PHPG

The Pacific Health Policy Group

***DRAFT** INTERIM PROGRAM EVALUATION*

Global Commitment to Health

11-W-00194/1

On behalf of:

State of Vermont
Agency of Human Services

Prepared by:

The Pacific Health Policy Group

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Introduction

Purpose of Evaluation

In compliance with the Special Terms and Conditions, the State of Vermont submits to the Centers for Medicare and Medicaid Services (CMS) this Interim Program Evaluation with its request to renew the Global Commitment to Health (GC) Section 1115 Demonstration waiver for the five-year period from January 1, 2017, through December 31, 2021. This evaluation reports the Demonstration's progress for the period of October 2013 to January 30, 2015, based on the reporting requirements contained in the Special Terms and Conditions in effect prior to the January 2015 Demonstration Amendment. For this evaluation, preliminary data on Choices for Care has been included; however, prior to the January 2015 Amendment, GC and Choices for Care evaluations were performed separately. The goal areas examined in this evaluation include:

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

This 2015 interim evaluation relies on a compilation of Vermont's quality assessment and improvement activities, as well as emerging results from Vermont's innovative programs for Chronic Care Management and its Patient Centered Medical Home Initiative, Blueprint for Health.

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

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

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

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

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

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

Background on Health Care Reform in Vermont

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

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

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

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

Background on Global Commitment

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

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

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

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

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

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

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

Contents of Evaluation

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

Goal 1: Increase Access to Care	• Evaluation of Global Commitment's ability to increase Medicaid beneficiary access to primary care
Goal 2: Enhance Quality of Care	• Evaluation of the extent to which Global Commitment has enhanced the quality of care for Medicaid beneficiaries
Goal 3: Control Cost of Care	• Evaluation of Global Commitment's ability to contain (by maintaining or reducing) Medicaid spending in comparison to what would have been spent absent the waiver
Goal 4: Allow Choice of LTSS Setttingss	• Evaluation of Global Commitment's ability to allow choice in LTSS and provide an array of HCBS alternatives that are more cost effective

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

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

- Global Commitment to Health Enrollment 2008-2014
- Vermont Department of Financial Regulation, formerly Department of Banking, Insurance, Securities, and Health Care Administration (BISHCA), Vermont Health Insurance Coverage Survey (2001-2006, 2008, 2012, and 2014)
- 2012-2015 External Quality Review Organization (EQRO) Technical Reports
- 2013-2014 HEDIS Measures
- 2012 and 2014 Consumer Assessment of Health Provider and Systems (CAHPS) Survey
- 2014 Vermont Chronic Care Initiative Annual Report for State Fiscal Year 2013
- 2014 Blueprint for Health Annual Report
- 2014 Global Commitment to Health Demonstration Annual and Quarterly Reports to CMS
- Choices for Care Program Evaluations
- Choices for Care Data Report July 2015
- NCQA, State of Health Care Quality 2014.

Goal 1: Increase Access to Care

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

Goal 1: Highlights:

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

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

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

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

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

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

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

- *Access to Mental Health Treatment:* The abrupt closure of Vermont's only state-run psychiatric

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

- *Blueprint for Health:* Primary care practices gained formal recognition as Patient Centered Medical Homes (PCMHs) for the first time and others re-scored against the National Committee for Quality Assurance (NCQA) quality standards. As of December 2014, there were 126 primary care practices operating in Vermont as PCMHs supported by multi-disciplinary Community Health Teams.

Goal 1: Data and Related Initiatives

Global Commitment Enrollment for 2008-2012

The GC Demonstration covers a significant portion of the total Vermont population, and its potential impact extends beyond those directly enrolled. As part of the Evaluation Plan, AHS must show that the GC Demonstration continues to enroll Medicaid beneficiaries. Data in Table 1-1 show the total lives (member months divided by 12) enrolled in the GC Demonstration from FFY 2008 through FFY 2014.

