State of Vermont
Agency of Human Services

Global Commitment to Health
11-W-00194/1

Annual Report
For Demonstration Year 2019
January 1, 2019 to December 31, 2019

Submitted via PMDA portal on March 31, 2020

Table of Contents

I. Background and Introduction 3
II. Highlights and Accomplishments 4
III. Project Status 5
IV. Findings 11
V. Cost Containment Initiatives 18
VI. Utilization Management 68
VII. Policy and Administrative Difficulties 77
VIII. Capitated Revenue Spending 77

Attachments

Attachment 1: Budget Neutrality

Attachment 2: Enrollment & Expenditures Report (Q4)

Attachment 3: Complaints from Member Services (Q4)

Attachment 4: Grievances & Appeals Report (Q4)

Attachment 5: Health Care Advocate Report (Q4)

Attachment 6: SFY 2018 Investments

Attachment 7: Investment Scorecard – *Institution for Mental Disease (IMD)*

Attachment 8: Payment Model Scorecard – *Integrating Family Services*

I. Background and Introduction

The Global Commitment to Health is a Demonstration Waiver authorized pursuant to Section 1115(a) by the Centers for Medicare and Medicaid Services (CMS), within the Department of Health and Human Services (HHS).

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

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

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

Implemented October 1, 2005, the Global Commitment converted the (then Office) Department of Vermont Health Access (DVHA), the state's Medicaid organization, to a public Managed Care Entity (MCE). The Agency of Human Services (AHS) paid the MCE a lump sum premium payment for the provision of all Medicaid services in the state (with the exception of the Long-Term Care Waiver, managed separately).

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

An extension effective January 1, 2011 was granted and included modifications based on the following amendments: 2006 - inclusion of Catamount Health to fill gaps in coverage for Vermonters by providing a health services delivery model for uninsured individuals; 2007 - a component of the Catamount program was added enabling the State to provide a premium subsidy to Vermonters who had been without health insurance coverage for a year or more, have income at or below 200 percent of the FPL, and who do not have access to cost effective employer-sponsored insurance, as determined by the State; 2009 - CMS processed an amendment allowing the State to extend coverage to Vermonters at or below 300 percent of the FPL; 2011 - inclusion of a palliative care program for children who are at or below 300 percent of the FPL, and have been diagnosed with life limiting illnesses that would preclude them from reaching adulthood. This program allows children to receive curative and palliative care services such as expressive therapy, care coordination, family training and respite for caregivers.

In 2011, DAIL was awarded a five year $17.9 million "Money Follows the Person" (MFP) grant from CMS to help people living in nursing facilities overcome barriers to moving to their preferred community-based setting.

In 2012, CMS processed a cost-sharing amendment providing the authority for the State to eliminate the $75 inpatient co-pay and to implement nominal co-pays for the Vermont Health Access Plan (VHAP).

In 2013, CMS approved Vermont's Waiver Renewal for the period from October 2, 2013-December 31, 2016. AHS and DVHA have been working closely with Vermont's Medicaid Fiscal Agent to support all ACA reporting requirements, including identification of those services reimbursed at a different Federal match rate and in support of the revised MEG bucketing effective with the latest STC package.

In 2013, the State based Exchange, Vermont Health Connect (VHC), went live. CMS approved Vermont's correspondence, dated November 19, 2013, which requested authorization for expenditure authority for the period from January 1, 2014-April 30, 2014, to ensure temporary coverage for individuals previously eligible and enrolled as of December 31, 2013, in coverage through VHAP, Catamount Premium Assistance, and pharmacy assistance under Medicaid demonstration project authority during the transition to VHC.

In 2015, Vermont consolidated the Choices for Care 1115 waiver with Vermont's Global Commitment to Health 1115 waiver. Choices for Care offers a broad system of long-term services and supports across all settings for adult Vermonters with physical disabilities and needs related to aging.

On October 24th, 2016 Vermont received approval for a five-year extension of the Global Commitment to Health 1115 waiver, 1/1/2017-12/31/2021.

As of July 1, 2018, the Global Commitment to Health demonstration was amended to include authority for Vermont to receive federal Medicaid funding for Substance Use Disorder treatment services provided to Medicaid enrollees in Institutions for Mental Disease (IMDs).

One of the Terms and Conditions of the Global Commitment Waiver requires the State to submit an annual report. This is the report for the thirteenth waiver year, demonstration year 2019, which ended on December 31, 2019. This report encompasses fourth quarter updates for this demonstration year (10/1/19 – 12/31/19).

II. Highlights and Accomplishments

- By the end of 2019, more than 187,577 Vermonters were enrolled in Vermont Health Connect (VHC) health plans either through the marketplace or directly through an insurance carrier. This enrollment consisted of 115,207 in Medicaid for Children and Adults (MCA) and 72,370 in Qualified Health Plans (QHPs), with the latter divided between 24,687 enrolled with VHC, 6,956 direct enrolled with their insurance carrier as individuals, and 40,727 enrolled with their small business employer.

- In 2018, the following payment and delivery system reform initiatives were either completed or in-progress: Vermont Medicaid Next Generation ACO program; Applied Behavior Analysis (ABA); Children's and Adult's Mental Health; Residential Substance Use Disorder (SUD) Program; Developmental Disabilities Services; and Children's Integrated Services.

- DVHA made technical and process improvements to the auto-renewal process, known as "ex parte", that increased the percentage of enrollees who could be renewed without an application to more than 45%. As a result, fewer than 55% of beneficiaries were required to fill out a renewal application and provide documentation.

- DVHA received certification for its care management system, EQHealth, in October of 2019 – marking the first care management solution ever certified by CMS. EQHealth is a care management system that is designed to provide both network population management and individual member management and facilitates the Vermont Chronic Care Initiative's (VCCI) coordination of care for Medicaid members to ensure effective management for physical and mental health needs and health-related social needs.

- The Developmental Disability Services Division is continuing work to establish a value-based payment methodology for developmental disability home and community-based services. The Division is working closely with providers, beneficiaries, and families to create a new payment model aimed at efficiency, economy, quality, transparency, accountability, and sufficient access to care.

- DVHA launched its new Provider Management Module (PMM) in May 2019 and has enrolled 3,873 providers. The Provider Management Team presented the PMM to CMS for certification and received high accolades to the team on preparedness and kudos for a well-done system. DVHA expects a certification letter soon.

- Vermont continues to demonstrate increased access to medication-assisted treatment for Vermonters with opioid use disorder, as evidenced by 3,542 clients enrolled in Regional Opioid Treatment Programs (OTP/Hubs) as of December 2019 and 3,276 Medicaid beneficiaries served by Office-Based Opioid Treatment (OBOT/Spoke) programs as of December 2019.

- In 2017, DVHA implemented the nation's first Medicaid Next Generation Accountable Care Organization program. The Vermont Medicaid Next Generation (VMNG) ACO pilot included four risk-bearing hospital communities and had approximately 29,000 attributed lives. The number of risk-bearing hospital communities increased from thirteen to fourteen for the 2020 performance year, with continued participation from other providers within the communities. The number of attributed lives for the 2020 performance year increased from approximately 79,140 lives to approximately 114,335 lives.

- DAIL has initiated phase II of the Conflict Free Case Management project for the Choices for Care and the TBI program which includes an outreach plan for feedback from key stakeholders, a mailing to all program participants along with a survey, and some in-person listening sessions with consumers. DAIL expects to have public feedback completed by the end of February 2020.

III. Project Status

i. Enrollment Information and Member Month Reporting

The State of Vermont certifies the accuracy of the member month reporting. The enrollment report is produced as of the 15th of every month. The member months are subject to revision over the course of a

twelve month period due to a beneficiary's change in enrollment status.

GC quarterly reports prior to 2017 provided an enrollment count by Demonstration Population only. Medicaid Eligibility Groups have been added for the new Budget Neutrality (see Attachment 1). To maintain continuity, the table below crosswalks the count from Medicaid Eligibility Group to Demonstration Population. Both counts use the same unduplicated enrollment count information.

The table below contains Member Month Reporting for CY2019, which includes QE1219.

Demonstration Population	**Medicaid Eligibility Group**	**Total CY 2019**
1, 4*, 5*	ABD - Non-Medicare - Adult	**81,411**
	SUD - IMD - ABD	**149**
1	ABD - Non-Medicare - Child	**23,807**
1, 4*, 5*	ABD - Dual	**256,766**
	SUD - IMD - ABD Dual	**158**
2	ANFC - Non-Medicare - Adult	**103,510**
	SUD - IMD - ANFC	**222**
2	ANFC - Non-Medicare - Child	**702,940**
	Medicaid Expansion	
7	Global RX	**77,581**
8	Global RX	**44,224**
6	Moderate Needs	**2,235**
	New Adults	
3	New Adult without child	**422,798**
	SUD - IMD New Adult w/o child	**1,352**
3	New Adult with child	**232,808**
	SUD - IMD New Adult with child	**259**
	Total	**1,950,220**
*** Long Term Care Group**	**Total CY 2019**	
4 only	ABD Long Term Care Highest Need	**35,005**
5 only	ABD Long Term Care High Need	**15,381**

The table below contains Member Month Reporting for CY2018, which includes QE1218.

Table 2. Member Month Reporting – Calendar Year 2018

Demonstration Population	**Medicaid Eligibility Group**	**Total CY 2018**
1, 4*, 5*	ABD - Non-Medicare - Adult	**83,071**
	SUD - IMD - ABD	**78**
1	ABD - Non-Medicare - Child	**25,577**
1, 4*, 5*	ABD - Dual	**257,263**
	SUD - IMD - ABD Dual	**78**

2	ANFC - Non-Medicare - Adult	**143,377**
	SUD - IMD - ANFC	**187**
2	ANFC - Non-Medicare - Child	**723,120**
	Medicaid Expansion	
7	Global RX	**79,488**
8	Global RX	**46,792**
6	Moderate Needs	**2,319**
	New Adults	
3	New Adult without child	**471,886**
	SUD - IMD New Adult w/o child	**791**
3	New Adult with child	**223,882**
	SUD - IMD New Adult with child	**114**
	Total	**2,058,023**
*** Long Term Care Group**	**Total CY 2018**	
4 only	ABD Long Term Care Highest Need	**34,856**
5 only	ABD Long Term Care High Need	**14,055**

ii. Global Commitment to Health Post Award Forum

A post award forum for the latest Global Commitment to Health 1115 waiver renewal was held on Monday, February 25, 2019. This forum was conducted in accordance with Special Terms & Condition 44 of the Global Commitment to Health 1115 Demonstration waiver. Public comments were solicited and accepted at this forum and public notice of the forum was posted to the Global Commitment Register on January 10, 2019. Below is a summary of the public comment received:

- Comment regarding case management rules: A commenter noted federal regulations regarding person centered planning and conflict free case management for home and community-based services. Concerns were raised by the commenter regarding Vermont's adherence with these provisions.

The 2020 post award form will be held in the second quarter 2020. Further information will be included in the second quarter report for 2020.

iii. Vermont Health Connect

Key updates:

- By the end of 2019, more than 187,577 Vermonters were enrolled in Vermont Health Connect (VHC) health plans either through the marketplace or directly through an insurance carrier. This enrollment consisted of 115,207 in Medicaid for Children and Adults (MCA) and 72,370 in Qualified Health Plans (QHPs), with the latter divided between 24,687 enrolled with VHC, 6,956 direct enrolled with their insurance carrier as individuals, and 40,727 enrolled with their small business employer. Vermont Health Connect's seventh open enrollment period launched successfully on November 1, 2019. In October 2019, 99% of eligible QHP renewals were handled through a single, clean automated process.
- Vermonters used the online Plan Comparison Tool more than 46,060 times between January 1, 2019 and December 31, 2019. This accounts for a 4% increase.

The State of Vermont launched Vermont Health Connect (VHC), a state-based health benefits exchange for individuals and small businesses in Vermont, in October 2013. The data shows that the exchange has combined with other efforts in the state to increase Vermont's health coverage and improve health access.

The Vermont Household Health Insurance Survey (VHHIS), published in December 2018, reported that Vermont cut its uninsured rate by more than half from 2012 to 2018, resulting in a 3.2% rate or fewer than 20,000 uninsured Vermonters. This result marks the lowest rate and lowest number of uninsured Vermonters of any VHHIS since it was first fielded in 2000.

By the end of 2019, more than 187,577 Vermonters were enrolled in Vermont Health Connect (VHC) health plans either through the marketplace or directly through an insurance carrier. This enrollment consisted of 115,207 in Medicaid for Children and Adults (MCA) and 72,370 in Qualified Health Plans (QHPs), with the latter divided between 24,687 enrolled with VHC, 6,956 direct enrolled with their insurance carrier as individuals, and 40,727 enrolled with their small business employer.

Medicaid Renewals

Annual Medicaid redeterminations are an important piece of DVHA's work to ensure that beneficiaries maintain eligibility for the programs in which they are enrolled. Redeterminations for Medicaid for Children and Adults (MCA) continued their normal cycle throughout 2019. Technical and process improvements to the auto-renewal process, known as "ex parte", improved the percentage of enrollees who could be renewed without an application to more than 45% of renewing beneficiaries each month. As a result, fewer than 55% of beneficiaries were required to fill out a renewal application and provide documentation.

QHP Renewals

DVHA kicked off a series of meetings with its internal stakeholders and Maintenance and Operations vendor in early summer 2019 to prepare for the coming Open Enrollment. The meetings focused on testing, notices, business, and transactional planning activities. QHP renewals presented major challenges for the marketplace in its early years. The last four years have gone increasingly well.

The first step in the renewal effort involves determining eligibility for the coming year's state and federal subsidies and enrolling beneficiaries in new comparable versions of their health and/or dental plans. In October 2019, this step was operated with a single, clean, automated run that took care of 99% of eligible cases. The 1% failure rate meant that only 409 cases needed to be renewed by staff the following day; allowing all beneficiaries to have updated accounts and 2020 information before the start of Open Enrollment. This meant that they could log onto their online accounts on the first day of Open Enrollment, see their benefits and net premiums for the coming year, and select a new plan if they wanted to do so. Beneficiaries also had the option to call the Customer Support Center or meet with an In-Person Assister and go through the same steps if they did not want or were unable to use the online option.

The second step involves sending these files to the payment and premium processor, Wex Health, and the insurance carriers to ensure appropriate billing and effectuation. In November 2019, this initial integration run was completed with 99.6% accuracy for WEX Health and 99.9% accuracy for the insurance carriers. DVHA and its partners collaborated to clean up and re-send the remaining cases well in advance of the new year.

The third step consists of a year-end business process that allows changes to be made on cases if the beneficiary reports changes in household or income information. In SFY 2019 this process ran with nearly a 100% success rate and all cases were ready to accept change requests in early January.

Altogether, performance on these three steps made the 2020 QHP renewal experience markedly different than the early years of the marketplace and left DVHA staff both optimistic and well-positioned to tackle other challenges.

Applying Online

Three years ago, DVHA set a goal for a continual 10% year-over-year increase in the adoption of self-service functionalities. Since that time, the actual growth in online applications has far exceeded the goal. The percentage of Vermonters applying for coverage online has more than tripled over the last three years, increasing from 16% of VHC applications in June 2016 to 56% in December 2019. The online option has the potential for improved customer experience as Vermonters can log in at their convenience. The increased automation can also allow state staff to spend less time processing applications and more time delivering on other priorities for Vermonters.

