGAs and selected PMPM rates. Vermont would bear a significant retroactive and ongoing financial risk in the event the selected PMPM rates in the IGAs and actuarial certifications for FFY11, FFY12 and FFY13 are not approved as submitted. Resolution of the remaining issues as expediently as possible remains a top priority for the State.

AHS worked with DVHA and HP throughout FFY12 to ensure that the State’s reporting system supports all MBES requirements; work continues with HP to support all ACA reporting requirements, including identification of those services reimbursed at a different Federal match rate.

Governor Peter Shumlin released his recommended budget for State fiscal year 2014 on January 24, 2013. This budget includes the assumption that the Global Commitment waiver will continue beyond 12/31/2013, and that Federal financial participation will be available for cost sharing/premium assistance for the current Catamount population when the Affordable Care Act becomes fully effective on January 1, 2014. AHS has subsequently learned that Federal financial participation will only be available for premium assistance.

AHS’ Financial Manager responsible for quarterly CMS-64/CMS-21/CMS-37/CMS-21B reporting, Connie Harrison, left AHS Central Office in December 2012 to accept a position at DVHA as Medicaid Fiscal Analyst. The AHS Financial Manager position has been filled by Ben Black, who previously served as a Financial Administrator within the AHS Central Office. Connie will be working with Ben for several quarters in FFY13 to ensure a smooth transition for CMS reporting.

In December 2012, Stephanie Beck formally replaced Suzanne Santarcangelo as the AHS Director of Health Care Operations, Compliance and Improvement. Stephanie will serve as the AHS lead for the Global Commitment Waiver.

VIII. Capitated Revenue Spending

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

FFY11	
Medicaid Eligibility Group	Monthly Premium PMPM per IGA
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 (VHAP)	\$ 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

FFY12

Medicaid Eligibility Group		Monthly Premium PMPM per IGA
ABD - Non-Medicare - Adult	\$	1,188.00
ABD - Non-Medicare - Child	\$	2,504.86
ABD - Dual	\$	1,303.12
ANFC - Non-Medicare - Adult	\$	751.19
ANFC - Non-Medicare - Child	\$	411.61
GlobalExp (VHAP)	\$	456.77
GlobalRx - Dual	\$	20.45
GlobalRx - Non-Medicare	\$	36.76
OptionalExp	\$	169.24
VHAP ESI	\$	241.39
ESI Premium Assistance	\$	178.53
Catamount Premium Assistance	\$	424.28

Investments made by the MCE for State fiscal year 2012 totaled \$89,836,470. Areas of capitated spending and the associated categories are outlined in Attachment 1.

