State of Vermont

Agency of Human Services

Global Commitment to Health
11-W-00194/1

Section 1115(e)
Demonstration Extension Request to CMS
(1/1/2017 – 12/31/2021)

Submitted 12/31/2015

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

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

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

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

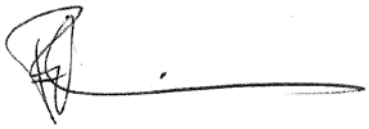
- **Appendix B:** Budget neutrality assessment, and projections for the projected 5-year extension period. The state will present an analysis of budget/allotment neutrality for the current demonstration approval period, including status of budget/allotment neutrality to date based on the most recent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

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

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

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

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



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

Governor Peter Shumlin

Appendix A: Historical Summary of the Demonstration

Background

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

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

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

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

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

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

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

Historical Summary

Global Commitment to Health

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

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

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

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

Choices for Care

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

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

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

Global Commitment to Health Demonstration Objectives

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

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

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

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

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

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

Evidence of How the Goals Have Been Met

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

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

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

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

- *Number of Uninsured:* The 2014 Vermont Household Health Insurance Survey found that Vermont's uninsured rate was reduced by 46% from the 2012 uninsured rate. The 3.7% rate in 2014 put Vermont second in the nation in health insurance coverage. By November 1 of 2014, over 140,000 Vermonters had received coverage through Vermont Health Connect, including 32,237 enrolled in Qualified Health Plans.

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

    - Significantly higher (14%) than the accredited Medicaid HMO average of 61.6% for the measure for Well Child Visits in the First 15 Months of Life;
    - High performance for the measure for Child and Adolescent Access to Primary Care Physician (PCP), with scores ranging from 93.9% to 98.6% across the childhood years; and
    - High scores related to the measure for Adult Access to Preventive and Ambulatory Care, 84.21% to 94.31% across the adult years.

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

- *Access to Medicaid Assistance Treatment (MAT) for Opioid-Dependence:* AHS is collaborating with community partners to increase access to MAT for patients through the use of a Specialized Health Home program. CMS approved Specialized Health Home State Plan Amendments for

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

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

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

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

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

- *Blueprint for Health:* Medicaid is an active partner in Vermont's Blueprint for Health, described in Vermont statute as "*a program for integrating a system of health care for patients, improving the health of the overall population, and improving control over health care costs by promoting health maintenance, prevention, and care coordination and management*" (18 VSA Chapter 13).

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

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

Goal #3: Contain Cost of Care

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

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

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

- *Participation:* SFY2014 participation in Choices for Care increased 6.5% from the previous year.
- *Balance of Settings:* As of October 2014, approximately 52% of people enrolled in Choices for Care's Highest/High Needs groups were served in a home- or community-based setting, while 48% were served in a nursing facility.
- *No Waiting List:* In September 2005, 241 people were on waiting lists for high- and highest-needs home- and community-based services; at the end of SFY2014, the number was 0.
- *Controlled Cost:* In recent years Choices for Care spending has been under State appropriations. This has provided program stability, as well as created opportunities for the State to support quality improvements as directive by the legislature. In SFY2014 Choices for Care expenditures were $5.6 million (3%) less than legislative appropriations.

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

1) Reduce the rate of uninsured and or underinsured in Vermont;
2) Increase the access of quality health care to uninsured, underinsured, and Medicaid beneficiaries;
3) Provide public health approaches and other innovative programs to improve the health outcomes, health status, and quality of life for uninsured, underinsured, and Medicaid beneficiaries in Vermont; or
4) Encourage the formation and maintenance of public-private partnerships in health care, including initiatives to support and improve the health care delivery system.

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

Future Goals

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

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

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

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

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

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

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

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

- Increasing access to affordable and high-quality health care;
- Improving access to primary care;
- Improving the health care delivery for individuals with chronic care needs;
- Containing health care costs through payment reform and other activities; and
- Allowing beneficiaries a choice in where they receive long term services and supports.

It is crucial to maintain these foundations of health care delivery for Vermont's most vulnerable and lower-income citizens while aligning our shared federal and state priorities.

Appendix B: Budget Neutrality Assessment and Projections

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

State of Vermont
Global Commitment to Health

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

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

State of Vermont
Global Commitment to Health

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

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

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

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

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

Background

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

The evaluation included a compilation of Vermont's quality assessment and improvement activities, as well as emerging results from Vermont's innovative programs for Chronic Care Management and its Blueprint for Health initiative. As part of the 2013 and 2014 CMS discussions, the state requested and ultimately received approval to incorporate the 1115 Long-Term Care Demonstration waiver, Choices for Care (CFC), into the GC Demonstration. Prior to January 30, 2015, evaluation activities of the two waivers had been separate. An updated evaluation plan for the consolidated waiver is currently under review with CMS.