Change Requests

During the first few years of Vermont's health insurance marketplace, many beneficiary change requests took several weeks or months to complete. For 2018, DVHA set a target to complete 95% of requests within ten days and met this goal for beneficiaries managed in the Vermont Health Connect system. In fact, in the last quarter of 2019, 97% of requests were completed within ten days – an especially impressive accomplishment given that the remaining three percent include requests that are not allowed to be processed immediately (such as post-partum cases).

Integration and Reconciliation

DVHA set a goal of integrating enrollment files across its insurance carrier partners' systems with no more than a 1.0% error rate and achieved this goal in all 12 months of 2019. DVHA and its partners also acted quickly to resolve errors that did arise. DVHA's goal was to ensure that no more than one-twentieth of one percent of cases sat in error status for more than ten days. That equates to an inventory of 15 or fewer errors open more than ten days.

DVHA also executed monthly reconciliation of the marketplace's enrollment systems in 2019. Multiple enrollment systems (Vermont Health Connect, payment processing vendor WEX, and the three insurance carriers) create the risk of discrepancies for Medicaid and QHP members across systems. In 2019, DVHA set a target of addressing 100% of potential discrepancies each month and, starting in February, met the goal every month with Blue Cross Blue Shield of Vermont (BCBSVT) and Northeast Delta Dental (NEDD).

DVHA also honed its Medicaid reconciliation process in 2019. The reconciliation team cut the number of Medicaid cases with open discrepancies from more than 2,000 in July 2019 to fewer than 1,800 in December 2019.

Customer Support Center

Callers to VHC's contracted Customer Support Center experienced prompt service throughout 2019 with some exceptions in the months of January, February, November, and December. During those months the percentage of phone calls answered within 24 seconds was less than 67%. In January and February, the

call center contractor Maximus was not adequately staffed for the incoming call volume. There was also an increase in call volumes during this time due to questions from customers about Silver Loading for the 2019 enrollment year. November and December typically have higher call volumes due to Open Enrollment. During the other eight months of 2019 the percentage of phone calls answered within 24 seconds was 80% or higher.

The overall inbound call volume in 2019 was higher than the corresponding months in 2018 for all but the three months of August, November and December. Despite the higher call volumes, there was a 2% increase in calls answered within 24 seconds in 2019 versus 2018. This improvement may be because the call center contractor Maximus ensured that they were adequately staffed for the 2019 open enrollment period. Additionally, Maximus has been working on retaining staff and reducing turnover, which leads to more experienced staff. During 2019 Maximus missed their service level agreements in January and December and paid a penalty for both months.

On a positive note there was a decrease in the percentage of calls that Maximus needed to escalate to DVHA in 2019. In 2018 7% of all calls were transferred to DVHA compared to 5% being transferred in 2019. Additionally, during the months of November and December in 2018 DVHA had to complete call backs to customers due to the overflow of call volume coming into Maximus. In 2019 DVHA did not have to complete call backs.

DVHA's Tier 2 call center maintained prompt service on escalated calls through 2019. In 2017, DVHA set a goal of answering 90% of calls within five minutes. In 2019, they exceeded that target in all months but December. In 2019, 94% of all calls transferred to DVHA were answered within five minutes. During December of 2019, Maximus transferred 1,100 more calls to DVHA than the previous December, making the transfer rate 9%, compared to a 5% transfer rate in December of 2018. This was a contributing factor to missing the service goal of 90% of calls answered within five minutes for this one month.

In-person Assisters

DVHA is currently supported by 198 Assisters (113 Certified Application Counselors, 2 Navigators, and 83 Brokers), working in 53 organizations including hospitals, clinics, and community-based organizations. Assisters support is available in all of Vermont's 14 counties to help Vermonters enroll in health coverage through Vermont's health insurance marketplace. There are currently 61 Certified Application Counselors in training.

DVHA continues strategic program recruitment to focus on the areas of the State that have the highest Assister need and utilization. The program has realized improvements in in training and communication methods as well as significant improvements to process consistency and data quality.

The program continues to leverage state-based resources and technologies.

Outreach & Education

DVHA uses advisory meetings, community and online events, media inquiries, social media, and other collaborative engagements with partners and stakeholders to educate Vermonters about the opportunities to apply for health benefits, how to compare plans, and how to get the most out of their health coverage. DVHA also values the input of Vermonters in the process of building its eligibility and enrollment systems, soliciting input through formal structures and informal interactions.

DVHA's educational work in advance of open enrollment focused on health insurance literacy and helping customers understand the total cost of insurance. VHC partnered with health care providers,

libraries, and other stakeholders to participate in events aimed at helping customers and potential customers better understand health insurance terms, financial help, and how to interact with the VHC system.

The online Plan Comparison Tool was a core piece of DVHA's health insurance literacy effort, helping Vermonters better understand their subsidies and assess how various plan designs and out-of-pocket costs could impact their total health care costs. The tool was created by the non-profit Consumers' Checkbook and was named the nation's best plan selection tool by Robert Wood Johnson.

DVHA strongly encouraged members to use the Plan Comparison Tool and other resources to actively shop in fall 2019. Vermonters used the online Plan Comparison Tool more than 22,500 times between November 1st and December 15th, which is a 30% decrease from the previous year.

Future Development

To make it easier for Vermonters to submit pay stubs and other personal documents to verify their eligibility for marketplace benefits, along with other health care and economic services programs, the State's Integrated Eligibility & Enrollment (IE&E) Program designed a technical solution that utilizes mobile and online technology to submit documents. This solution will improve the efficiency of the eligibility determination process and result in better customer experience for Vermonters. A 2019 pilot found that the tool enabled 55% of pilot users to submit documents on the same day of their request, compared to 11% of non-pilot users. IE&E also found that the average time from document request to submission was nearly cut in half, from nine days to five. VHC will roll out the Uploader by the end of the first quarter of 2020.

IV. Findings

i. *External Quality Review*

Key updates:

- DVHA received a compliance score of 87% during this year's EQRO Audit.
- DVHA received an overall PIP validation score of Met – with 100% of all applicable evaluation elements receiving a score of Met.
- All DVHA performance measures reported to AHS were determined to be reliable and valid.

During 2019, the AHS Quality Improvement Manager (QIM) worked with the External Quality Review Organization (EQRO) to develop timelines for each of the required annual external quality review activities (i.e., performance improvement project validation, performance measure validation, and compliance review). All timelines included the following elements: start date, completion date, task, and responsible party. In addition to timelines, letters, tools, and reference documents were also developed for each activity. Once all documents were finalized and distributed, the EQRO initiated the Compliance Review, Performance Measure Validation, and Performance Improvement Project Validation activities. In addition, technical assistance calls with the EQRO and face-to-face meetings with DVHA were held to clarify elements contained in the PIP data collection tool, prepare for the Performance Measure Validation on-site review, and clarify the requirements for this year's compliance on-site review. As with all previous years, the three activities were conducted on time and in accordance with the work plans. Once the activities were completed, final reports were produced and shared with DVHA and AHS.

The following sections provide a brief overview of the EQRO activities that took place this year.

Monitoring Compliance with Standards

During this year, the onsite compliance review took place during July and focused on 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 Intergovernmental Agreement (IGA). This year's performance audit focused on the following standards:

- Availability of Services
- Furnishing of Services
- Cultural Competence
- Coordination and Continuity of Care
- Coverage and Authorization of Services
- Emergency and Post-stabilization Services
- Disenrollment Requirements

The audit resulted in a compliance score for these standards of 86%, which is a decrease from our score during the last cycle to cover these standards. Several of the findings related to language we need to add to our manuals, procedures and written notices. A few of the findings were repeat findings on issues that had been previously resolved. The Medicaid Compliance officer is developing a review process for updates to documents that have content related to our compliance with federal statutes and our GC waiver.

A corrective action process was initiated to communicate our required actions to program staff. We do not anticipate any issues that will prevent us from fully correcting all of the areas requiring corrective action.

Performance Improvement Project Validation

HSAG validated DVHA's PIP, *Initiation of Alcohol and Other Drug Abuse or Dependence Treatment.* HSAG used CMS' PIP validation protocol as the methodology to validate the PIP. HSAG's validation assessed Steps I through IX. The PIP topic addresses the initiation of alcohol and other drug abuse or dependence treatment for adolescent and adult beneficiaries with a new alcohol or other drug abuse or dependence diagnosis. This PIP topic represents a key area of focus for improvement by DVHA. Members receiving the appropriate care and services for alcohol or other drug abuse or dependence in the recommended time frames is essential to the recovery process. DVHA's *Initiation of Alcohol and Other Drug Abuse or Dependence Treatment* PIP received a score of 100 percent for all applicable evaluation elements scored as *Met*, a score of 100 percent for critical evaluation elements scored as *Met*, and an overall validation status of *Met*. DVHA continued the PIP this year and reported first remeasurement results for the study indicator. The improvement from the baseline to the first remeasurement was statistically significant, indicating real improvement in outcomes

Performance Measure Validation

The EQRO visited Vermont to conduct Performance Measure Validation (PMV) activities during the month of July. The validation activities were conducted as outlined in the Centers for Medicare & Medicaid Services (CMS) publication, *EQR Protocol 2: Validation of Performance Measures Reported by the MCO: A Mandatory Protocol for External Quality Review (EQR), Version 2.0, September 1, 2012.* Information was collected using several methods, including interviews, system demonstration, review of

data output files, primary source verification, observation of data processing, and review of data reports. The on-site activities are described as follows: opening session, evaluation of system compliance, overview of data integration and control procedures, and closing conference.

DVHA performed at or above the 75th percentile for 31 of 57 (54.4 percent) measure rates appropriate for comparison to benchmarks, demonstrating strengths with ensuring access to primary care and dental screenings for children and adolescents, appropriate ED utilization, and appropriate management of medications for members with asthma. Conversely, 21 of 57 rates (36.8 percent) fell below the 50th percentile, indicating efforts should be focused on ensuring older adult members have access to preventive and ambulatory care, young children and adolescents are receiving necessary well-child/well-care visits, young women are appropriately screened for chlamydia, women are appropriately screened for breast cancer, and members with diabetes receive appropriate care.

The EQRO identified overall strengths and areas for improvement for DVHA. In addition, the EQRO evaluated DVHA's data systems for the processing of each type of data used for reporting the required performance measures. Identified strengths were as follows: DVHA implemented a new provider management system that greatly decreased error rates of provider data capture and decreased the amount of time needed to manage provider profiles and applications. This process improvement reduced the application approval process from weeks to just days. In addition, DVHA continues to review alternative methods for member outreach to increase compliance with HEDIS measures.

Areas for improvement were as follows:

DVHA should continue to train MRR staff in all hybrid measures to decrease the error rates among abstractors. This year a critical error was found in the abstraction process for the *CBP* measure. DVHA should increase the number of over-reads for abstractors to ensure accuracy.

SUD Monitoring Protocol

Also, during this year, members of the SUD implementation team attended CMS-sponsored training designed to introduce updated tools and measure specifications. The webinars are designed to assists state representatives with developing and implementing SUD requirements. The webinars addressed changes to the Monitoring Protocol, the Monitoring Report, and Measure Specifications. Since Vermont's Monitoring Protocol was approved by CMS as of October 2019 – the state is not required to resubmit their protocol using the updated tools recently released by CMS. However, Vermont must complete a Protocol Alignment Form to communicate how it plans to comply with the guidance issued in the new guidance. The team has been able to leverage learning obtained from the webinars to support the development of their protocol as well as the completion of their alignment form.

SMI/SED Monitoring Protocol

Similarly, members of the SMI/SED implementation team participated in CMS-sponsored trainings related to SMI/SED amendment requirements. The webinars are designed to introduce state representatives to the tools and specifications required to support the development and implementation of SMI/SED requirements. The webinars addressed the Monitoring Protocol, Monitoring Report, and Measure Specifications. The team plans to leverage the learning obtained from the trainings to support the development of the CMS required Monitoring Protocol and Monitoring Report in the first two quarters of 2020.

ii. Quality Assurance and Performance Improvement Activities

Key updates:

- The Quality Unit continued to lead a formal CMS PIP project focused on improving substance use disorder treatment through the promotion of telehealth services.
- The DVHA Quality Unit met all CMS Quality Measure Set reporting deadlines in 2019 and continued to explore innovative approaches to producing hybrid measures within those Core Sets by partnering with the State's Health Information Exchange (HIE).

The DVHA Quality Improvement and Clinical Integrity (QICI) Unit monitors, evaluates and improves the quality of care to Vermont Medicaid beneficiaries through the use of performance and utilization management frameworks. The Unit makes data-driven decisions about beneficiaries' care and improvement projects through measuring and monitoring efforts. Efforts are aligned across the Agency of Human Services (AHS) as well as with community providers. The unit is responsible for instilling the principles of quality management throughout DVHA; helping everyone in the organization to achieve excellence. The Unit's goal is to develop a culture of continuous quality improvement throughout DVHA.

PIHP Quality Committee

The Quality Committee remained active throughout 2019 and consists of representatives from all departments within AHS that serve the Medicaid population. The committee continues to structure its work around the federal managed care quality program guidelines and the triple aims of health care: improving the patient experience, improving the health of populations, and reducing the per capita cost of health care. During this time period, the Quality Committee reviewed the *Global Commitment to Health* (GC) Core Measure Set results and updated measure targets where appropriate.

Additionally, the committee reviewed the annual Child and Adult CAHPS surveys, a grievances and appeals summary, confidentiality procedures, including HIPAA breach tracking and updated the PIHP Quality Management Plan.

Formal CMS Performance Improvement Project (PIP)

In 2019 the Quality Unit continued to coordinate VT Medicaid's formal CMS Performance Improvement Project (PIP) – the topic of which is substance use disorder treatment. The cross-departmental PIP team is focused on a multi-pronged telehealth-related intervention. Targeted communications about telehealth were dispersed via provider banners and newsletter articles during 2019. DVHA's Quality Improvement Administrator prepared and submitted the annual PIP Summary report to the EQRO during the QE0919. DVHA received a score of 100%, demonstrating a solid study design and statistically significant improvement in our study measure results from CY 2017 – CY 2018.

Interim indicator data on telehealth use is also being collected to monitor progress. Data points include: number of telehealth episodes of care, number of unduplicated providers billing for telehealth and number of unduplicated members receiving telehealth services. There was an increase in all metrics from the baseline of Q2 SFY 18. The Quality Unit also sorts these episodes of care by HEDIS diagnosis code value sets for mental health and substance use disorder. Data continues to show that SUD treatment providers are using telehealth in comparatively small numbers and continued focus here could be meaningful.

To that end, Quality staff joined a state-wide stakeholder group lead by the Vermont Program for Quality in Health Care (VPQHC) during 2019. The purpose of this group is to explore the expansion of

telemedicine across the state, including the provision of technical assistance with telehealth platform implementation.

Other Collaborative Quality Improvement Projects

The Quality Unit staff led two informal quality improvement projects during 2019. The topics were chlamydia screening (CHL) and adults' access to ambulatory/preventive services (AAP), which wereselected after annual review of program performance by the Quality Committee, MCMC, and the CURB. Project charters and work plans were completed, and inter-departmental project teams completed their work during 2019.