Table 1-1: Global Commitment Average Number of Enrollees

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

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

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

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

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

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

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

	2005	2008	2009	2012	2014	2005	2008	2009	2012	2014
Private Insurance*	59.4%	59.9%	57.2%	56.8%	54.4%	369,348	370,981	355,358	355,857	341,077
Medicaid	14.7%	16.0%	17.6%	17.9%	21.2%	91,126	99,159	109,353	111,833	132,829
Medicare	14.5%	14.3%	15.3%	16.0%	17.7%	90,110	88,915	95,182	100,505	110,916
Military	1.6%	2.4%	2.2%	2.5%	3%	9,754	14,910	13,917	15,477	18,578
Uninsured	9.8%	7.6%	7.6%	6.8%	3.7%	61,057	47,286	47,460	42,760	23,231

2014 HEDIS Measures

Table 1-3 shows four HEDIS measures used to evaluate access to primary care for 2013 and 2014. Where available, data are displayed with comparisons made to NCQA-reported averages for accredited Medicaid HMO scores for 2014. GC Demonstration measures for children and adolescents include Annual Dental Visits; Well-Child Visits in the First 15 Months of Life (6 or more visits); Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life; Adolescent Well Care; and Child/Adolescent Access to PCP.

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

HEDIS Measure	VT EQRO Year		VT Average: 2013-2014	NCQA Accredited Medicaid HMO Average	VT vs. NCQA HMO Average
	2013	2014			
Well Child Visits 1st 15 Months (6 or more)	75.23%	75.96%	75.59%	61.6%	13.99%
Well Child 3rd, 4th, 5th, 6th year	69.32%	71.49%	70.41%	71.5%	-1.09%
Adolescent Well Care	46.27%	46.97%	46.62%	50.0%	-3.38%
Annual Dental Combined <21 years	68.23%	67.72%	67.98%	47.1%	20.88%
Child/Adolescent Access to PCP					
12-24months	98.31%	98.55%	98.43%	96.1%	2.33%
25 months-6 yrs	91.70%	92.13%	91.92%	88.3%	3.62%
7-11 yrs	94.48%	94.46%	94.47%	90.0%	4.47%
12-19 yrs	93.73%	93.90%	93.82%	88.5%	5.32%

*n/a – not available

Table 1.3 can be summarized as follows:

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

- Well-Child Visits (ages 3 -6 years) and Adolescent Well Care fell slightly below the Medicaid HMO scores in 2014.

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

Table 1-4 Adult Access Measures

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

n/a: not available

For most adult access measures, NCQA comparison scores for accredited Medicaid HMOs were not available. However, the state's contracted External Quality Review Organization (EQRO), Health Services Advisory Group (HSAG), notes that Vermont achieved a significantly higher score than the national average for 2014 for Antidepressant Medication Management: Acute and Continuation Phase (by 12.8% and 8.92% respectively).

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

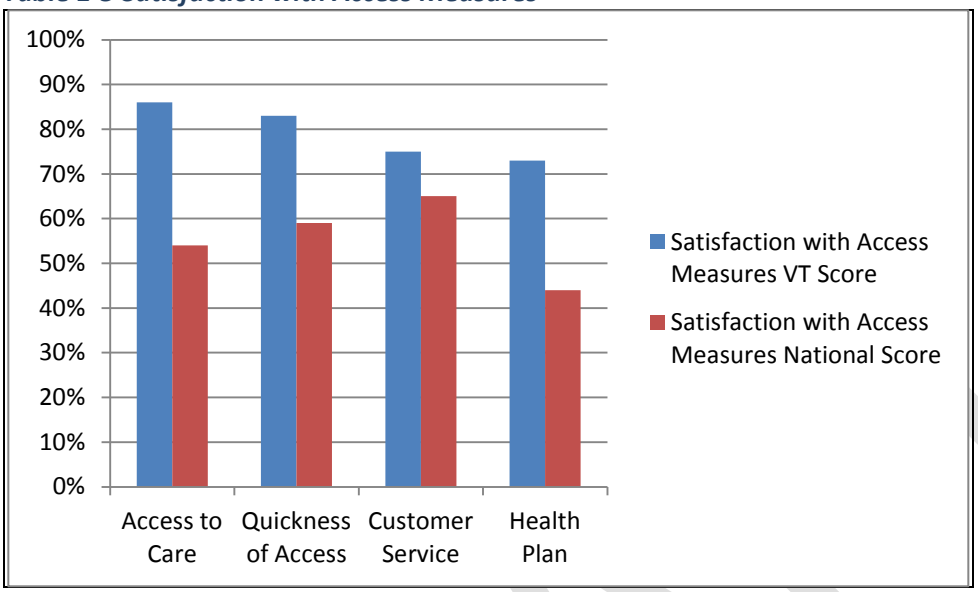
DVHA contracted with a private vendor, WBA Market Research, who assisted in the administration and scoring of the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan 5.0H Adult Medicaid survey. DVHA added questions to the CAHPS Health Plan 5.0H Adult Medicaid survey for a total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