2015 Interim Program Evaluation Report

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

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

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

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

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

Vermont Premium Assistance Program Evaluation

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

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

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

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

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

Draft Demonstration Evaluation Design

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

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

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

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

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

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

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

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

Appendix D: Summary of EQRO Reports and Quality Assurance Monitoring

External Quality Review Organization Reports

As a Managed Care model, DVHA adheres to federal rules contained in 42 CFR 438. Since 2007 AHS has contracted with the Health Services Advisory Group (HSAG) to conduct an external independent review of the quality outcomes and timeliness of—and access to—care furnished by DVHA to its Medicaid enrollees. These audits are known as External Quality Review Organization (EQRO) audits. The audits have three major areas of review:

- Performance Measures Validation;
- Monitoring Compliance with Standards; and
- Performance Improvement Projects Validation.

EQRO Report 2012 – 2013

Performance Measures Evaluation

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

Monitoring Compliance with Standards

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

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

Performance Improvement Validation

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

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

EQRO Report 2014-2015

Performance Measures Validation

The EQRO conducted the validation of 13 performance measures for 2014 (CY 2013). The auditors identified several aspects in the calculation of performance measures as crucial to the validation process. These include data integration, data control, and documentation of performance measure calculations. DVHA received a passing score on all of these aspects. There was a recommendation that DVHA conduct additional root cause analysis on performance measures and incorporate national/regional benchmarks to manage rates.

HSAG evaluated eligibility system data and claims processing data and found no areas requiring corrective action.

Performance Measure Specific Findings:
DVHA contracted with a software vendor to assist in producing the performance measures. HSAG conducted primary source verification for each required performance measure and identified no errors. All member eligibility strings matched the Hewlett-Packard (HP) Medicaid Management Information System (MMIS) and the Verisk performance measure software vendor system's numerators.

The auditors identified a potential for underreporting of some lab-related measures due to case rates and minimal monitoring of data submitted by DVHA's Federally Qualified Health Centers (FQHCs). HSAG recommended that DVHA conduct further investigation on this data.

Monitoring Compliance with Standards

The EQRO also reviewed DVHA's compliance with the Managed Care performance requirements described in 42 CFR §438, as well as state-specific requirements contained in the AHS/DVHA IGA. The performance audit focused on the following eight standards:

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

DVHA's overall compliance score for this set of standards improved from 90% three years ago (the last time these standards were measured) to 92% this year. All programs either *Met* or *Partially Met* the required compliance standards. No programs were graded as having *Not Met* a required standard.

In their final report, the auditors noted that:

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

Performance Improvement Validation

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

The *Follow-up after Hospitalization for Mental Illness* PIP received a *Met* score for 100% of critical evaluation elements and 100% of overall evaluation elements in the Study Design, Implementation, and Evaluation stages.

Quality Assurance and Performance Improvement Activities

The DVHA Quality Improvement (QI) and Clinical Integrity Unit monitors, evaluates, and improves the quality of care to our Vermont Medicaid beneficiaries by improving internal processes, identifying performance improvement projects, and performing utilization management. Efforts are aligned across the Agency of Human Services as well as with community providers.

The Quality Committee focused during the Demonstration period on the CMS core performance measures for adults and children, evaluating DVHA's performance and receiving updates on performance improvement projects related to the measures. The committee agreed to structure its work around the triple aims of health care: improving the patient experience, improving the health of populations, and reducing the per capita cost of health care.

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

Throughout the Demonstration period DVHA worked on developing the internal capacity to complete hybrid Healthcare Effectiveness Data and Information Set (HEDIS) chart reviews for a limited number of measures. Training was delivered via the online web portal of DVHA's HEDIS vendor for medical record abstractions.

During the Demonstration period the AHS Performance Accountability Committee (PAC) recommended performance measures for the GC Waiver and for the Medicaid/Shared Savings Program (ACO). During the process, members of the committee reviewed/considered performance measures associated with the following AHS-sponsored/supported initiatives: Blueprint for Health, Healthy Vermonters 2020, AHS Strategic Plan, and the CMS Adult/Child core measure sets. Now that the Choices for Care waiver has been consolidated with the Global Commitment waiver, the group has added long-term services and

supports (LTSS) measures to the Global Commitment measure set. The committee also supported the planning/design aspects of the AHS Results Scorecard. This is an electronic scorecard/dashboard that graphically displays AHS performance/accountability data relative to a number of population-based indicators of health and well-being. In addition to the tool, the group will continue their work to align measures associated with the Global Commitment waiver with those found in the AHS Strategic Plan/Results Scorecard.