- CHL Screening Quality Improvement Project: The project team included DVHA Quality Unit, Data Unit & Blueprint staff as well as Vermont Department of Health (VDH) staff from Maternal and Child Health and Health Surveillance Divisions. The learning collaborative was offered through the Blueprint's Women's Health Initiative and included 5 practices from around the state. Eight monthly webinars were held April-November 2019; content included (but not limited to) effective and efficient workflows, shared decision making, confidentiality, trauma-based approaches and expedited partner therapy (EPT). Quality improvement strategies and tools were also covered; all practices implemented and carried out Plan-Do-Study-Act (PDSA) cycles. Interventions included pre-visit planning, using the EMR to flag those due for a screen, minor changes to workflow, using non-judgmental language, and normalizing the screen as a standard of care. All practices implemented one or more changes to their workflow and intend to sustain them in the future.

- AAP Adults' Access to Ambulatory/Preventative Services Project: The project team included DVHA Quality Unit, Clinical, Data, Vermont Chronic Care Initiative (VCCI) and Provider & Member Relations (PMR) staff. During 2019 this team circulated a banner release related to medical record transfers (an activity that can increase the wait time for appointment scheduling) and wrapped up their work with a provider Advisory article on that topic in June 2019.

Quality Measure Reporting

- CMS Medicaid Quality Core Sets - The Quality Unit and the Data Unit prepared and submitted the Adult and Child Quality Core Set reports by the deadline of 12/31/2019.

- Also, during 2019, the Quality Unit staff collaborated with the Blueprint for Health who submitted the Health Home Core measure set.

- Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey - the DVHA Quality Unit's QI Administrator coordinated the 2019 Consumer Assessment of Healthcare Providers and Systems (CAHPS) Children's and Adults Medicaid 5.0H survey. The contracted vendor, DataStat, Inc., distributed and collated the surveys according to AHRQ and NCQA protocols in the fall of 2019. The results of the surveys were delivered to the DVHA in February 2020 and will be presented by the QI Administrator to the PIHP Quality Committee and DVHA's Senior Leadership Team in March 2020.

- HEDIS measure production – In 2019, the Quality Unit staff worked with the Business Office, Payment Reform Unit and Data Unit to extend and amend the contract with Cotiviti, the HEDIS measure production vendor. In addition to producing administrative (claims based) measures, the Quality Unit began preparing for the HEDIS 2020 season by requested that Cotiviti perform medical record retrieval for five hybrid measures and abstraction for one of those measures. DVHA clinicians will abstract the other four measures. Quality Unit staff spearheaded

conversations with staff from Vermont Information Technology Leaders (VITL) in 2019 to explore using the data stored in the Vermont Health Information Exchange (VHIE) for hybrid measure production in the future. Initial system testing will be performed in CY 2020.

Results Based Accountability (RBA)/Process Improvement

Results Based Accountability (RBA) scorecards are being developed at DVHA for both internal and external performance management purposes. The use of this performance management framework and corresponding presentation tool has been spearheaded by the Agency's Central Office QI staff. The DVHA Quality Unit staff received training and has used this tool to create a Global Commitment Core Measure scorecard, Experience of Care, and other performance budgeting scorecards. Additional scorecards that were newly developed or actively maintained in 2019 include the following: Early and Periodic Screening, Diagnostic and Treatment (EPSDT), DVHA Strategic Priorities, GC/Delivery System Related Investments, Payment Reform Models, and an overall DVHA performance accountability scorecard - which includes key performance measures for each unit within the Department for use by the Management Team to evaluate programs and services.

Quality Unit staff also maintained their Green Belt status during 2019. Green Belt is the highest level of internal training offered through the State based on LEAN/RBA principles. The trainings are centered around process improvement and contribute to the Governor's initiative called PIVOT, or Program to Improve Vermont Outcomes Together.

Vermont Next Generation Medicaid ACO

Throughout 2019 (Year 3 of the DVHA/VMNG ACO contract) the Quality Unit staff received, reviewed and approved quarterly VMNG ACO quality management reports. Quality and Clinical staff from DVHA and the VMNG ACO also met quarterly during 2019 with a focus on quality measurement and ongoing QI efforts.

AHS Performance Accountability Committee

During this year, the AHS Performance Accountability Committee (PAC) reviewed the Global Commitment to Health Comprehensive Quality Strategy (CQS)/Statewide Transition Plan (STP). In addition to serving as a blueprint or road map for Vermont and its "contracted health plan" in assessing the quality of care that beneficiaries receive, the CQS also demonstrates the state's compliance with the new HCBS settings rules and serves as its Statewide Transition Plan (STP). The group's attention focused on the following sections: performance measures, performance framework, healthcare reform efforts including payment models, and improvements. Feedback from AHS stakeholders was incorporated into the document. The updated strategy/plan will be posted for public comment during the next quarter.

Also during this year, the PAC reviewed the current GC Investment and Payment Model scorecards that are used to communicate the performance of programs/services that use GC investment funding as well as payment models. Group discussions centered on the use of the Clear Impact Scorecard and how it might be modified to address the GC investment and payment model reporting needs.

In addition, the group reviewed the AHS Oversight and Monitoring Framework that was proposed in the Program Integrity Monitoring Standard Operating Procedure (SOP). The framework identifies the structures, processes, and tools associated with oversight and monitoring. Feedback from the group was incorporated into the document.

Finally, during this year, the group reviewed AHS Data Governance activities and discussed how performance measures could be used to assess the performance of the initiative as well as the implementation of individual policies. In addition to discussing the deliverables and timelines associated with the program, the group continued to craft recommended roles/responsibilities that they might play with program implementation. Much of the conversation continues to focus on how the group might leverage monitoring performance competencies to support DG activities.

Global Commitment (GC) Investment Review

During this year, each department continued to submit financial monitoring data to AHS and evaluative data that highlights the performance of a subset of their investments following an agreed upon schedule. Evaluative data continues to be reported using a Clear Impact GC Investment Scorecards and includes the following data elements: investment description (i.e., the goal of the investment, the activities being supported, and information on how they are provided), performance measures (i.e., the data being collected and analyzed to determine if the investment is achieving its desired goal), results (performance measure rates for most recent reporting period), and an interpretation of the results (i.e., comparing actual to expected rates using performance targets and/or benchmarks and to characterize trends or patterns in the data). The schedule for Monitoring and Evaluation of investments was updated for the year to come – but will continue following a similar cadence. All Departments will continue to highlight the performance of at least one of their investments in the Quarterly/Annual report.
During this most recent quarter, DVHA highlighted the performance of its investment related to Institutions for Mental Disease. The Clear Impact Scorecard for this DVHA investment is included in this report as Attachment 7. Payment Models & Performance Monitoring

During the year, the AHS QIM reviewed the CMS quality criteria and framework sections of the payment model preprints for payment models that were due for renewal. Edits were suggested to ensure that the payment arrangement advances at least one of the goals/objectives of the Comprehensive Quality Strategy (CQS) and that there was a corresponding evaluation plan which measures the degree to which the payment arrangement advanced the CQS goals/objectives.

AHS Departments are required to monitor and evaluate the performance of their payment models on an ongoing basis and subject them to formal review according to a periodic schedule. Performance monitoring is accomplished via a quarterly and annual review of payment model performance information contained in a web browser-based software application (Clear Impact Scorecard).

During this most recent quarter, DMH highlighted the performance of its Integrating Family Services (IFS) payment model. The Clear Impact Scorecard for this payment model is included in this report as Attachment 8.

Comprehensive Quality Strategy (CQS)/State Transition Plan (STP)

During this year, the Vermont HCBS implementation team continued to implement the settings assessment and validation activities associated with the STP. On August 1, 2019, the State learned that their survey vendor, SurveyGizmo inadvertently deleted/disabled their account – which ultimately resulted in the loss of all of the program provider self-assessment and member validation surveys and their associated data. The unintentional loss of data resulted in rework that not only impacted the state's ability to complete the STP submission milestone by the originally anticipated due date – but it also impacted the state's ability to meet due dates for other dependent Milestones. The state notified CMS of the incident and was granted a 6-month extension on all impacted Milestones. The group anticipates the provider self-assessments and validation activates to be completed by the first quarter of the 2020. Once

this work is done, aggregate results for all setting will be incorporated into the final version of the STP and released for public comment.

Global Commitment (GC) Evaluation Activities (including SUD and SMI/SED)

During this year, the AHS QIM continued to work with an independent evaluator to conduct the evaluation activities outlined in the evaluation design. This includes the data collection needed to support the testing of general and SUD-related hypotheses.

In December of this past year, CMS approved an amendment to Vermont's Global Commitment to Health Demonstration to include authority for inpatient services provided to Medicaid eligible beneficiaries while residing in IMDs for diagnoses of Serious Mental Illness (SMI) and/or Serious Emotional Disturbance (SED). In order to respond to the evaluation requirements of the SMI/SED waiver, the GC evaluation contract was amended to add payment provisions and their associated dollar amounts. During the first two quarters of 2020, Vermont will work with its evaluation contractor to modify the existing waiver evaluation design/plan to incorporate the new SMI/SED components/requirements. An updated GC evaluation design is due to CMS 180 days after the approval of the amendment.

iii. Provider and Member Relations

Key updates:

- Provider Management Module (PMM) Certification
- Payment Error Rate Measurement (PERM) Audit

The Provider and Member Relations (PMR) Unit ensures beneficiaries have access to appropriate health care for their medical, dental, and mental health needs. The PMR Unit monitors the adequacy of the Green Mountain Care (GMC) network of providers and is responsible for implementation of the enrollment, screening, and revalidation of providers in accordance with 42 CFR §455.410 and §455.450 requiring that all participating providers be screened upon initial enrollment and revalidation of enrollment.

The PMR Unit also collaborates with GMC's Customer Support Center to better address and assess GMC member issues and needs.

Provider Management Module (PMM) Certification

The Provider Management Team presentation to CMS for Certification of the Provider Management Module was conducted onsite on Thursday, November 21, 2019. CMS walked away with three action items for the team and offered high accolades to the team on preparedness, as well as kudos for a well-done system. Provider Member Relations is expecting the response letter for certification within in the next 60 days.

On December 4th and 5th, three members from Puerto Rico's Medicaid Team came to Vermont to view the Provider Management Module (PMM) and learn best practices. The Vermont team reviewed the module, discussed lessons learned and best practices. Puerto Rico will be going live with their Provider Management Module in April 2020 and Vermont advised that the team was available to assist and answer questions.

Finally, both Virginia and Maine are scheduling time to talk with PMR about the Provider Management Module in the next month. Provider Member Relations continues to work with other departments, such as the Blueprint, to use the PMM for additional departmental needs to ensure the department has a single source for provider information.

Payment Error Rate Measurement (PERM) Audit

The PERM Auditors were on site in late October and early November 2019 to review systems and ensure that DVHA is enrolling providers correctly as well as processing claims. On site visits went well and PMR staff continue to work with CMS and their contracted entities: AdvanceMed, The Lewin Group, and Booz Allen Hamilton. PMR will send information in lieu of a second on-site visit in February 2020. PMR continues to work with providers to ensure their compliance with sending in requested medical record documentation. Providers that are included in the audit are selected based on a claims sample drawn by CMS from DVHA's universe of Medicaid claims data. The universe includes claims data between July 1, 2018 through June 30, 2019. Providers selected in the sample are required to submit medical record and adjoining documentation on their claims. Selected providers are required to participate, as stated in their signed General Provider Agreement with DVHA. Providers have 30 days from the date of receipt of notice to submit required claims medical records and adjoining documents to AdvanceMed. Providers have 7 days from the date of receipt of notice of request for additional information to submit additional claims documentation for inaccurate medical record and adjoining documents to AdvanceMed.

DVHA will enforce a 10% withholding of all VT Medicaid payments for all providers that do not submit the required medical records and adjoining documents within 30 days or the additional documentation within 7 days, until the issue is resolved. We continue to have a high response rate and to date have not had to enforce any withhold.

V. Cost Containment Initiatives

i. Vermont Chronic Care Initiative (VCCI)

Key updates:

- Alignment of VCCI with state health care reform and ACO.
- Enhanced VCCI Population
- Hospital service utilization for members enrolled during 2018 demonstrates decrease one-year post enrollment of inpatient, emergency department, and on 30-day readmissions.
- The AHS MMIS Enterprise Care Management System received CMS certification.
- Working on bidirectional interface with VITL of 2020

The VCCI provides case management services to Medicaid beneficiaries throughout each of the fourteen counties in Vermont. The VCCI team is comprised of licensed, field-based case managers who provide clinical case management services to the complex beneficiaries within the communities they serve, utilizing their knowledge of their communities and culture and of their health and health related providers and resources. Two non-licensed professional staff complement the team, with their primary role as outreach to those members new to the health plan. This past year, VCCI continued efforts toward improved alignment with health care reform and the system of care; formalizing its shift from historically serving only those who were predicted to be high cost/high risk to needs based eligibility and outreach screening. The VCCI team delivers short term, intensive case management to beneficiaries with complex

health needs; meeting with them face to face. Perhaps it is the person who is homeless, who has alcohol abuse disorder, who utilizes the ED for wound care/infection control and does not have a primary care provider. It could also be someone who was just discharged from the hospital, without primary care establishment and with unstable housing. Face to face visits can occur at the homeless camp, or at shelters, in beneficiaries' homes, at provider co visits or at motel – it can change from one visit to another even with the same beneficiary. In alignment with the ACO model, the VCCI implements the complex care model, utilizing patient engagement tools, pulling together care teams and helping beneficiary in the identification of a long-term lead care coordinator. In addition to the beneficiary, potential care team members may include primary care providers, hospital case managers, community and designated mental health agency providers, AHS partners such as Economic Services Division and Employment Specialists. Lead Care Coordinators help to support the member in leading with his/her goal setting and in the development of the shared care plan. The Lead Care Coordinator facilitates care team meetings and ensures communication continues across the care team. VCCI case managers may be the beneficiary selected Lead Care Coordinator, but only for time enough to ensure beneficiary status is stabilized and member able to identify a long- term Lead Care Coordinator.

	SFY19						SFY20						
	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20
Measure	02/15/19	03/15/19	04/15/19	05/15/19	06/15/19	07/15/19	08/15/19	09/17/19	10/15/19	11/15/19	12/15/19	01/15/20	02/15/20
# new VCCI eligible members enrolled monthly in care management	70	87	80	78	82	61	58	40	58	56	43	46	
% of VCCI enrolled members with a face to face visit during the month	77.5%	68.3%	74.6%	82.1%	79.1%	73.7%	80.6%	63.8%	58.9%	66.2%	62.3%	60.7%	

Another population the VCCI team has supported this past year, are beneficiaries new to the health plan. with case managers completing telephonic outreach completing a screening tool that screens for access to primary care, health conditions and risky behaviors, and social determinants of health. The goal is to orient the beneficiary to the system of care, including navigating services for health and health-related needs such as facilitating access to primary and dental care, to housing/food security resources, to tobacco cessation services, and facilitating connections to local domestic violence resources, Beneficiaries' responses to screening questions coupled with the clinical judgment of VCCI case managers allows stratification into 1 of 4 risk levels – mirroring the ACO's framework. If a member is stratified as Risk 3 or higher, the beneficiary is offered VCCI case management services for the short-term community-based case management services, described above, for the initial stabilization and implementation of the complex care model.