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

- 86% of Vermont beneficiaries report satisfaction with access to care, as compared to 54% of Medicaid beneficiaries nationally.
- 83% of Vermont beneficiaries report satisfaction in getting needed care quickly as compared to 59% of Medicaid beneficiaries nationally.

- 75% of Vermont beneficiaries report satisfaction with customer service as compared to 65% of Medicaid beneficiaries nationally.
- 73% of Vermont beneficiaries report satisfaction with their health plan as compared to 44% of Medicaid beneficiaries nationally.

Table 1-5 Satisfaction with Access Measures



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

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

Hub and Spoke Initiative: Integrated Treatment for Opioid Dependence

AHS is collaborating with community providers to create a coordinated, systemic response to the complex issues of opioid addictions in Vermont, referred to as the Care Alliance for Opioid Addiction (a Hub and Spoke model). The Hub and Spoke Initiative creates a framework for integrating treatment services for opioid addiction into Vermont's Blueprint for Health. This initiative is focused on beneficiaries receiving Medication Assisted Treatment (MAT) for opioid addiction. MAT is the use of medications, in combination with counseling and behavioral therapies, to provide a whole-patient approach to the treatment of substance use disorders. Overall health care costs are approximately three times higher among MAT patients than within the general Medicaid population, not only from costs directly associated with MAT, but also due to high rates of co-occurring mental health and other health issues, and high use of emergency departments, pharmacy benefits, and other health care services.

The two primary medications used to treat opioid dependence are methadone and buprenorphine, with most MAT patients receiving office-based opioid treatment (OBOT), with buprenorphine prescribed by specially licensed physicians in a medical office setting. These physicians generally are not well integrated with behavioral and social support resources. In contrast, methadone is a highly regulated treatment provided only in specialty opioid treatment programs (OTPs) that provide comprehensive

addictions treatment but are not well integrated into the larger health and mental health care systems. The Hub and Spoke Model addresses this service fragmentation.

Vermont succeeded in getting two SPAs approved in January and March of 2014 for Health Home services to the MAT population under section 2703 of the Affordable Care Act. Health Home services include comprehensive care management, care coordination, health promotion, comprehensive transitional care, individual and family support, and referral to community and social support services. State-supported nurses and licensed clinicians provide the Health Home services and ongoing support to both OTP and OBOT providers.

The comprehensive Hub and Spoke Initiative builds on the strengths of the specialty OTPs, the physicians who prescribe buprenorphine in OBOT settings, and the local Blueprint PCMH and Community Health Team (CHT) infrastructure. Each MAT patient has an established physician-led medical home, a single MAT prescriber, a pharmacy home, access to existing Blueprint CHTs, and access to Hub or Spoke nurses and clinicians for Health Home services.

There are five regional Hubs that build upon the existing methadone OTPs and provide buprenorphine treatment to a subset of clinically complex buprenorphine patients, as well as serve as the regional consultants and subject matter experts on opioid dependence and treatment. The goal is for Hubs to replace episodic care based exclusively on addictions illness with comprehensive health care and continuity of services.

Spokes include a physician prescribing buprenorphine in an OBOT and the collaborating health and addictions professionals who monitor adherence to treatment; coordinate access to recovery supports and community services; and provide counseling, contingency management, care coordination, and case management services. Support is given to Spoke providers and their Medicaid MAT patients by nurses and licensed addictions/mental health clinicians, adding to the existing Blueprint CHTs. Similar to all CHT staff, Spoke staff are provided free of cost to MAT patients. Staff are embedded directly in the prescribing practices to allow more direct access to mental health and addiction services, promote continuity of care, and support the provision of multidisciplinary team care.