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

Appendix E: Compliance with Public Notice Process

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

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

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

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

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

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

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

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

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

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

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

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

Public Comments and Associated Responses

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

Attachment 1:

Interim Demonstration Evaluation Report
October 2013 to January 2015

PHPG

The Pacific Health Policy Group

INTERIM PROGRAM EVALUATION

Global Commitment to Health Section 1115 Demonstration

11-W-00194/1

On behalf of:

State of Vermont
Agency of Human Services

Prepared by:

The Pacific Health Policy Group

December 2015

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Introduction

Purpose of Evaluation

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

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

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

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

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

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

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

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

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

Background on Health Care Reform in Vermont

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

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

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

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

Background on Global Commitment

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

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

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

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

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

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

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

Contents of Evaluation

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

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

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

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

- Global Commitment to Health Enrollment 2008-2014
- Vermont Department of Financial Regulation, formerly Department of Banking, Insurance, Securities, and Health Care Administration (BISHCA), Vermont Health Insurance Coverage Survey (2001-2006, 2008, 2012, and 2014)
- 2012-2015 External Quality Review Organization (EQRO) Technical Reports
- 2013-2014 HEDIS Measures
- 2012 and 2014 Consumer Assessment of Health Provider and Systems (CAHPS) Survey
- 2014 Vermont Chronic Care Initiative Annual Report for State Fiscal Year 2013
- 2014 Blueprint for Health Annual Report, as revised January 2015
- 2014 Global Commitment to Health Demonstration Annual and Quarterly Reports to CMS
- Choices for Care Program Evaluations
- Choices for Care Data Report July 2015
- 2014 LTSS Consumer Survey Report
- Vermont 2015: Reforming Vermont's Mental Health System, Report to the Legislature on the Implementation of Act 79, January 2015
- Integrated Family Services: Early Indicators of Success, 2014
- NCQA, State of Health Care Quality 2014.

Goal 1: Increase Access to Care

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

Goal 1: Highlights:

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

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

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

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

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

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

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

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

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

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

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

Goal 1: Data and Related Initiatives

Global Commitment Enrollment for 2008-2012

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

Table 1-1: Global Commitment Average Number of Enrollees

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

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

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

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

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

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

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

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

2014 HEDIS Measures

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

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

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

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

*n/a – not available

Table 1.3 can be summarized as follows:

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

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

Table 1-4 Adult Access Measures

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

n/a: not available

For most adult access measures, NCQA comparison scores for accredited Medicaid HMOs were not available. However, the state's contracted External Quality Review Organization (EQRO), Health Services Advisory Group (HSAG), notes that Vermont achieved a significantly higher score than the national

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

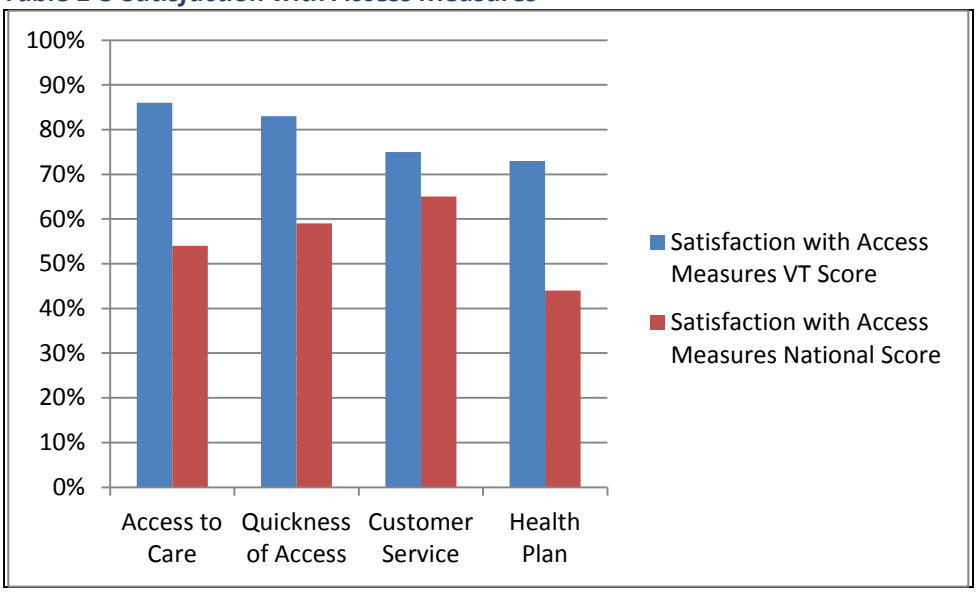
2014 Customer Assessment of Health Care Providers and Systems (CAHPS) Survey