Old Dates-Month reported	Jul-19	Aug-19	Sep-19	Oct-19		
Old due Dates	8/15/2019	9/15/2019	10/15/2019	11/15/2019		
Updated Dates - month reported		Jun-19	Jul-19	Aug-19	Sep-19	Oct-19
received from data unit		7/15/2019	8/15/2019	9/15/2019	10/15/2019	11/15/2019
Updated Dates - due date		10/15/2019	11/15/2019	12/15/2019	1/15/2020	2/15/2020
# of new to Medicaid members	307	367	419	432	360	364
# of new to Medicaid members reached	129	76	87	76	91	83
# of new to Medicaid members screened	110	111	163	145	115	117
% of new to Medicaid members screened	35.83%	30.25%	38.90%	33.56%	31.94%	32.14%

Figure 1. VCCI Screening

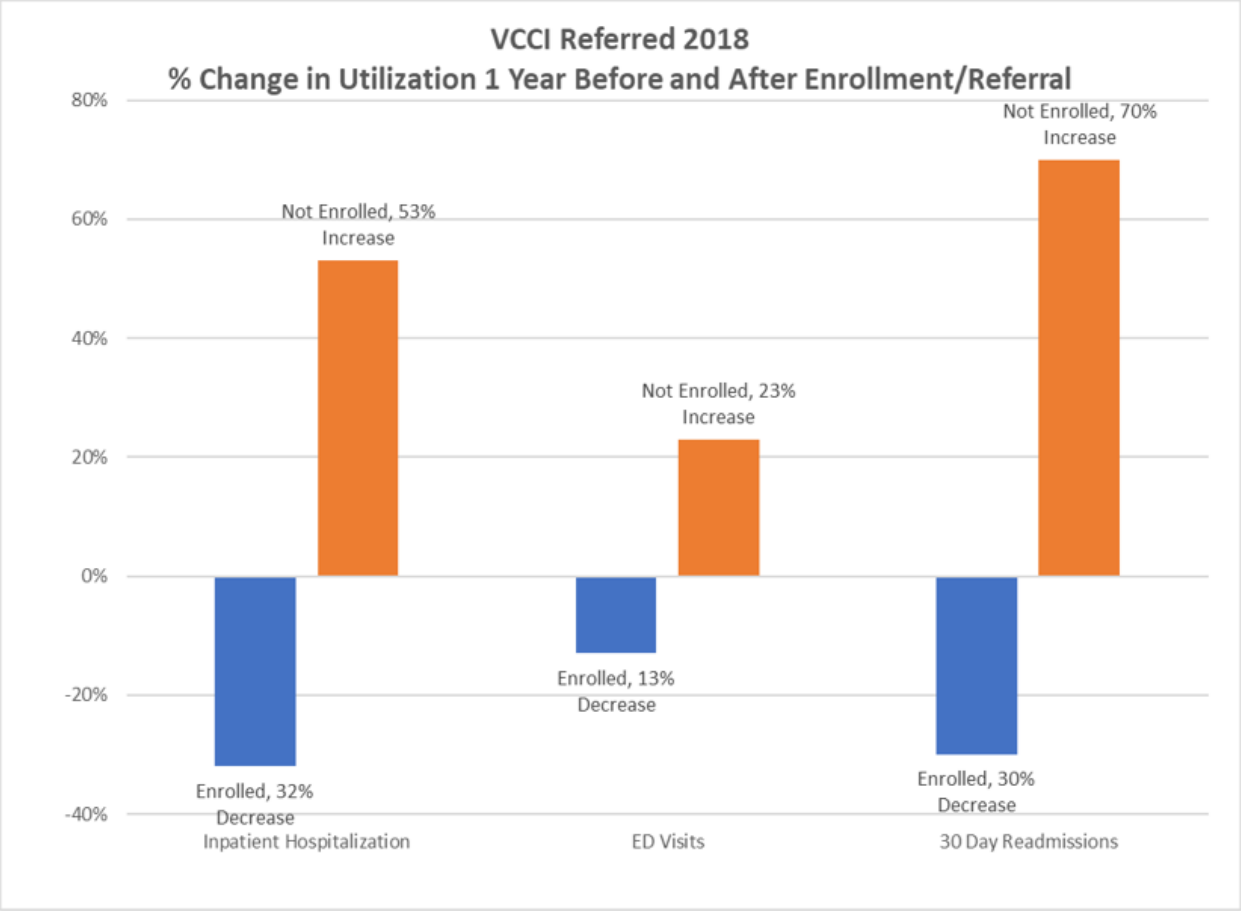
In the Spring of 2019, the VCCI team supported the St. Johnsbury community in an expanded ACO attribution pilot with goal of ensuring the care is the same for the entire population. The beneficiary cohort the VCCI local team outreached had been on the health plan, but without any evidence of claims. The St. Johnsbury VCCI team utilized the screening used on the outreach to those new to the health plan;

with same goal of facilitating access to primary care and dental, along with other health and health related services the beneficiary identified as a need. 275 members were assigned: 67 screened. Through screenings with beneficiaries, some were identified as medically complex and referred to community VCCI case manager for further clinical assessment and to begin to pull together a care team to help wrap community resources, following a shared care plan, to help the beneficiary stabilized and improve health and quality of life. To help operationalize the complex care model delivery alongside community care teams, our local VCCI team was granted access and received training on/in Care Navigator - communication platform used by our Vermont ACO – OCV. This helped to support VCCI being identified as part of care team, allowed VCCI to upload shared care plans and provided mechanism for communication with the other care team members.

The VCCI approaches case management from the lens that a holistic model of service delivery to encompass both health and health related issues helps to support likelihood of sustained health improvement and overall quality of life. Assessment of the presence of social determinants of health occurs early in VCCI's outreach and work, followed by appropriate referrals and navigation to services. In addition to the experience out in the field, VCCI case managers easily navigate the web of various state services available to Vermonters. Over this upcoming year, VCCI will continue to work and coach community partners to transfer this knowledge and provide support as needed so that navigational assistance for beneficiaries will be seamless.

Available data demonstrated continued reduction in hospital service utilization among beneficiaries referred to VCCI with recent data showing sustained change.

Figure 2. Change in Utilization 1 Year Before & After VCCI Enrollment/Referral



The eQHealth care management system utilized by VCCI for daily operations and programmatic reports is now CMS certified – making eQHealth the only CMS certified case management system.
This past year marks the 4thyear that the VCCI team has been functional in the eQHealth care management system. eQHealth supported the VCCI's program evolution and population enhancement by way of:

- Interface for the VITL data;
- ADT messaging through VITL;

Data from the Health Information Exchange is now part of the beneficiary record in eQHealth. This data includes ADT messages, lab data, vaccination data and care documents for those facilities that are sending the data through the VHIE interface. This data allows for more comprehensive, medically focused care management.

ii. Behavioral Health Services

Key updates:

- Applied Behavior Analysis
- Team Care program revitalized

The Behavioral Health Team is responsible for concurrent review and authorization of inpatient psychiatric and detoxification services for Medicaid primary beneficiaries. Team members work closely with discharge planners at inpatient facilities to ensure timely and appropriate discharge plans. DVHA collaborates with other departments to support coordination of care. The team refers members to VCCI services and helps ensure continuity of care for beneficiaries already enrolled with VCCI admitted to inpatient or residential care facilities. In recognition of the inherent challenges in providing strong clinical documentation to justify admission and continued stay within 24 hours of admission, over the past two years DVHA has engaged in a pilot project in which there is automatic initial authorization of 5 days for all beneficiaries meeting the acute level of care criteria at the Brattleboro Retreat. This practice allows time for the assessment and formulation of an individualized plan of care and discharge plan for each beneficiary admitted. The team has engaged in quarterly reviews of admissions of 5 days or less to determine whether authorization would have been given without the pilot. For each quarter greater than 90% of the admissions and stays would have been authorized with strict adherence to the criteria.

The Behavioral Health Team also manages the Team Care program. Team Care can be a useful tool for members who may need additional support getting the most appropriate healthcare available to meet their needs. Clinical review of all available data supports continued review of current enrollees' need to remain in the program. Standards for inclusion and removal have been operationalized by the team. A new procedure for inclusion, screening tool, and a manual have been developed. Team Care program beneficiaries are also referred to VCCI when appropriate. Outreach with providers and pharmacies is ongoing, an outward facing brochure for Providers has been created and an internal and outward facing educational campaign on the Team Care program has been developed. There have been minimal referrals to the program. The lack of referrals may demonstrate success of the Vermont Prescription Monitoring System (VPMS) and new opiate rules associated with VPMS. Team members participate in the SFI Interagency Team and the Youth Service System Enhancement Council (a collaborative with ADAP, DMH, VCRIP, Vocation Rehabilitation, DCF, and more). Team members are active in ensuring that beneficiaries with multi-department involvement are getting appropriate services delivered in the most efficient manner. This is accomplished through participation in state interagency team meetings, the Mobile Crisis Response Initiative, by attending monthly CRC meetings, participating in weekly case review, and development of protocols for cross departmental service delivery. Our unit worked with other

departments on developing a system to notify DVHA regarding all children with Medicaid that are awaiting placement in Emergency Departments in order for DVHA to assist with placements when needed.

After two years of working with the DVHA Payment Reform and Policy Units, the Applied Behavior Analysis case rate payment methodology became effective on 07/01/2019. The goal of this payment reform project was to increase utilization and access to services. Since the initiation of the case rate, we have seen an increase in new members that have begun receiving ABA services. In 2019, two new agencies that provide ABA services enrolled with Vermont Medicaid and began serving members. We are currently working with Payment Reform, Policy, and the Business Unit to develop a reconciliation process that will begin in January 2020 for dates of service July 1, 2019 through December 31, 2019.

Yearly surveys have been sent to Medicaid members who are receiving ABA services. The purpose of this survey is to gain feedback of the effectiveness of ABA treatment. We use the feedback in our unit Scorecard and compare feedback from years past.

The Autism Specialist participates in the Autism Workgroup, which happens on a bi-monthly basis and includes community partners, including several ABA providers across the State. This meeting gives ABA providers the opportunity to ask questions and allows them to provide feedback directly to the Autism Specialist.

The unit Autism Specialist will be conducting bi-annual site visits/audits with ABA providers who are enrolled with Vermont Medicaid and providing services to Medicaid members. Site visits began in January 2020. The purpose of these visits/audits is to assure that members are receiving quality care, that providers are accurately reimbursed for services that they are providing, assuring that required documentation is included in members charts, and that documentation of services is being completed and is thorough and of quality.

The Applied Behavior Analysis Clinical Practice Guidelines as well as the ABA Medicaid Policy have been revised and are available to providers. Changes to the benefit with the case rate becoming effective in July 2019 are reflected.

The Quality team has partnered with VCCI to assist in conducting 'Initial Screening Birth to 18 Years' survey. Our unit attended a training with VCCI in early 2020 and has begun surveying members/guardians. This will be an ongoing project throughout the year that our team will be assisting.

iii. Mental Health System of Care

Key updates:

- The Department of Mental Health initiated payment reform for its Child and Adult Mental Health programming
- Integrating Family Services Activity
- Release of DMH 10-Year Plan | Vision 2030: An Integrated and Holistic System of Care

The Department of Mental Health is responsible for mental health services provided under state funding to special-needs populations including children with serious emotional disturbances (SED) and adults with severe and persistent mental illnesses (SPMI). Funding is provided through the Vermont Agency of

Human Services (AHS) Master Grants to ten Designated Agencies and two Specialized Service Agencies. These agencies are located across the state of Vermont for the provision of

- Community Rehabilitation and Treatment (CRT) services for adults with severe and persistent mental illness;
- Adult Outpatient for adults who are experiencing emotional or behavioral distress severe enough to disrupt their lives but who do not have long-term disabling conditions;
- Emergency Services for anyone, regardless of age, in a mental-health crisis; and
- Children, Youth, and Family Services, including children who have a serious emotional disturbance and their families.

The Department also contracts with several peer and family-run organizations to provide additional support and education for peers and family members who are seeking supplemental or alternative supports outside of the Designated Agencies in their catchment area. Peer and family-run organizations also help educate individuals and families to advocate for their needs within the Designated Agencies and across multiple service provider organizations.

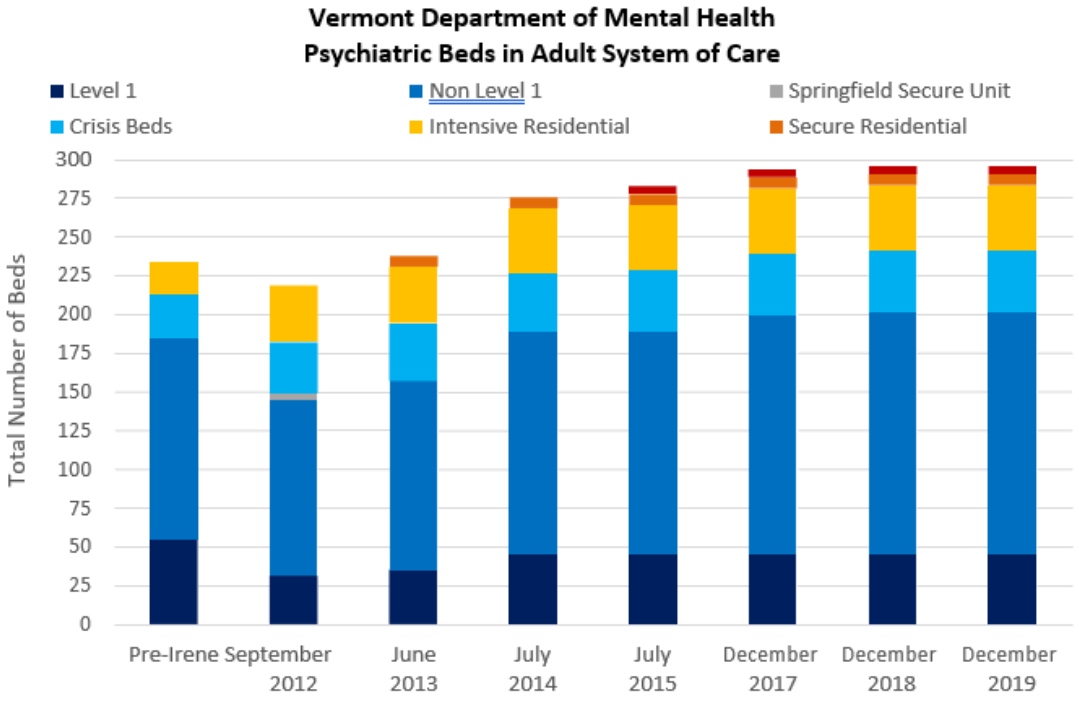
Inpatient care is provided through a decentralized system which includes one state-run psychiatric care hospital and five Designated Hospitals located across the state.

Community services support hospital diversion through expanded crisis services and increased residential treatment using the least restrictive setting that is appropriate for the level of care required. In many cases, treatment can be provided closer to individuals' homes.