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Attachments

MCO Investment Expenditures										
Department	Criteria	Investment Description	SFY06 Actuals - 3/4 SFY	SFY07 Actuals	SFY08 Actuals	SFY09 Actuals	SFY10 Actuals	SFY11 Actuals	SFY12 Actuals	
DOE	2	School Health Services	\$ 6,397,319	\$ 8,956,247	\$ 8,956,247	\$ 8,956,247	\$ 8,956,247	\$ 4,478,124	\$ 11,027,579	
AOA	4	Blueprint Director	\$ -	\$ -	\$ 70,000	\$ 68,879	\$ 179,284	\$ -	\$ -	
GMCB	4	Green Mountain Care Board	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 789,437	
BISHCA	2	Health Care Administration	\$ 983,637	\$ 914,629	\$ 1,340,728	\$ 1,871,651	\$ 1,713,959	\$ 1,899,342	\$ 1,897,997	
DII	4	Vermont Information Technology Leaders	\$ 266,000	\$ 105,000	\$ 105,000	\$ 339,500	\$ -	\$ -	\$ -	
VVH	2	Vermont Veterans Home	\$ 747,000	\$ 913,047	\$ 913,047	\$ 881,043	\$ 837,225	\$ 1,410,956	\$ 1,410,956	
VSC	2	Health Professional Training	\$ 283,154	\$ 391,698	\$ 405,407	\$ 405,407	\$ 405,407	\$ 405,407	\$ 405,407	
UVM	2	Vermont Physician Training	\$ 2,798,070	\$ 3,870,682	\$ 4,006,152	\$ 4,006,152	\$ 4,006,152	\$ 4,006,152	\$ 4,006,152	
VAAF	3	Agriculture Public Health Initiatives	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 90,278	
AHSCO	2	Designated Agency Underinsured Services	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 2,510,099	\$ 5,401,947	
AHSCO	4	2-1-1 Grant	\$ -	\$ -	\$ -	\$ 415,000	\$ 415,000	\$ 415,000	\$ 415,000	
VDH	2	Emergency Medical Services	\$ 174,482	\$ 436,642	\$ 626,728	\$ 427,056	\$ 425,870	\$ 333,488	\$ 274,417	
VDH	2	AIDS Services/HIV Case Management	\$ 152,945	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	
VDH	2	TB Medical Services	\$ 27,052	\$ 29,129	\$ 15,872	\$ 28,359	\$ 41,313	\$ 36,284	\$ 39,173	
VDH	3	Epidemiology	\$ 326,708	\$ 427,075	\$ 416,932	\$ 204,646	\$ 241,932	\$ 315,135	\$ 329,380	
VDH	3	Health Research and Statistics	\$ 276,673	\$ 403,244	\$ 404,431	\$ 217,178	\$ 254,828	\$ 289,420	\$ 439,742	
VDH	2	Health Laboratory	\$ 1,369,982	\$ 1,908,982	\$ 2,012,252	\$ 1,522,578	\$ 1,875,487	\$ 1,912,034	\$ 1,293,671	
VDH	4	Tobacco Cessation: Community Coalitions	\$ 938,056	\$ 1,647,129	\$ 1,144,713	\$ 1,016,685	\$ 535,573	\$ 94,089	\$ 371,646	
VDH	3	Statewide Tobacco Cessation	\$ -	\$ -	\$ -	\$ 230,985	\$ 484,998	\$ 507,543	\$ 450,804	
VDH	2	Family Planning	\$ 365,320	\$ 122,961	\$ 169,392	\$ 300,876	\$ 300,876	\$ 275,803	\$ 420,823	
VDH	4	Physician/Dentist Loan Repayment Program	\$ 810,716	\$ 439,140	\$ 930,000	\$ 1,516,361	\$ 970,000	\$ 900,000	\$ 970,000	
VDH	2	Renal Disease	\$ 15,000	\$ 7,601	\$ 16,115	\$ 15,095	\$ 2,053	\$ 13,689	\$ 1,752	
VDH	2	Newborn Screening	\$ 74,899	\$ 166,795	\$ 136,577	\$ -	\$ -	\$ -	\$ -	
VDH	2	WIC Coverage	\$ 161,804	\$ 1,165,699	\$ 562,446	\$ 86,882	\$ -	\$ 36,959	\$ -	
VDH	4	Vermont Blueprint for Health	\$ 92,049	\$ 1,975,940	\$ 753,087	\$ 1,395,135	\$ 1,417,770	\$ 752,375	\$ 454,813	
VDH	4	Area Health Education Centers (AHEC)	\$ -	\$ 35,000	\$ 310,000	\$ 565,000	\$ 725,000	\$ 500,000	\$ 540,094	
VDH	4	Community Clinics	\$ -	\$ -	\$ -	\$ 640,000	\$ 468,154	\$ 640,000	\$ 600,000	
VDH	4	FQHC Lookalike	\$ -	\$ -	\$ 30,000	\$ 105,650	\$ 81,500	\$ 87,900	\$ 102,545	
VDH	4	Patent Safety - Adverse Events	\$ -	\$ -	\$ 190,143	\$ 100,509	\$ 44,573	\$ 16,829	\$ 25,081	
VDH	4	Coalition of Health Activity Movement Prevention Program (CHAMPPS)	\$ -	\$ 100,000	\$ 291,298	\$ 486,466	\$ 412,043	\$ 290,661	\$ 318,806	
VDH	2	Substance Abuse Treatment	\$ 1,466,732	\$ 2,514,963	\$ 2,744,787	\$ 2,997,668	\$ 3,000,335	\$ 1,699,198	\$ 2,928,773	