Goal 2: Enhance Quality of Care

The second goal of Global Commitment (GC) Demonstration is to enhance the quality of care to all Vermont Medicaid beneficiaries, with a focus on beneficiaries with chronic conditions.

Goal 2: Highlights

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

- *Compliance with required Managed Care quality- of-care standards identified by AHS*: DVHA has consistently improved its compliance, scoring 100% compliant with all CMS measurement and improvement standards in 2014.

- *HEDIS Measures:* Vermont scored above the 75th percentile for several 2014 HEDIS measures related to quality.
- *Performance Improvement Project (PIP):* In 2014 DVHA' s new PIP, *Follow-up after Hospitalization for Mental Illness,* received a score of 100% for all applicable evaluation elements scored as *Met*, a score of 100% for critical evaluation elements scored as *Met*, and an overall validation status of *Met.*
- *Vermont Chronic Care Initiative (VCCI):* VCCI has made improvements in health outcomes for Vermont's highest-risk Medicaid beneficiaries. SFY13 utilization change offers further evidence of this strategy with documented reduction of Acute Ambulatory Care Sensitive Conditions inpatient admissions by 37%, 30-day hospital readmission rates by 34%, and an ED utilization decline of 15% for eligible VCCI members in the top 5% utilization category.
- *Blueprint for Health:* Medicaid is an active partner in Vermont's Blueprint for Health. In 2014 Blueprint participants had lower hospitalization rates and lower expenditures on pharmacy and specialty care. In spite of lower expenditures, the results for measures of effective and preventive care for Blueprint participants were either better for participants or similar for both Blueprint and comparison groups (cervical cancer screening, breast cancer screening, imaging studies for low back pain, and five Special Medicaid Services (SMS), such as transportation, residential treatment, dental, and home- and community-based services.
- *Integrated Family Services Program (IFS):* The Integrated Family Services Initiative seeks to bring all agency children, youth, and family services together in an integrated and consistent continuum of services for families, regardless of federal funding stream (Title V, Title XIX, IDEA part B and C, Title IV-E, etc.). Vermont has worked to integrate a variety of separate and discreet children and family services funded under the Medicaid program. Using a bundled payment approach to provider reimbursement, several disparate Medicaid programs were unified in a single payment model with clear provider expectations for treatment. This unified care coordination should reduce duplication and close gaps in the system, especially at pivotal transition times. In FFY14, the one AHS district with a fully implemented IFS program showed positive outcomes for clients and more efficient service delivery with the same level of funding providers received in previous years. In addition, there was a nearly 50% decrease in crisis interventions needed for children, since the community now has the flexibility to provide supports and services earlier than they were able to under the traditional fee-for-service model.

Goal 2: Data and Related Initiatives

2014 Medicaid Managed Care Quality Strategy

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

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

1. Average Overall Percentage of Compliance Score of 92% for eight standards reviewed, including provider selection and credentialing, beneficiary information and rights, confidentiality, and grievance system, improved from 90% three years ago (the last time these standards were measured);
2. A 100% *Met* score for The *Follow-up after Hospitalization for Mental Illness* PIP critical evaluation elements and overall evaluation elements in the Study Design, Implementation, and Evaluation stages; and
3. A passing score on the validation of 13 performance measures for 2014 (CY 2013). The auditors identified several aspects in the calculation of performance measures as crucial to the validation process. These include data integration, data control, and documentation of performance measure calculations. DVHA received a passing score on all of these aspects.

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

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

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

In their final report, the auditors noted that:

"It was clear from the review of DVHA's documentation, organizational structure, and staff responses during the interviews that DVHA staff members were passionate about providing quality, accessible, timely care and services to members and regularly went well beyond the minimum required to ensure that they took care of the members and adequately responded to their needs, while complying with the applicable CMS and AHS requirements related to this year's compliance review activity. It was also clear that, during the year, AHS and DVHA initiated numerous new, or enhanced existing projects and programs, designed to both improve member care and access to quality, accessible, and timely services."