Enhancements of the Mental Health System of Care through DMH:

<u>Hospital Services</u>

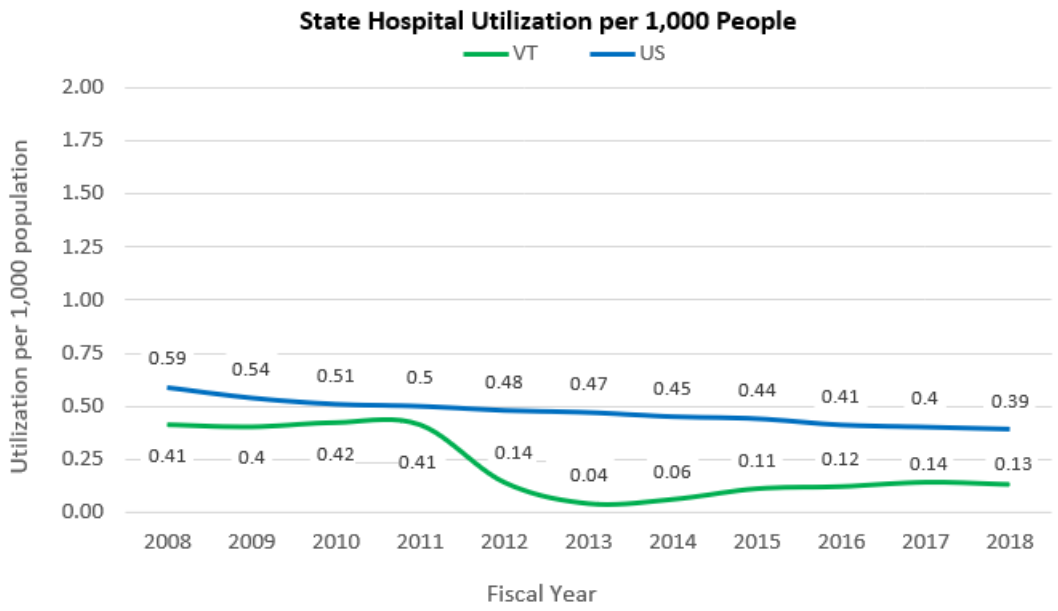
- There are 45 Level 1 beds and a total of 199 adult psychiatric inpatient beds across the system of care
- The Designation of White River Junction VA Medical Center added 10 adult inpatient beds to the system of care at last report. As of December 2018, the VA Medical Center increased to 12 psychiatric inpatient beds and continues to allocate two to three beds for involuntary care for Veterans.
- Act 190 (2018) provided $5.5 million dollars for the development of 12 inpatient Level I beds at the Brattleboro Retreat. Additional inpatient bed capacity is currently anticipated to come online in 2020.



Adult inpatient bed occupancy decreased slightly in 2018 and has remained level in 2019 (see Fig. 2). During FY 2019, involuntary inpatient lengths of stays have seen an upward trend from the two preceding fiscal years. Readmission rates were relatively unchanged, a trend that remains below the national readmission rate trends. Additionally, adults being referred to involuntary inpatient care remained elevated consistent with the prior year's report.

DMH also compares the utilization of its system of care to national benchmarks. The following two charts provide information on Vermont utilization as compared to national benchmarks. Data from these two charts are calculated by the Substance Abuse and Mental Health Services Administration's (SAMSHA) Uniform Reporting System (URS), which generates the National Outcomes Measures (NOMs). FY 2018 is the most recent data available.

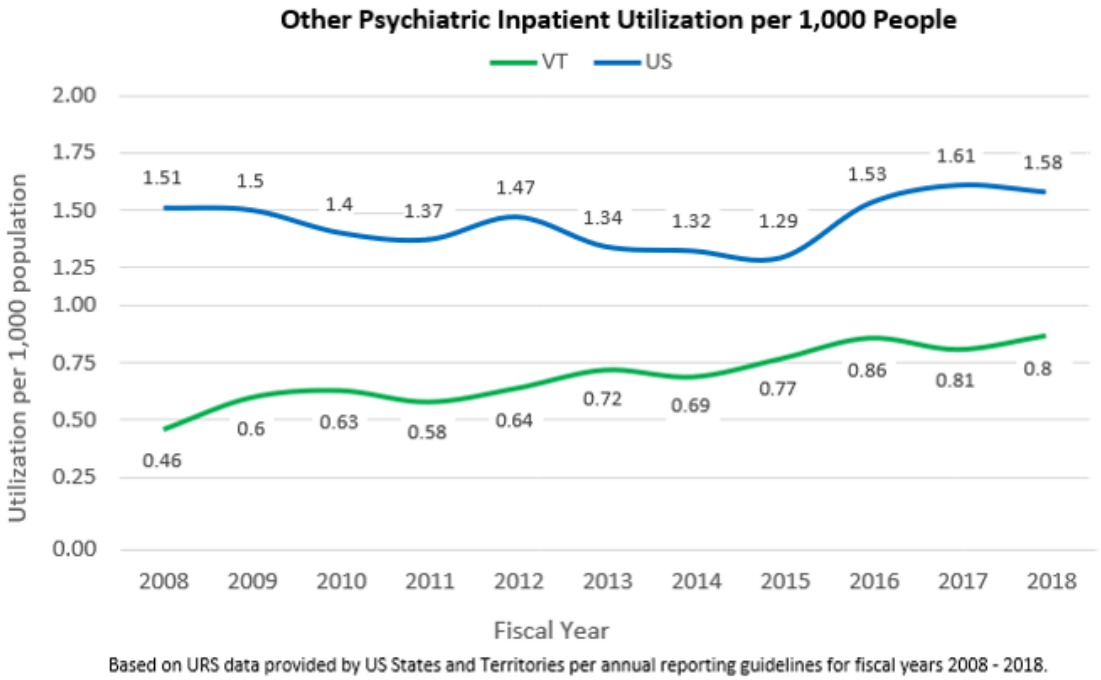
Figure 3. State Hospital Utilization per 1,000 people (in Vermont and the United States)



Based on URS data provided by US States and Territories per annual reporting guidelines for fiscal years 2008 - 2018.

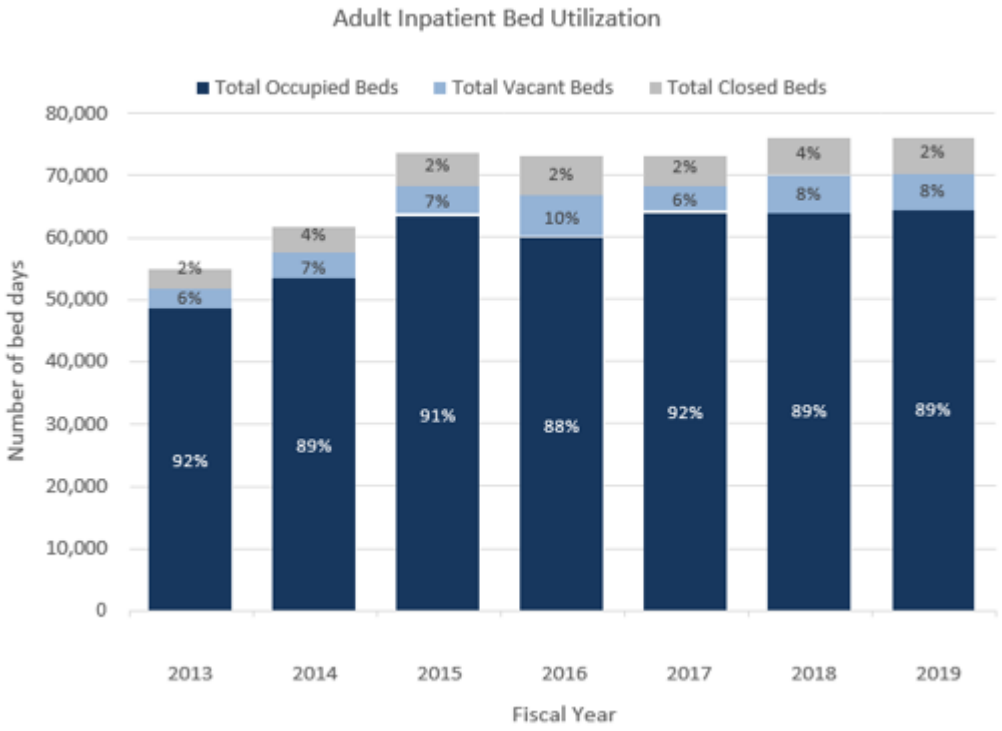
The national rate of state hospital utilization continues to decline year-over-year. Vermont Psychiatric Care Hospital opened in FY 2015 with 25 beds and Vermont's rate of inpatient utilization continues to be lower than the national average in the United States. The significant decrease from FY 2011 to FY 2012 represents the closure of Vermont State Hospital due to flooding from Tropical Storm Irene in August 2011. The Vermont hospital utilization data is showing a slowly progressing upward trend since 2012. Vermont is one of a handful of states that only has one state hospital. Nationally, the number of state hospital beds and residents at the end of the year has been steadily decreasing.

Figure 4. Other Psychiatric Hospital Utilization per 1,000 people (in Vermont and the United States)



Other involuntary psychiatric hospital unit admissions, such as those at Designated Hospitals, are included in chart above. The national rate of psychiatric hospital utilization since 2008 has generally declined year-over year through 2016 while Vermont's rate of utilization has increased. However, in both 2017 and 2018 there have been substantial increases in national utilization of psychiatric hospital beds. Vermont experienced a slight decline in 2017. Inpatient utilization is still below the national averages while rates of community services utilization in Vermont continues to be markedly higher than national averages (Community Utilization per 1,000 Populations).

Figure 5. Adult Inpatient Utilization and Bed Closures



This chart depicts the total bed day capacity across the Vermont Designated Hospital system through FY 2019. The total bed day availability across the system has remained relatively constant in 2018 and 2019 with new bed capacity coming online in 2020. In 2019, bed closures represented 2% of adult inpatient utilization. Vacant beds have remained consistent at 8% in the two most recent years and have fluctuated between a low of 6% (2013, 2017) and a high of 10% in 2016. Adult inpatient bed utilization has remained consistently at 88% or above during this seven-year period. The Department, in concert with the Designated Hospitals, works to maximize utilization of inpatient beds through the bed board system.

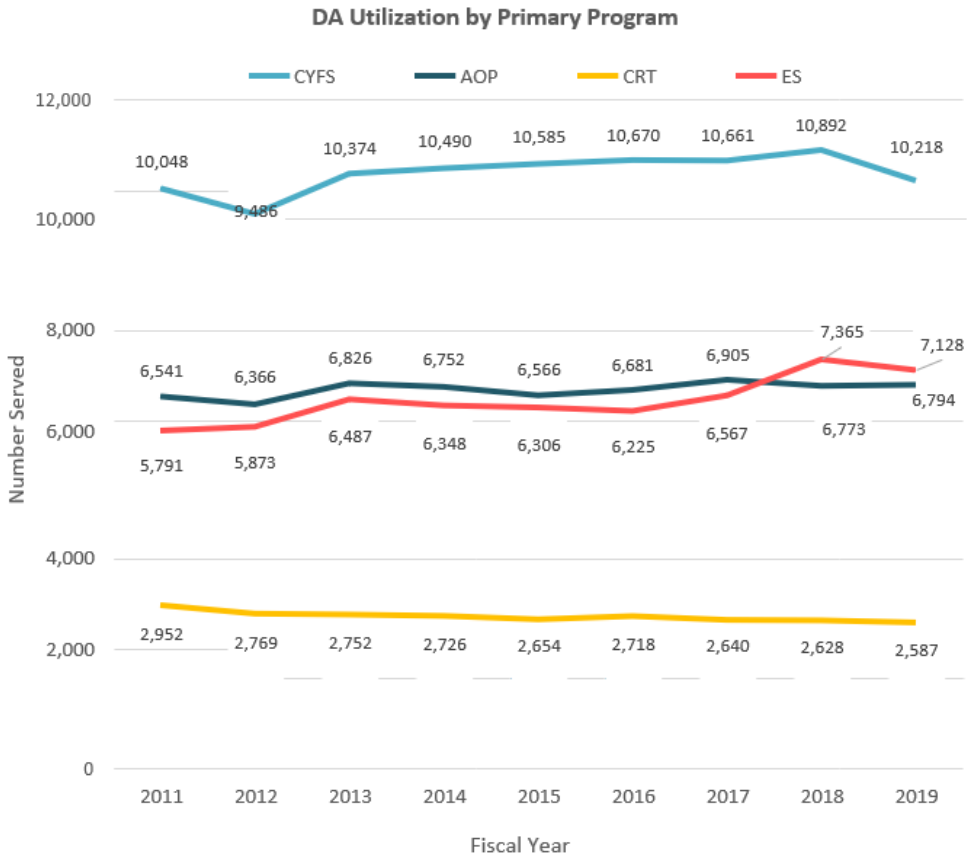
Community Services

- Establish Community Outreach Team in Washington County (Collaboration with Public Safety)
- Increased capacity within Community Rehabilitation and Treatment and peer programs to provide community support, outreach, and crisis response continues to develop
- Broad utilization of non-categorical case management services for Adult Outpatient and Emergency Services programs
- Increased capacity to provide mobile crisis responses to those needing screening and intervention in the community
- Increased and additional training for Team Two collaboration between law enforcement and mental health responders
- Additional availability of soft-restraints for law enforcement transports for mental health hospitalizations
- Resources to assist individuals in finding and keeping stable housing
- Expansion of warmline hours

Enhanced community services funding provided by the legislature through increased appropriations to key mental health programs in the community over the last several years has helped, but staff recruitment and retention necessary to meet and expand these service capacities continues to be a struggle. The payment reform initiative beginning 1/1/2019 has also been an effort to reduce barriers to access and promote more “needs” driven service delivery that can be more responsive to individuals seeking mental health services. The new payment reform methodology, more flexible service delivery, and value-based

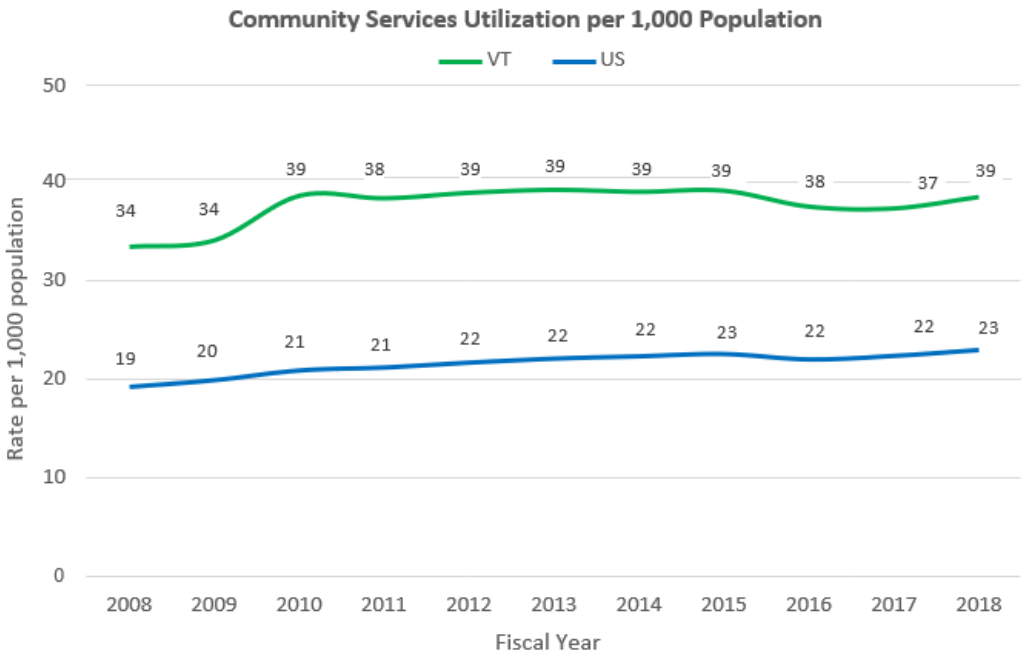
incentive payment framework focused on quality and outcomes supports a more streamlined approach to adult program access and the service capacity available in each DA catchment area.