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

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

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

Table 1-5 Satisfaction with Access Measures



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

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

Hub and Spoke Initiative: Integrated Treatment for Opioid Dependence

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

The two primary medications used to treat opioid dependence are methadone and buprenorphine, with most MAT patients receiving office-based opioid treatment (OBOT), with buprenorphine prescribed by specially licensed physicians in a medical office setting. These physicians generally are not well integrated with behavioral and social support resources. In contrast, methadone is a highly regulated treatment provided only in specialty opioid treatment programs (OTPs) that provide comprehensive addictions treatment but are not well integrated into the larger health and mental health care systems. The Hub and Spoke Model addresses this service fragmentation.

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

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

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

Spokes include a physician prescribing buprenorphine in an OBOT and the collaborating health and addictions professionals who monitor adherence to treatment; coordinate access to recovery supports and community services; and provide counseling, contingency management, care coordination, and case management services. Support is given to Spoke providers and their Medicaid MAT patients by nurses

and licensed addictions/mental health clinicians, adding to the existing Blueprint CHTs. Similar to all CHT staff, Spoke staff are provided free of cost to MAT patients. Staff are embedded directly in the prescribing practices to allow more direct access to mental health and addiction services, promote continuity of care, and support the provision of multidisciplinary team care.

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

Goal 2: Enhance Quality of Care

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

Goal 2: Highlights

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

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

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

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

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

Goal 2: Data and Related Initiatives

2014 Medicaid Managed Care Quality Strategy

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

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

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

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

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

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

In their final report, the auditors noted that:

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

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

- Above-average performance (greater than the national HEDIS 75th percentile) in 2014 for the following HEDIS measures that also relate to quality of care:
  - ✓ Antidepressant Medication Management—Effective Acute Phase Treatment;
  - ✓ Antidepressant Medication Management—Effective Continuation Phase Treatment;
  - ✓ Well-Child Visits in the First 15 Months of Life—Six or More Visits;
  - ✓ Use of appropriate medications for adults age 51-64 with asthma;
  - ✓ Children's and Adolescents' Access to Primary Care Practitioners (all indicators); and
  - ✓ Annual Dental Visits measure, which involve distinct provider specialties.
- Vermont's Performance Improvement Project (PIP), *Increasing Adherence to Evidence-Based Pharmacy Guidelines for Members Diagnosed with Congestive Heart Failure*, received a score in the 2011-2012 EQRO review of 96% for all applicable evaluation elements, a score of 100% for critical evaluation elements, and an overall validation status of *Met*, indicating a finding of high confidence in the reported baseline and re-measurement results.

<u>Vermont Chronic Care Initiative</u>

The goal of the Vermont Chronic Care Initiative (VCCI) is to improve health outcomes of Medicaid beneficiaries through addressing the increasing prevalence of chronic illness. Specifically, the VCCI is

designed to identify and assist Medicaid beneficiaries with chronic health conditions in accessing clinically appropriate health care information and services; coordinate the efficient delivery of health care by attempting to remove barriers, bridge gaps, and avoid duplication of services; and educate, encourage, and empower these beneficiaries in eventually self-managing their chronic conditions. VCCI has targeted the top 5% of Medicaid utilizers, who account for 39% of Medicaid costs.

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

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

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

Blueprint for Health

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

Perhaps the most important innovation in the Blueprint is the CHT concept, which recognizes that, for many patients, support and coordination services have not been well integrated into the primary care

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

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

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

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

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

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

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

Vermont Health Care Innovation Project (VHCIP)

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

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

2014 HEDIS Measures

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

Table 2-1 HEDIS Quality Measures

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

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

Behavioral Health System of Care

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

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

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

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

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

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

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

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

The 2014 CAHPS revealed these results for 2014:

Table 2-2 Person-Centered Care

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

Goal 3: Contain Cost of Care

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

Goal 3: Summary

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

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

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

Goal 3: Data

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

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

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

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

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

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

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

- ✓ Overall, capitated spending has grown consistently at an average annual rate of approximately 7.1% from 2011 to 2013.
- ✓ Total program expenditures grew more rapidly adult enrollment groups compared to children's enrollment groups.

Growth in Expenditures per Member per Month, by Enrollment Group

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

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

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

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

Comparison of Estimated Expenditures with and without Demonstration

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

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

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

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

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

Goal 4: Allow Choice of LTSS Settings

Supporting Individual Choice

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

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

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

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

Serving More People

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

Shifting the Balance

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

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

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

Expanding the Range of Service Options

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

Attachment 2: Public Comment Received and State Responses

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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