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

- Above-average performance (greater than the national HEDIS 75th percentile) in 2014 for the following HEDIS measures that also relate to quality of care:

- ✓ Antidepressant Medication Management—Effective Acute Phase Treatment;
- ✓ Antidepressant Medication Management—Effective Continuation Phase Treatment;
- ✓ Well-Child Visits in the First 15 Months of Life—Six or More Visits;
- ✓ Use of appropriate medications for adults age 51-64 with asthma;
- ✓ Children's and Adolescents' Access to Primary Care Practitioners (all indicators); and
- ✓ Annual Dental Visits measure, which involve distinct provider specialties.

- Vermont's Performance Improvement Project (PIP), *Increasing Adherence to Evidence-Based Pharmacy Guidelines for Members Diagnosed with Congestive Heart Failure*, received a score in the 2011-2012 EQRO review of 96% for all applicable evaluation elements, a score of 100% for critical evaluation elements, and an overall validation status of *Met*, indicating a finding of high confidence in the reported baseline and re-measurement results.
- Vermont's newest PIP, *Follow-up after Hospitalization for Mental Illness*, received a *Met* score for 100% of critical evaluation elements and 100% of overall evaluation elements in the Study Design, Implementation, and Evaluation stages.

Vermont Chronic Care Initiative

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

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

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

SFY13 utilization change offers further evidence of this strategy with documented reduction of Acute Ambulatory Care Sensitive Conditions inpatient admissions by 37%, 30-day hospital readmission rates by 34%, and an ED utilization decline of 15% for eligible VCCI members in the top 5% utilize category.

Blueprint for Health

In each area of the state, participating Patient Centered Medical Homes (PCMHs) and Community Health Teams (CHTs) have organized their operations to meet the NCQA medical home standards. This process is supported by Practice Facilitators, planning and learning forums, and by the network of self-management programs that help practices meet a particularly challenging section of the standards (Support Self-Care Process). A team based at the University of Vermont, in the Vermont Child Health Improvement Program, scores each practice to assure a consistent and independent assessment of health care quality. As of Blueprint's 2014 annual report, this approach has led to successful recognition of 126 practices serving 347,489 patients, successful re-scoring of 61 practices, and a statewide base of primary care tested against difficult national standards.

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

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

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

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

- Primary care practices gained formal recognition as Patient Centered Medical Homes for the first time and others re-scored against the National Committee for Quality Assurance (NCQA)

quality standards. As of December 2014, there were 126 primary care practices operating in Vermont as PCMHs supported by multi-disciplinary CHTs.

- Community Health Team (CHT) operations matured, and the CHTs worked to coordinate care across medical and community partnering organizations.
- Local multi-stakeholder workgroups, staffed by the Blueprint, focused on bridging health and human services to maximize available resources, improve outcomes, and drive clinical quality improvement.
- A new unified reporting capability for clinical, cost, and utilization measures produced timely reports across all payers at the practice, Health Services Area, and state levels. These reports form the basis for aligning local and statewide quality improvement efforts.

Vermont Health Care Innovation Project (VHCIP)

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

2014 HEDIS Measures

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

Table 2-1 HEDIS Quality Measures

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

HEDIS Measure	VT EQRO Year		VT Average: 2013-2014	NCQA Medicaid Accredited HMO's Average	VT vs. NCQA HMO Average
	2013	2014			
19-50	79.93%	75.92%	77.93%	74.4%	3.53%
51-64	84.65%	80.62%	82.64%	70.3%	12.34%
Total	84.71%	82.41%	83.56%	84.1%	-0.54%
Anti-Depressant Medication Management					
Effective Acute Phase Treatment	68.81%	63.30%	66.06%	50.5%	15.56%
Continuation Phase Treatment	51.98%	44.12%	48.05%	35.2%	12.85%

Behavioral Health System of Care

In March 2014, Managed Substance Abuse Services and Mental Health Services consolidated into one unit to provide integrated Behavioral Health Services. This collaboration offers a more comprehensive approach for behavioral health care coordination and utilizes the combined staff's expertise in substance abuse, mental health, and quality improvement. The consolidation of the two teams allows beneficiaries with co-occurring mental health and substance abuse conditions to receive coordinated services from DVHA, as well as provide DVHA with resources from the efficiencies gained in consolidation to work on improving access to care.