Figure 6. Designated Agency Volume by Program



The highest number of persons served by programs offered by the Designated Agencies (DAs) continues to be in services for children, youth, and families. This program has until FY 2019 shown a slow upward trend for a seven-year period with FY 2019 showing a nearly 6% decrease in numbers serve. The Emergency services Programs also experienced a slow upward progression over a number of years and likewise demonstrated a slight decline in FY 2019 of just 3%. Adult Outpatient programs remain reasonably level in performance to resources available. Community Rehabilitation and Treatment (CRT) programs continue a slow overall declining trend in adults engaged in the services of this program.

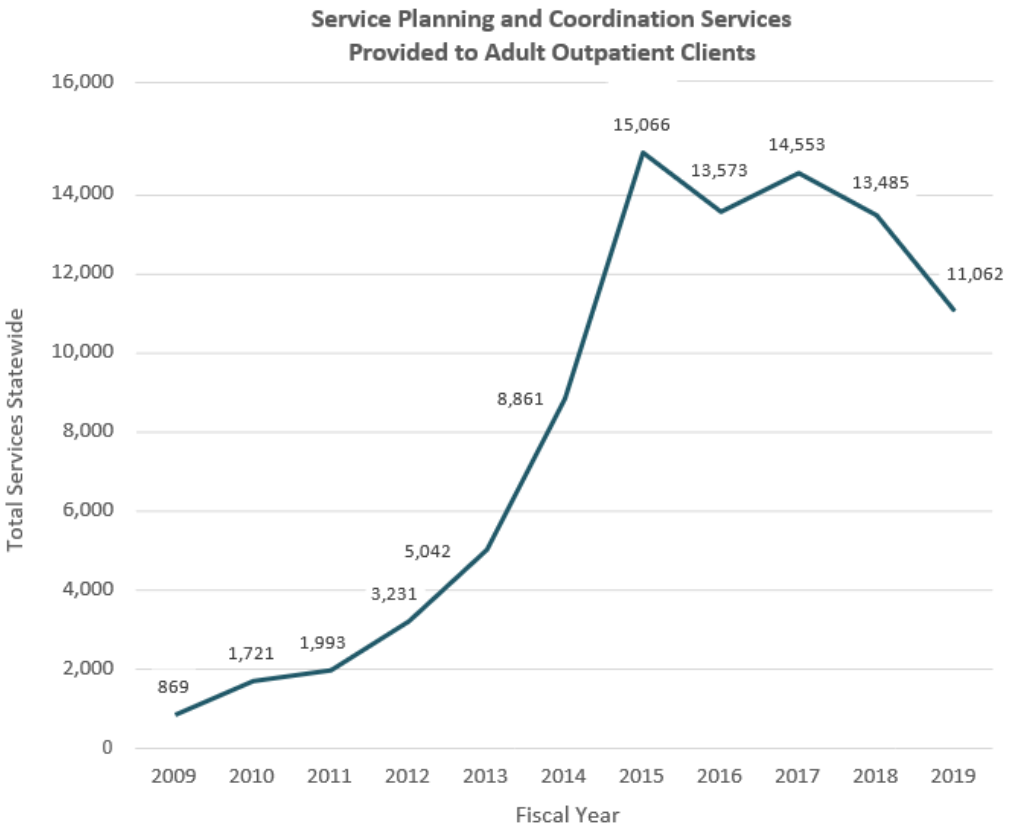
Figure 7. Community Utilization per 1,000 Populations



Based on URS data provided by US States and Territories per annual reporting guidelines for fiscal years 2008 - 2018.

The Vermont community mental health system serves nearly 40 out of every 1,000 Vermonters, which is substantially higher than the national figure. The most recent national data available through 2018 shows that Vermont has a strong and fairly consistent record of service delivery in community-based programs. While the progress appears to be static, data shown in Figure 8 below, indicates that significantly higher rates of service are being provided to fewer numbers of clients who may otherwise have needed hospital levels of care. This number however is also showing a downward trend since 2015.

Figure 8. Service Delivery: Planning and Coordination

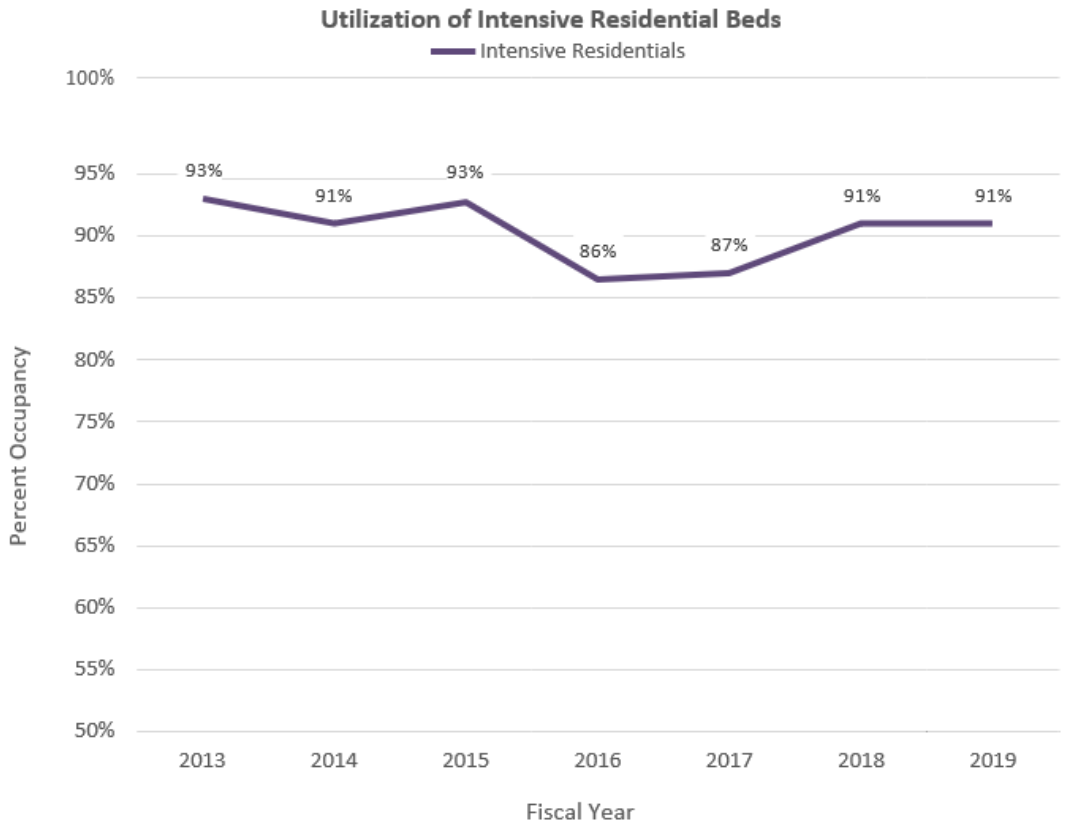


The support of non-categorical case management led to a steady increase in the number of services provided to adult outpatient clients allowing additional support to those in need but ineligible for case management through Community Rehabilitation and Treatment services through FY 2015. Levels remain elevated for this population FY 2016 through FY 2018, but the data shows a decline in recent years. It is still worth noting that the expansion of services provided for service planning and coordination has met a population need for this level of case management services for adults. The Department's payment reform launched in January 2019 continues to support flexible service delivery including case management services.

The system of care is established on the principle that the intensity of services an individual requires will change over time. Individuals receive community-based treatment appropriate to their needs and move to higher or lower levels of care only as necessary to support them. For many who have a chronic illness this is more challenging, as they continuously require higher level of service needs within the system. For others, they enter and exit intermittently depending on their individual needs. The system must have the flexibility to meet the needs of the individuals and provide the necessary services.

Residential and Transitional Services

Figure 9. Intensive Residential Bed Utilization



- Soteria, a five-bed, peer supported alternative residential program opened in Chittenden County
- Maintaining full occupancy at the secure residential recovery program, the Middlesex Therapeutic Community Residence, serving 7 individuals
    - 45 individuals served since opening
    - 67% stepped down to less restrictive facilities or independent housing
- Continued planning for permanent replacement capacity for the Secure Residential Program

The Intensive Residential Recovery Programs (IRRs) continue to meet a key need for a significant number of individuals who are ready to leave higher levels of care, but who still require intensive supervision and support before taking steps toward independent living. The chart above illustrates the utilization of beds in these programs. Fiscal year 2018 and FY 2019 reflect a plateauing of utilization at 91% with a seven-year utilization history averaging between 86-93%. The IRR programs provide both transitional and longer term supports, averaging residential program lengths of stay within a 12-18 month time frame for residents.

Performance and Reporting

- Along with AHS, DMH has adopted the Results-Based Accountability (RBA) framework for assessing performance of providers via grants and contracts
    - Creation of a "Vermont Psychiatric Care Hospital Outcomes" scorecard to meet legislative reporting requirements
    - Migration of the "DMH Snapshot" and the "DMH continued reporting" report to the RBA scorecard reporting tool
- Exploration of visualization tools to create more responsive reporting
- Participation in development of the Agency of Human Services Community profiles

- The Department of Mental Health has several RBA scorecards containing data and performance measures related to our system of care.
- To view the RBA Scorecards for the Department of Mental Health:
  http://mentalhealth.vermont.gov/reports/results-based-accountability
  The Department of Mental Health (DMH) Scorecard
  Reducing Seclusion and Restraint in Vermont's Psychiatric Hospitals
  Vermont Psychiatric Care Hospital (VPCH) Outcomes
  DMH System Snapshot
  DMH Continued Reporting

Regulation and Guidance

- Revision of the Designated Hospital Manual and Standards to better reflect the scope of review and designation and creation of a designation protocol to efficiently manage the process
- Revision of the Minimum Standards Chart Review tool for Designated Agencies to align with the Mental Health Payment Reform Manual
- Creation of involuntary transportation manual to consolidate the expectations of the department into a single document
- Revision of the emergency services standards

Payment Reform

DMH continues to work on payment reform, building off the Medicaid Pathways work and aligning necessary changes in the provider system with the All-Payer Model. The Department is working toward having several—if not all—children's mental health programs in a model similar to Integrating Family Services. Work is underway on a similar initiative for adult mental health services. The goal of this work is to move toward a simple, but accountable system that reduces the complexities of payment and shifts the focus of the providers and the department on outcomes and quality. DMH is committed to reforming the system to better serve Vermont's population and continue to move towards full integration.

Integrating Family Services

The initial IFS implementation site in Addison County began on July 1, 2012, and the second pilot region in Franklin/Grand Isle counties began on April 1, 2014. These pilots included consolidation of over 30 state and federal funding streams into one unified whole through one AHS Master Grant agreement. The State created an annual aggregate spending cap for two providers in Addison County (the Designated Agency and the Parent Child Center) and one in Franklin/Grand Isle (this provider is both the Designated Agency and Parent Child Center). This has created a seamless system of care to ensure no duplication of services for children and families.

Beginning on January 1, 2019, the IFS sites became aligned with larger payment reform efforts occurring across AHS including having incentives tied to them in alignment with statewide implementation. At the same time, IFS regions have additional requirements for performance measurement in accordance with the broader scope of services included in those regions. Vermont submitted a multiyear payment model for consideration to CMS in September 2018 and received approval in late December.

Both IFS regions have been utilizing the Child and Adolescent Needs and Strengths (CANS) to look at the needs and strengths of children they are serving. The agencies are using this progress monitoring tool to track progress over time. They are showing that through supports and services children/youth are increasing in their strengths and decreasing needs. The caveat to this is that for children involved in the child welfare system it is taking longer to see positive results; not surprising given the fact that these children experience high levels of trauma, exposure to substances, and/or abuse and neglect—this data also follows national trends in data analysis for this subset of the population. A team of three (one from a Designated Agency and two from the Department of Mental Health) recently attended the annual National CANS conference and presented on the implementation of CANS in Vermont and shared data.

Vision 2030

Through summer, fall, and early winter 2019, DMH has been engaging in a public planning and development process, soliciting stakeholder involvement and feedback as an integral part of planning. The Plan, "Vision 2030: A 10-Year Plan for An Integrated and Holistic System of Care," will be delivered to the Vermont State Legislature in January 2020. The "Planning for the Future" section of this document outlines the work underway to move the mental health system forward.

The Vision 2030 Plan aims to provide Vermonters timely access to whole health, person-led care that achieves the Quadruple Aim of healthcare: 1) increasing the quality of care and patient experience; 2) improving population health, wellness and equity; 3) lowering per capita costs; and 4) creating a better environment for Vermont's care teams. By fully embracing an integrated system that works collectively to address population health, wellness and equity, Vermonters will have improved access to care, will be healthier and happier, and the state will realize significant economic benefits as a whole.[i]

This plan identifies eight specific Action Areas to guide mental health stakeholders toward the Quadruple Aim, with short, mid and long-term strategies recommended for each action. These recommendations reflect the expertise and input gathered during statewide listening sessions and numerous planning activities with Think Tank members and advisory committees (including persons with lived experience, legislators, care providers, state agency representatives and community members).

Vision 2030 leverages our system's current strengths to shape an integrated system of whole health—with holistic mental health promotion, prevention, recovery and care in all areas of healthcare—across every Vermont community. This requires improved coordination across sectors, between providers, community organizations and agencies. Our workforce must use the best technologies, evidence-based tools and practices for data-informed decisions, supporting systems-learning and producing measurable outcomes.

Links to materials generated throughout this process are posted at this link:

https://mentalhealth.vermont.gov/about-us/department-initiatives/10-year-planning-process- mental-health-think-tank

iv. Blueprint for Health

Key updates:

- The majority of Vermont's primary care practices are now Blueprint-participating Patient-Centered Medical Homes, as evidenced by 133 of Vermont's primary care practices are Blueprint-participating practices. The estimated total number of primary care practices operating in the state is 169, of which an estimated 148 employ more than one provider;
- Vermont continues to demonstrate increased access to medication-assisted treatment for Vermonters with opioid use disorder. As of December 2019, the number of clients enrolled in Regional Opioid Treatment Programs (OTP/Hubs) was 3,542, and the average monthly number of Medicaid beneficiaries served by Office-Based Opioid Treatment (OBOT/Spoke) programs increased to 3,276;
- Vermont continues to increase access to enhanced preventative health, psychosocial screening, and comprehensive family planning services, as evidenced by the commitment of 43 practices to participate in the Women's Health Initiative as of December 2019.

Patient-Centered Medical Home Program

The Blueprint uses national standards to drive improvements in primary care delivery and payment. The program helps primary care providers transform their practices into National Committee for Quality Assurance (NCQA)-certified Patient-Centered Medical Homes. Patient-Centered Medical Home model supports care that is patient-centered, team-based, comprehensive, coordinated, accessible, and focused on quality and safety. The model also promotes care that is provided when and where the patient needs it, and in a way that the patient understands it. Patient-Centered Medical Homes in Vermont are supported by multi-disciplinary teams of dedicated health professionals in each of the state's health service areas. These teams provide supplemental services that allow Blueprint-participating primary care practices to focus on promoting prevention, wellness, and coordinated care. The Community Health Team support primary care providers in identifying root causes of health problems, including mental health and screening for social determinants of health. They also connect patients with effective interventions, manage chronic conditions, or provide additional opportunities to support improved well-being.