VDH	4	Recovery Centers	\$ 171,153	\$ 287,374	\$ 329,215	\$ 713,576	\$ 716,000	\$ 648,350	\$ 771,100	
VDH	2	Immunization	\$ -	\$ -	\$ -	\$ 726,264	\$ -	\$ -	\$ 23,903	
VDH	2	DMH Investment Cost in CAP	\$ -	\$ -	\$ -	\$ 64,843	\$ -	\$ 752	\$ 140	
VDH	4	Poison Control	\$ -	\$ -	\$ -	\$ -	\$ 176,340	\$ 115,710	\$ 213,150	
VDH	4	Challenges for Change: VDH	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 309,645	
VDH	3	Fluoride Treatment	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 43,483	
VDH	4	CHIP Vaccines	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 196,868	
DMH	2	Special Payments for Treatment Plan Services	\$ 101,230	\$ 131,309	\$ 113,314	\$ 164,356	\$ 149,068	\$ 134,791	\$ 132,021	
DMH	2	MH Outpatient Services for Adults	\$ 775,899	\$ 1,393,395	\$ 1,293,044	\$ 1,320,521	\$ 864,815	\$ 522,595	\$ 974,854	
DMH	2	Mental Health Elder Care	\$ 38,563	\$ 37,682	\$ 38,970	\$ -	\$ -	\$ -	\$ -	
DMH	4	Mental Health Consumer Support Programs	\$ 451,606	\$ 546,987	\$ 673,160	\$ 707,976	\$ 802,579	\$ 582,397	\$ 67,285	
DMH	2	Mental Health CRT Community Support Services	\$ 2,318,668	\$ 602,186	\$ 807,539	\$ 1,124,728	\$ -	\$ 1,935,344	\$ 1,886,140	
DMH	2	Mental Health Children's Community Services	\$ 1,561,396	\$ 3,066,774	\$ 3,341,602	\$ 3,597,662	\$ 2,569,759	\$ 1,775,120	\$ 2,785,090	
DMH	2	Emergency Mental Health for Children and Adults	\$ 1,885,014	\$ 1,988,548	\$ 2,016,348	\$ 2,165,648	\$ 1,797,605	\$ 2,309,810	\$ 4,395,885	
DMH	2	Respite Services for Youth with SED and their Families	\$ 385,581	\$ 485,586	\$ 502,237	\$ 412,920	\$ 516,677	\$ 543,635	\$ 541,707	
DMH	2	CRT Staff Secure Transportation	\$ -	\$ -	\$ 52,242	\$ -	\$ -	\$ -	\$ -	
DMH	2	Recovery Housing	\$ -	\$ -	\$ 235,267	\$ -	\$ 332,635	\$ 512,307	\$ 562,921	
DMH	2	Transportation - Children in Involuntary Care	\$ 4,768	\$ 1,075	\$ -	\$ -	\$ -	\$ -	\$ -	
DMH	2	Vermont State Hospital Records	\$ -	\$ -	\$ -	\$ -	\$ 19,590	\$ -	\$ -	
DMH	4	Challenges for Change: DMH	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 229,512	\$ 945,051	
DMH	2	Seriously Functionally Impaired	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 68,713	\$ 160,560	
DMH	2	Acute Psychiatric Inpatient Services	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 12,603,067	
DVHA	4	Vermont Information Technology Leaders/HIT/HIE	\$ -	\$ -	\$ -	\$ -	\$ 339,500	\$ 646,220	\$ 1,425,017	
DVHA	4	Vermont Blueprint for Health	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 2,616,211	\$ 1,841,690	
DVHA	1	Buy-In	\$ 4,594	\$ 314,376	\$ 419,951	\$ 248,537	\$ 200,868	\$ 50,605	\$ 24,000	
DVHA	1	Vscript Expanded	\$ 1,695,246	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	
DVHA	1	HIV Drug Coverage	\$ 31,172	\$ 42,347	\$ 44,524	\$ 48,711	\$ 38,904	\$ 39,176	\$ 37,452	
DVHA	1	Civil Union	\$ 373,175	\$ 543,986	\$ 671,941	\$ 556,811	\$ 627,976	\$ 999,084	\$ 1,215,109	
DVHA	1	Vpharm	\$ -	\$ -	\$ -	\$ 278,934	\$ 210,796	\$ -	\$ -	
DVHA	4	Hospital Safety Net Services	\$ -	\$ -	\$ 281,973	\$ -	\$ -	\$ -	\$ -	
DVHA	2	Patent Safety Net Services	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 36,112	\$ 73,487	
DCF	2	Family Infant Toddler Program	\$ -	\$ 199,064	\$ 326,424	\$ 335,235	\$ 81,066	\$ 624	\$ -	
DCF	2	Medical Services	\$ 69,893	\$ 91,569	\$ 120,494	\$ 65,278	\$ 45,216	\$ 64,496	\$ 47,720	
DCF	2	Residential Care for Youth/Substitute Care	\$ 9,181,386	\$ 10,536,996	\$ 10,110,441	\$ 9,392,213	\$ 8,033,068	\$ 7,853,100	\$ 9,629,269	
DCF	2	AABD Admin	\$ 988,557	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	