The Mental Health Team is responsible for concurrent review and authorization of inpatient psychiatric and detox services for Medicaid primary beneficiaries. The team works closely with discharge planners at inpatient facilities to ensure timely and appropriate discharge plans. The Substance Abuse Team coordinates its Medication Assisted Treatment (MAT) efforts with the Care Alliance for Opioid Addiction (Hub and Spoke), the VCCI, and the DVHA Pharmacy Unit to provide beneficiary oversight and outreach. All beneficiaries receiving MAT services and who are prescribed buprenorphine will continue to have a Pharmacy Home that dispenses all of their prescriptions. The team also manages the Team Care program (formally the lock-in program).

Throughout the year, the Behavioral Health Team was an active participant in the AHS Substance Abuse Treatment Coordination Workgroup. This workgroup is a coordinated effort to standardize substance abuse screening and referral processes throughout the Agency of Human Services. The workgroup is developing an AHS-wide training for substance abuse screening. Team members also participate in monthly meetings with the VDH's Alcohol and Drug Abuse Prevention Division to coordinate efforts between the two departments to provide substance abuse services to Vermont Medicaid beneficiaries.

Also during this year, the Behavioral Health Team adopted the McKesson/Interqual tool for authorizing mental health and substance abuse services. Significant research was done on the criteria, as well as on the effectiveness of the tool. DVHA hosted a two-day training on the McKesson/InterQual behavioral health care criteria tool for internal DVHA staff, as well as for Vermont Department of Health, Department of Mental Health, and the Department for Children and Families. DHVA hosted an informational webinar on the tool for providers. As part of the consolidation of the two teams, the Substance Abuse Team was able to implement an electronic record system utilizing Covisint. Covisint

has been utilized by the Mental Health Team for the past year, and it allows for improved coordination of services.

In 2014 DVHA hired an Autism Specialist who is a member of the Behavioral Health Team. This position was created in response to the additional funding appropriated by the state legislature for the provision of services for children diagnosed with autism spectrum disorders. The Autism Specialist is developing a system for managing and authorizing payment of these services. DVHA worked with other AHS departments to provide interim guidance to the Designated Agencies regarding the additional funding allocated to enhance the delivery of Applied Behavioral Analysis (ABA) services.

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

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

The 2014 CAHPS revealed these results for 2014:

Table 2-2 Person-Centered Care

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

Goal 3: Contain Cost of Care

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

Goal 3: Summary

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

- *Decreased Expenditures:* The Demonstration generated a surplus associated with overall decreased expenditures relative to the aggregate budget neutrality limit (ABNL). Actual expenditures have been consistently below projected and the Demonstration surplus is projected to be $994 million at the end 2016.
- *VCCI Savings:* In state fiscal year (SFY) 2013, the Vermont Chronic Care Initiative (VCCI) documented net savings of $23.5 million over anticipated expense among the top 5% of eligible Medicaid members (high utilizers).
- *Blueprint for Health Savings:* Year-to-year growth in health care expenditures was lower for Blueprint participants, particularly from 2011 forward as more of the 126 practices underwent preparation, scoring, and began working with community health teams.

Goal 3: Data

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

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

Growth in Total Expenditures, by Enrollment Group

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

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

	Federal Fiscal Year			Average Annual Growth
	2011 (Oct '10-Sept '11)	2012 (Oct '11-Sept'12)	2013 (Oct '12-Sept '13)	
Capitation Payments				
ABD - Non-Medicare - Adult	$ 176,533,340.07	$ 196,485,337	$ 212,291,903	9.7%
ABD - Non-Medicare - Child	$ 98,394,380	$ 103,970,781	$ 100,828,815	1.2%
ABD - Dual	$ 223,405,044	$ 235,290,439	$ 252,607,145	6.3%
ANFC - Non-Medicare - Adult	$ 76,485,531	$ 86,167,567	$ 93,174,370	10.4%
ANFC - Non-Medicare - Child	$ 236,275,482	$ 258,028,089	$ 265,930,690	6.1%
Global Expansion (VHAP)	$ 180,323,101	$ 196,237,736	$ 207,777,299	7.3%
Global Rx	$ 7,800,691	$ 9,801,310	$ 10,633,937	16.8%
Optional Expansion (Underinsured)	$ 2,353,178	$ 2,542,533	$ 2,305,144	-1.0%
VHAP ESI	$ 1,917,976	$ 1,660,128	$ 1,189,221	-21.3%
ESIA	$ 861,905	$ 844,135	$ 785,505	-4.5%
CHAP	$ 40,210,567	$ 40,947,623	$ 45,962,054	6.9%
ESIA Expansion - 200-300% of FPL	$ 298,915	$ 234,632	$ 119,805	-36.7%
CHAP Expansion - 200-300% of FPL	$ 18,276,722	$ 20,287,457	$ 25,846,789	18.9%
Total Capitation Payments	*$ 1,063,136,831*	*$ 1,152,497,766*	*$ 1,219,452,678*	*7.1%*