Blueprint Program Managers, who are local leaders in each community, are responsible for contacting all primary care practices within their health service area to encourage, engage, and support practice participation in the Blueprint for Health and learning health system activities. Annually, Program Managers report on the remaining primary care practices in each region that have not begun the process of transforming their practice into Patient-Centered Medical Homes and indicate the rationale provided by each practice contact. Importantly, Blueprint Program Managers report very few practices in each health service area remaining who are not currently engaged with the Blueprint for Health program. In addition to Program Managers, the Blueprint further supports participating practice with a quality improvement coach, called a Quality Improvement Facilitator. Quality Improvement Facilitators bring Blueprint generated all-payer data about practice performance (Blueprint Practice Profiles, Blueprint Community Health Profiles) and their own training and expertise in process improvement methodologies (such as Clinical Microsystems, Model for Improvement, and Lean process improvement). Quality Improvement Facilitators initially help launch patient-centered practices and secure NCQA Patient-Centered Medical Home recognition. After recognition is achieved, the facilitators regularly return to help with quality

improvement efforts related to panel management and outreach, care coordination, promotion of individual health and wellness, chronic condition management, and ongoing practice transformation in alignment with State-led health care reform priorities. These include:

- focusing quality improvement activities on All Payer Model agreement and Accountable Care Organization quality measures;
- team-based care;
- implementation of new initiatives (e.g. Spoke program, Women's Health Initiative, improving opioid prescribing patterns);
- prevention and management of chronic conditions (e.g. for diabetes and hypertension through connections with learning collaboratives, self-management programs, health coaches, registered dieticians, and care management).

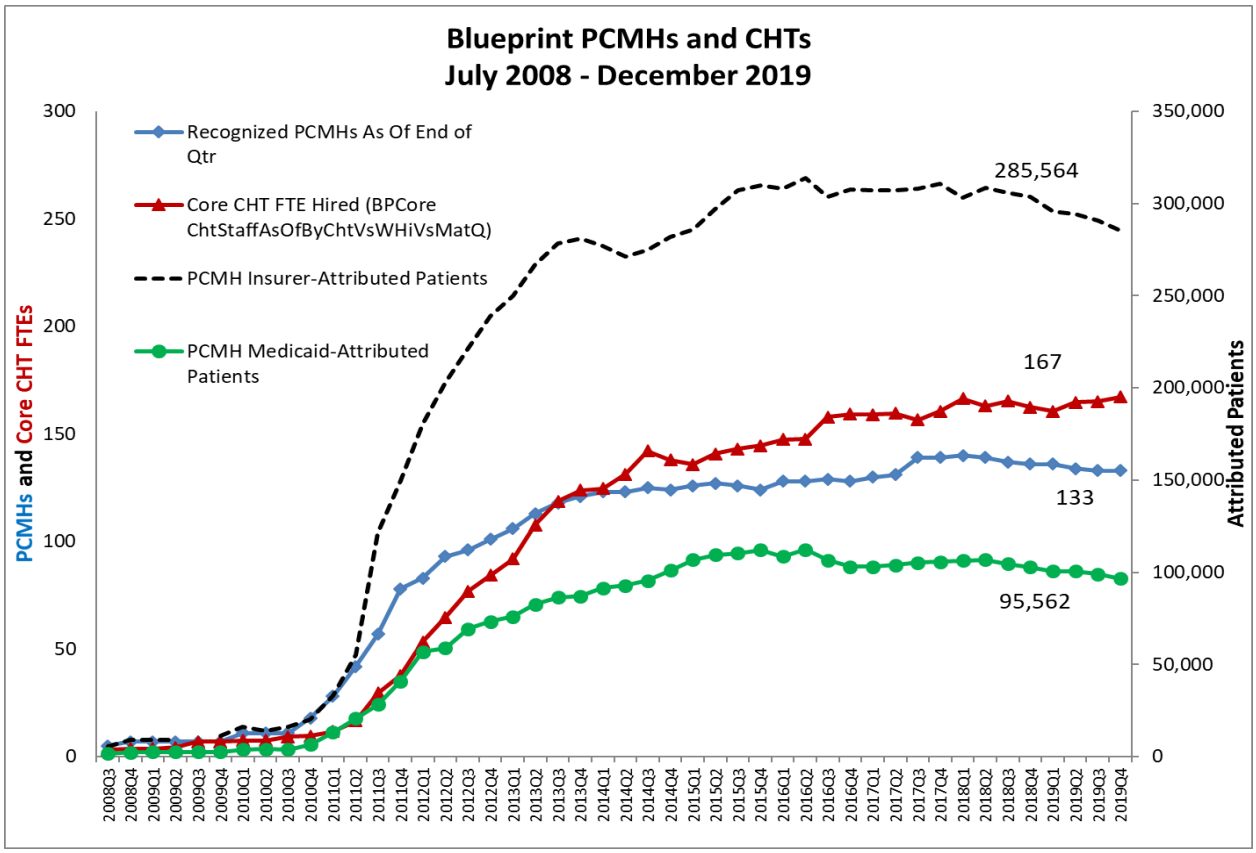
Blueprint-participating Patient-Centered Medical Homes currently serve 285,564 insurer-attributed patients, of which 96562 are Medicaid enrollees. Attribution to a practice is determined by the practice at which the patient has received the majority of their primary care within the 24 months prior to the date the attribution process is conducted. These practices and patients are supported by 167 full-time equivalents of Community Health Team staff.

Quarterly Highlights

At the end of the 4th quarter of 2019, 133 Vermont practices were operating as Patient-Centered Medical Homes, thanks to the commitment of providers and staff, the support of Program Managers, and the technical assistance of Quality Improvement Facilitators. The number of practices participating in the Blueprint for Health program is a key performance measure; the Blueprint estimates that there are about 169 total primary care practices operating in the state, of which an estimated 148 employ more than one provider.

During 2019, new and renewing practices went through the 2017 NCQA Patient-Centered Medical Home recognition process. This new recognition process has been greatly streamlined and is composed of three tracks based on a practice's history as a Patient-Centered Medical Home.

Figure 1. Patient-Centered Medical Homes and Community Health Teams



Practice Health Profiles and Community Health Profiles

The Blueprint for Health supports data-driven population health improvement by producing profiles that describe the health status and health care utilization, expenditures, and outcomes of individuals in each health service area and patients in each Patient-Centered Medical Home. Both practice-level and community-level profiles use all-payer administrative data, clinical outcomes, and survey information for adult and pediatric populations. Practice Health Profiles help practices identify ways that they can better serve their patients.

Community Health Profiles are used by the regional Accountable Communities for Health (Community Collaboratives) and other local workgroups to inform and complement Community Health Needs Assessments and other community data products. These profiles report on the whole population of patients residing in each health service area (the closest possible approximation of "whole population" reporting from available claims data). Some measures are also broken out into three categories: patients attributed to area Blueprint-participating Patient-Centered Medical Homes, patients receiving most of their primary care in a non-Blueprint practice (such as a specialty practice or an out-of-state practice), and patients with no record of a primary care visit within the last two years. The whole-population reporting approach was new in 2018, and feedback suggests it has made the Community Health Profiles more useful. The Community Health Profiles are now part of Vermont's hospital budget approval process and Health Resource Allocation Plan, both responsibilities of the state's health care regulatory body, the

Green Mountain Care Board. Onpoint Health Data produced these profiles. Practice Health Profiles and Community Health Profiles have been distributed to practices and healthcare organizations for the following data time periods:

i. 01/2013 - 12/2013
ii. 07/2013 - 06/2014
iii. 01/2014 - 12/2014
iv. 07/2014 - 06/2015
v. 01/2015 – 12/2015
vi. 07/2015 – 06/2016
vii. 01/2016 – 12/2016
viii. 07/2016 – 06/2017
ix. 01/2017 – 12/2017
x. 01/2018 – 12/2018

Practice Health and Community Health Profiles for the data period 01/2018 – 12/2018 were distributed in November 2019. The Practice Health Profiles for this data period is in a new format that the Blueprint for Health central office team designed and prototyped with profile users over a six-month period. The new format is intended to make practice performance information more accessible to busy providers and practice staff. Practice profiles are sent to the practices directly, while Community Health Profiles are posted at http://blueprintforhealth.vermont.gov/community-health-profiles.

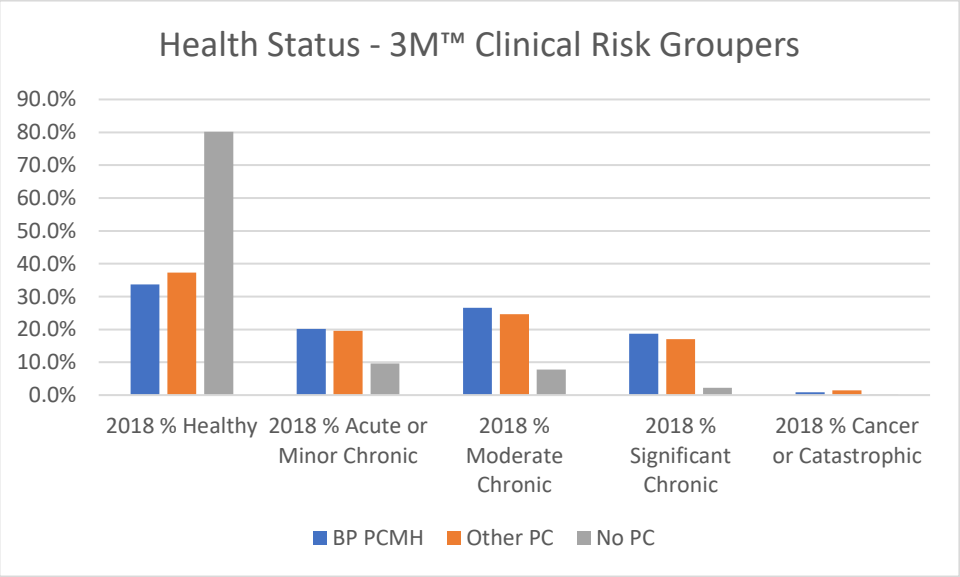
Blueprint for Health Annual Report, 2018 Outcomes for Patient-Centered Medical Homes

The 2019 Blueprint Annual Report, using the state's all-payer claims database for years 2013 through 2018, compared outcomes across patients attributed to Patient-Centered Medical Homes (BP PCMH), patients who received primary care services in a setting other than a Blueprint Patient-Centered Medical Home (Other PC), and patients who did not receive primary care (No PC). Table 1 shows the demographic characteristics of these groups. Over this period of time, the average age for the BP PCMH population increase almost 5%, while the Other PC population consistently had a higher average age. The No PC group was the youngest. Both primary care groups were similar in the proportion female (~55%), while the No PC had a substantially lower proportion of females. The BP PCMH group had a slightly higher proportion Medicaid and lower proportion Medicare and Commercially covered patients than the Other PC group. The No PC group was mostly covered under Commercial payers. Regarding their health status as measured by the 3M™ clinical risk groupers (Figure 2), the BP PCMH group had the lowest proportion categorized as healthy and the highest proportions categorized as having Moderate and Significant chronic conditions. The No PC group had the a substantially higher proportion in the healthy category, and the lowest proportions in each of the higher risk groups.

Table 1. Demographic Characteristics between 2013 and 2018 by Primary Care Group

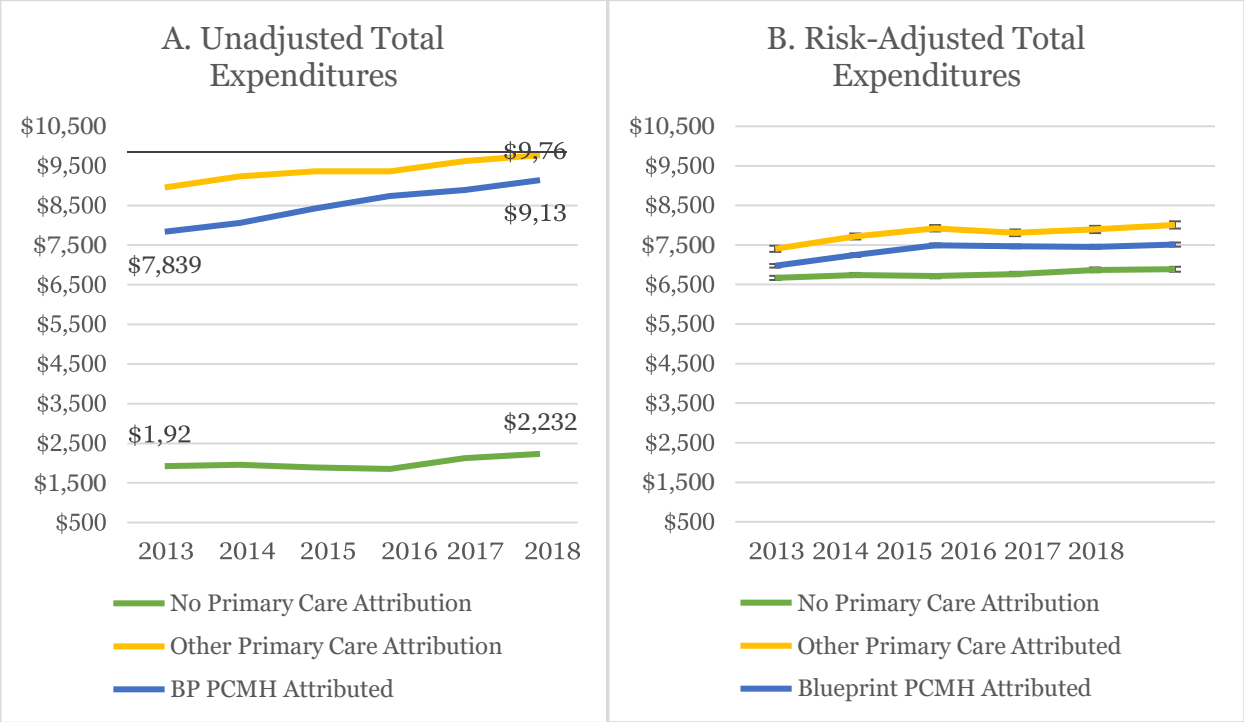
Demographics	BP PCMH	Other PC	No PC
2013 Total	254,362	101,791	**41,779**
2018 Total	286,844	98,571	**41,219**
% Change	*12.8%*	*-3.2%*	***-1.3%***
2013 Avg. Age	41	45	**40**
2018 Avg. Age	43	45	**41**
% Change	*4.9%*	*0.0%*	***2.5%***
2013 % Female	54.1%	55.9%	**37.3%**
2018 % Female	54.3%	54.5%	**38.2%**
% Change	*0.3%*	*-2.5%*	***2.6%***
2013 % Medicaid	30.7%	24.2%	**24.5%**
2018 % Medicaid	31.6%	27.6%	**29.1%**
% Change	*3.0%*	*14.2%*	***18.7%***
2013 % Medicare	25.2%	30.9%	**19.4%**
2018 % Medicare	29.5%	30.8%	**19.5%**
% Change	*17.1%*	*-0.1%*	***0.6%***
2013 % Commercial	44.2%	45.0%	**56.2%**
2018 % Commercial	39.0%	41.6%	**51.5%**
% Change	***-11.8%***	***-7.6%***	***-8.4%***

Figure 2. Health Status Characteristics by Primary Care Group



The below figures show both crude and risk-adjusted per member per year expenditures for each of these three primary care groups. Both figures indicate that those receiving the plurality of their care at a Patient-Centered Medical Home have lower annual expenditures than those that receive the plurality of their primary care in another setting, despite having higher proportions with higher risk health status. The No PC group had the lowest annual expenditures.