DCF	2	AABD	\$ 2,415,100	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	
DCF	2	Aid to the Aged, Blind and Disabled CCL Level III	\$ 96,000	\$ 2,617,350	\$ 2,615,023	\$ 2,591,613	\$ 2,827,617	\$ 2,661,246	\$ 2,563,226	
DCF	2	Aid to the Aged, Blind and Disabled Res Care Level III	\$ -	\$ 143,975	\$ 170,117	\$ 172,173	\$ 137,356	\$ 136,466	\$ 173,833	
DCF	2	Aid to the Aged, Blind and Disabled Res Care Level IV	\$ 210,989	\$ 312,815	\$ 349,887	\$ 366,161	\$ 299,488	\$ 265,812	\$ 273,662	
DCF	2	Essential Person Program	\$ 542,382	\$ 675,860	\$ 614,974	\$ 620,052	\$ 485,536	\$ 736,479	\$ 775,278	
DCF	2	GA Medical Expenses	\$ 254,154	\$ 339,928	\$ 298,207	\$ 380,000	\$ 583,080	\$ 492,079	\$ 352,451	
DCF	2	CUPS/Early Childhood Mental Health	\$ -	\$ -	\$ 52,825	\$ 499,143	\$ 166,429	\$ 112,619	\$ 165,016	
DCF	2	VCRHYP/Vermont Coalition for Runaway and Homeless Youth Program	\$ -	\$ -	\$ 1,764,400	\$ -	\$ -	\$ -	\$ -	
DCF	2	HBKF/Healthy Babies, Kids & Families	\$ -	\$ -	\$ 318,321	\$ -	\$ -	\$ -	\$ -	
DCF	1	Calamount Administrative Services	\$ -	\$ -	\$ -	\$ 339,894	\$ -	\$ -	\$ -	
DCF	2	Therapeutic Child Care	\$ -	\$ -	\$ -	\$ 978,886	\$ 577,259	\$ 570,493	\$ 596,406	
DCF	2	Lund Home	\$ -	\$ -	\$ -	\$ 325,516	\$ 175,378	\$ 196,159	\$ 354,528	
DCF	2	GA Community Action	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 199,762	\$ 338,275	
DCF	3	Prevent Child Abuse Vermont Shaken Baby	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 44,119	\$ 74,250	
DCF	3	Prevent Child Abuse Vermont Nurturing Parent	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 107,184	
DCF	4	Challenges for Change: DCF	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 50,622	\$ 196,378	
DCF	2	Strengthening Families	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 465,343	
DCF	2	Lamoille Valley Community Justice Project	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 162,000	
DDAIL	2	Elder Coping with MMA	\$ 441,234	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	
DDAIL	2	Mobility Training/Other Svcs -Elderly Visually Impaired	\$ 187,500	\$ 250,000	\$ 250,000	\$ 250,000	\$ 245,000	\$ 245,000	\$ 245,000	
DDAIL	2	DS Special Payments for Medical Services	\$ 394,055	\$ 192,111	\$ 880,797	\$ 522,058	\$ 469,770	\$ 757,070	\$ 1,498,083	
DDAIL	2	Flexible Family/Respite Funding	\$ 1,086,291	\$ 1,135,213	\$ 1,341,698	\$ 1,364,896	\$ 1,114,898	\$ 1,103,748	\$ 1,103,749	
DDAIL	4	Quality Review of Home Health Agencies	\$ -	\$ 77,467	\$ 186,664	\$ 126,306	\$ 90,227	\$ -	\$ 128,399	
DDAIL	4	Support and Services at Home (SASH)	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 773,192	
DOC	2	Intensive Substance Abuse Program (ISAP)	\$ 382,230	\$ 299,602	\$ 310,610	\$ 200,000	\$ 591,004	\$ 591,000	\$ 458,485	
DOC	2	Intensive Sexual Abuse Program	\$ 72,439	\$ 46,078	\$ 85,542	\$ 88,523	\$ 68,350	\$ 70,002	\$ 60,585	
DOC	2	Intensive Domestic Violence Program	\$ 109,692	\$ 134,663	\$ 230,353	\$ 229,166	\$ 173,938	\$ 174,000	\$ 164,218	
DOC	2	Women's Health Program (Tapestry)	\$ 460,130	\$ 487,344	\$ 487,231	\$ 527,956	\$ -	\$ -	\$ -	
DOC	2	Community Rehabilitative Care	\$ 1,038,114	\$ 1,982,456	\$ 2,031,408	\$ 1,997,499	\$ 2,190,924	\$ 2,221,448	\$ 2,242,871	
DOC	2	Return House	\$ -	\$ -	\$ -	\$ 51,000	\$ -	\$ -	\$ -	
DOC	2	Northern Lights	\$ -	\$ -	\$ -	\$ -	\$ 40,000	\$ 40,000	\$ -	
DOC	4	Challenges for Change: DOC	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 687,166	
			\$ 45,455,809	\$ 55,495,719	\$ 59,918,097	\$ 62,419,988	\$ 55,554,314	\$ 56,275,877	\$ 89,836,470	
Last Updated:		August 21, 2012								