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

- ✓ Overall, capitated spending has grown consistently at an average annual rate of approximately 7.1% from 2011 to 2013.
- ✓ Total program expenditures grew more rapidly adult enrollment groups compared to children's enrollment groups.
- ✓ After growing approximately 4% per year between 2006 and 2009, capitated spending for Optional Expansion (Underinsured) has remained essentially level as of 2012.

Growth in Expenditures per Member per Month, by Enrollment Group

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

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

	Federal Fiscal Year			Average Annual Growth
	2011 (Oct '10-Sept '11)	2012 (Oct '11-Sept'12)	2013 (Oct '12-Sept '13)	
ABD - Non-Medicare - Adult	$ 1,063.14	$ 1,167.43	$ 1,236.30	7.8%
ABD - Non-Medicare - Child	$ 2,218.64	$ 2,330.19	$ 2,281.04	1.4%
ABD - Dual	$ 1,151.67	$ 1,164.80	$ 1,226.49	3.2%
ANFC - Non-Medicare - Adult	$ 580.55	$ 633.24	$ 687.47	8.8%
ANFC - Non-Medicare - Child	$ 357.34	$ 388.40	$ 400.61	5.9%
Global Expansion (VHAP)	$ 406.08	$ 441.33	$ 462.38	6.7%
Global Rx	$ 51.33	$ 64.81	$ 70.07	16.8%
Optional Expansion (Underinsured)	$ 176.14	$ 201.69	$ 202.26	7.2%
VHAP ESI	$ 181.73	$ 168.20	$ 127.63	-16.2%
ESIA	$ 144.81	$ 150.50	$ 131.77	-4.6%
CHAP	$ 462.38	$ 441.60	$ 450.78	-1.3%
ESIA Expansion - 200-300% of FPL	$ 94.27	$ 80.96	$ 40.06	-34.8%
CHAP Expansion - 200-300% of FPL	$ 536.32	$ 527.40	$ 644.49	9.6%
Total	**$ 539.89**	**$ 577.82**	**$ 604.86**	*5.8%*

- ✓ Adjusted for caseload growth, the Global Commitment Demonstration experienced average annual expenditure growth of 5.8 percent between 2011 and 2013.
- ✓ Average annual per member per month expenditure growth for traditional Medicaid enrollment groups ranged from a low 1.4 percent (ABD Child) to a high of 8.8 percent (ANFC Adult).

Comparison of Estimated Expenditures with and without Demonstration

CMS guidelines state that Section 1115 waivers are required to be budget neutral, i.e., do not increase federal funding over what would have been spent without the waiver. To evaluate budget neutrality, actual expenditures are measured against projections on what otherwise would have spent, based on the state's historical experience for the years prior to implementation of the waiver (e.g., enrollment, benefits, utilization, and cost of care). The cumulative spending projections are referred to as the aggregate budget neutrality limit, or ABNL.

Table 3-2 on the following page summarizes actual ("with Demonstration") and projected ("without Demonstration") expenditures through September 2013, including the federal share of any surpluses or deficits.

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

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

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

Goal 4: Allow Choice of LTSS Settings

Supporting Individual Choice

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

Serving More People

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

excludes the Moderate Needs Group. If the moderate needs group is included, the increase jumps to 52.6%.

Shifting the Balance

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

Expanding the Range of Service Options

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