Figure 3 a) and b). Total Per Member Per Year Expenditures, Unadjusted and Adjusted



Contributing to the lower annual per member cost, the BP PCMH group had lower rates of inpatient discharges than the Other PC group. While, the BP PCMH group had a higher rate of Emergency Department (ED) visits, including potentially avoidable ED visits, the overall per member outpatient expenditures were lower (subcategory expenditures data available in the 2019 Blueprint for Health Annual Report available at: https://blueprintforhealth.vermont.gov/annual-reports). In addition, the BP PCMH group had higher rates of primary care visits and proportion with a primary care visit in 2018.

Table 2. Calendar Year 2018 Utilization Rates by Primary Care Group, Rates per 1,000 Member Years

	Inpatient Discharge Rate	*All ED Visits Rate*	*Potentially Avoidable ED Visit Rate*	PCP Visits Rate	% with Primary Care Visit in Year
Blueprint PCMH	108	409	68	3,452	**81.1%**
Other Primary Care	114	374	60	3,218	**76.8%**
No Primary Care	**27**	**132**	**21**		

Hub & Spoke Program

Medication-assisted treatment for opioid use disorder is the use of FDA-approved medications, in combination with counseling and behavioral therapies, to provide a "whole patient" approach to the treatment of opioid use disorder. The Hub and Spoke system of care in Vermont provides medication-assisted treatment for opioid use disorder in two settings – regional, specialty Opioid Treatment Programs (OTPs, Hubs), which provide higher intensity treatment and office-based opioid treatment (OBOT, Spokes) in community-based medical practice settings. The Blueprint administers the Spoke part of the Hub & Spoke system of care. Peer-reviewed literature has established medication-assisted treatment as an evidence-based, effective approach to the treatment of opioid use disorder, based upon notable, published outcomes such as decreased opioid use, decreased opioid-related overdose deaths, decreased criminal activity, decreased infectious disease transmission and increased social functioning and retention in

treatment.

Many of these outcomes were supported by the recent evaluation of Vermont's Hub & Spoke system. The State Plan Amendment for the Vermont Medicaid Program, approved by the Centers for Medicare and Medicaid Services, established a Health Home for Vermonters with opioid use disorder. As of July 1, 2013, Medicaid beneficiaries receiving medication-assisted treatment for opioid use disorder in a Hub or Spoke setting were eligible to receive enhanced services, such as comprehensive care management, care coordination, comprehensive transitional care, health promotion, individual and family support, and referral to community and social support services. The Health Home functions to enhance Hub programming and embeds essential support staff (1 registered nurse and 1 licensed mental health clinician per every 100 Medicaid patients receiving medication-assisted treatment) into Spoke practices for a patient-centered, team- and evidenced-based approach to the treatment of opioid use disorder and the provision of Health Home services. Based upon the "significant impact" demonstrated by the Hub and Spoke system, Vermont is working towards gaining All Payer participation in the Opioid Use Disorder Health Home model.

The Blueprint, in partnership with the Division of Alcohol and Drug Abuse Programs (Department of Health), continues to offer learning sessions with expert-led, and peer-supported, training in best practices for providing team- and evidence-based medication-assisted treatment for opioid use disorder. For many physicians, nurse practitioners, and physician assistants, access to specialized staffing and ongoing training opportunities provide the support and confidence the providers need to accept the challenge of treating opioid use disorder in community-based medical practice settings (Spokes). For patients, the Spoke staff become a critical part of their care team, working together week-by-week and month-by-month towards long-term recovery and improved health and well-being. At the end of the 4th quarter of 2019, capacity for receiving medication-assisted treatment in Spoke settings continued to increase, as evidenced by 3,276 Vermonters with Medicaid insurance receiving medication-assisted treatment for opioid use disorder from 269 prescribers and 73.2 full-time equivalent Spoke staff, working as teams, across more than 75[1] different Spoke settings (as of December 2019).

Quarterly Highlights

- Vermont continues to demonstrate increased access to medication-assisted treatment for Vermonters with opioid use disorder, as evidenced by the 3,542 clients enrolled in Regional Opioid Treatment Programs (OTP/Hubs) as of December 2019 and the monthly average of 3,276 Medicaid beneficiaries served by Office-Based Opioid Treatment (OBOT/Spoke) programs as of December 2019.

- Medication-assisted treatment for opioid use disorder is being offered across the State of Vermont by more than 114 different spoke settings and by 269 medical doctors, nurse practitioners and physician assistants who work with 73.2 FTE licensed, registered nurses and licensed, Master's-prepared, mental health / substance use disorder clinicians as a team to offer evidence-based treatment and provide Health Home services for Vermonters with opioid use disorder (as of December 2019).

- As of November 1, 2019, the Blueprint has a contract with Dartmouth College for the 2019-2020 MAT Learning Collaborative. The 2019-2020 MAT Learning Collaborative will include a series of five webinars, six regional in-person training sessions, and one statewide conference. For the remainder of the 4th quarter, the curriculum content was finalized in collaboration with the

[1] Number of Spoke settings is defined as the number of unique practices where Spoke providers are located. This is a change from previous reporting.

Vermont Department of Health's Division of Alcohol and Drug Abuse Programs and Vermont subject matter experts. The logistics for the Learning Collaborative offerings has also been secured.

v. Pharmacy Program

Key updates:

- Pharmacy Key Drug Spend Statistics for SFY2019
- Hepatitis C Drugs
- Pharmacy Care Management (PCM) Program
- Opioid Utilization
- Continuous Glucose Monitoring (CGM)
- Changes to Vaccine Administration

The DVHA Pharmacy Unit is responsible for managing the pharmacy benefits for beneficiaries enrolled in Vermont's publicly funded health care programs. Functions include:

- processing pharmacy claims
- making drug coverage determinations
- assisting with drug appeals and exception requests
- overseeing federal, state and supplemental drug rebate programs and the state's manufacturer fee program
- resolving drug-related pharmacy and medical provider issues
- overseeing and managing the Drug Utilization Review Board (DURB) and managing the Preferred Drug List (PDL)
- assuring compliance with state and federal pharmacy and pharmacy-benefits regulations

In addition, the pharmacy unit manages drug spend and routinely analyzes national and DVHA-specific drug trends and drug utilization. The pharmacy unit strives to deliver high-quality customer service, optimal drug therapy for DVHA beneficiaries and successful management of drug utilization and costs.

Change Healthcare (CHC), DVHA's contracted Prescription Benefit Manager (PBM) since January 1, 2015, provides many clinical and operational support services, in addition to managing a provider call center in South Burlington, Vermont.

Key Drug Spend Statistics for State Fiscal Year 2019 (SFY19):

- Total GC Drug Spend for SFY19 was $198.8 million. This represents an increase in gross expenditures of approximately $1.6 million (or .82%) from SFY18.

- In SFY19, specialty drugs represented 25.5% of DVHA's overall drug spend, compared to SFY18 when specialty drug spend represented 24.2% of DVHA's drug spend.

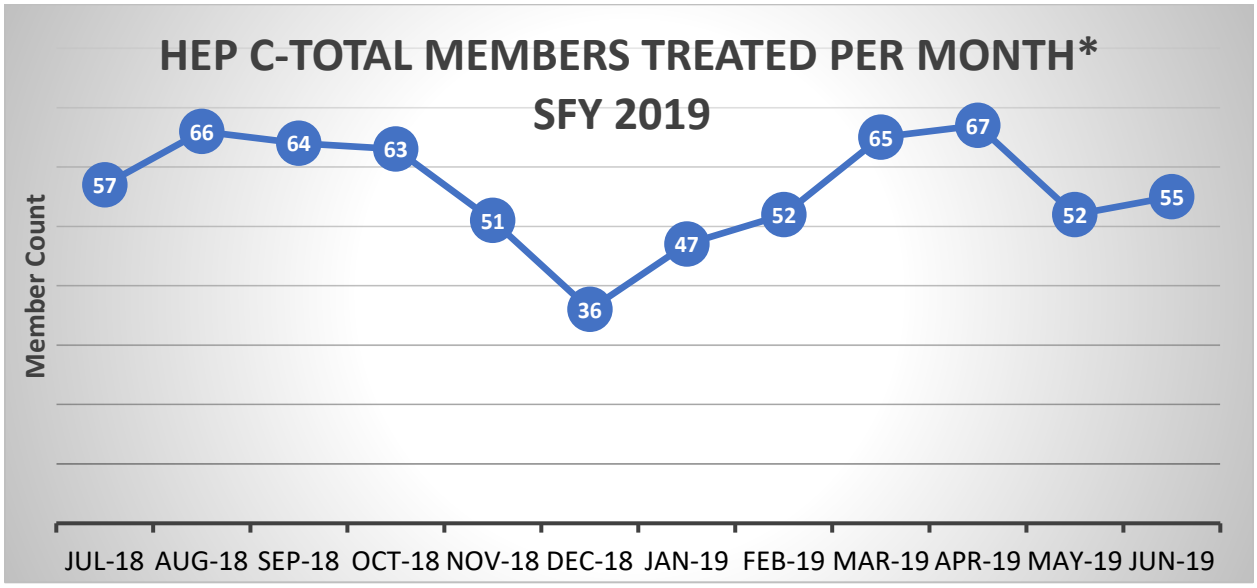
- Total number of GC paid prescription claims in SFY19 was 2,010,107.

- The average cost per prescription for specialty drugs in SFY19 was $7,004 which represents a decrease of $172 from SFY18.

Hepatitis C Drugs

Direct Acting Antivirals are very effective drugs and although still expensive, competition has driven the cost down considerably. We continue to see a significant financial impact of these drugs and more people will continue to be treated for Hepatitis C Virus (HCV). There were two Direct Acting Antivirals (DAA) for treating Hepatitis C on the top 10 list by Gross Spend, Mavyret and Epclusa. Harvoni is no longer a preferred drug and was replaced by Mavyret toward the middle of SFY2018 and into SFY2019. Mavyret is very effective, can be used for all genotypes, can have an eight-week course of therapy versus 12 weeks for some other DAA agents, and has a lower cost of treatment. In January 2018 the Fibrosis Score=2 or more requirement was removed, and in February 2019 we removed several other requirements which opened the door for broader access to treatment for Hepatitis C infected patients. DAA's continue to be high on the Top Therapeutic Categories by gross spend list. These drugs are a focus of PCM services to facilitate adherence and patient follow-up to enable the best clinical outcomes.

Although the Hepatitis C antiviral drug prescription count and gross spend has declined in SFY2019 the data is misleading, and the number of patients treated is going up over time. The decrease in prescriptions is due to a change in our policy of requiring two 14-day prescriptions as a starting course of therapy to one 28-day prescription late in 2018 which decreases the overall prescription count but not the number of capsules or tablets dispensed. In addition, our preferred product Mavyret has a lower wholesale acquisition cost, so payments to the pharmacy are lower overall, thus spend looks lower on a gross basis. If we compare the number of unique members utilizing Direct Acting Antivirals for treatment of Hepatitis C, the number increased from 267 in SFY2018 to 348 in SFY2019.



Hepatitis C Direct Acting Antiviral Utilization

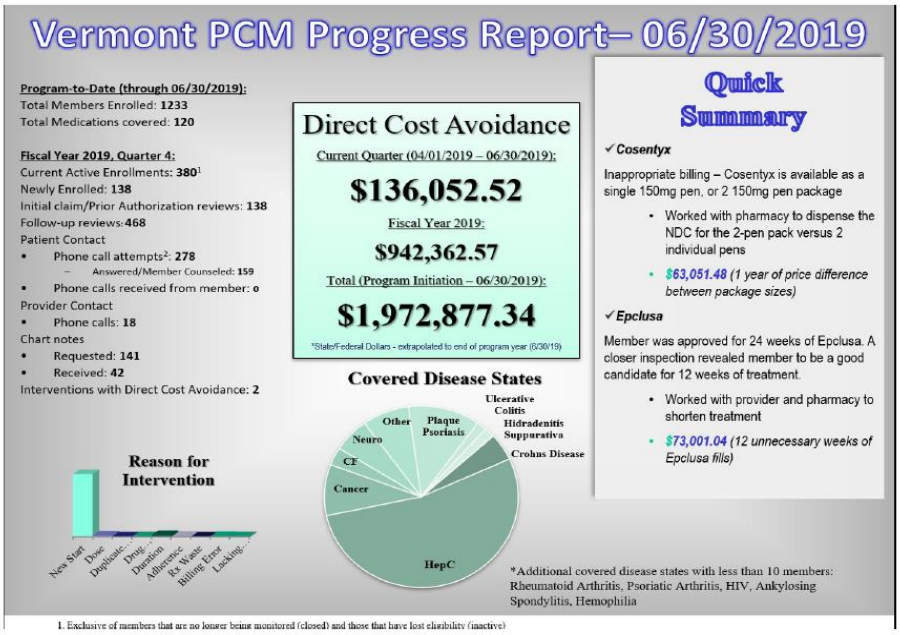
2018 RX Count	2019 RX Count	% Change	2018 Unique Members	2019 Unique Members	% Change	2018 Total Paid	2019 Total Paid	% Change
806	799	-0.87%	267	348	30.34%	11,984,997	116,221,356	-3.03%

Pharmacy Cost Management (PCM) Program

In late SFY 2017, DVHA, in collaboration with Change Healthcare, implemented the Pharmacy Cost Management (PCM) Program. The goal of the program is to mitigate the impact of high-cost specialty drugs on pharmaceutical expenditures while ensuring that the full value of these medications in improving patient outcomes and reducing medical expenditures can be realized. Achieving this goal requires focused and attentive oversight and management of both the drugs and the patients receiving them to ensure that patients are not only prescribed the optimal drug for their specific condition, but that they are taking the drug as prescribed and are receiving the appropriate monitoring, testing and follow-up care.

Provider Outreach and Coordination

The PCM pharmacist provides direct outreach to prescribers and pharmacies to discuss the goals of therapy as well as the appropriateness of drug, dose, and duration of therapy and follow up. The pharmacist works directly with prescribers to choose the most cost-effective treatment regimens for each patient with consideration of age, gender, co-morbidities and, when pertinent, biologic and genetic markers. In addition, they communicate directly with pharmacies to ensure that the medications are dispensed to the patients at the correct times and are billed appropriately. Prescribers are notified when a patient demonstrates poor adherence.



The Vermont Medicaid Pharmacy Cost Management Program documented savings of $942,360 for DVHA during State Fiscal Year 2019. The PCM program currently has 380 active enrollments. PCM interventions may not always result in direct drug cost avoidance however they are in place to encourage adherence and ultimately improve member outcomes and avoid future health spending. The program

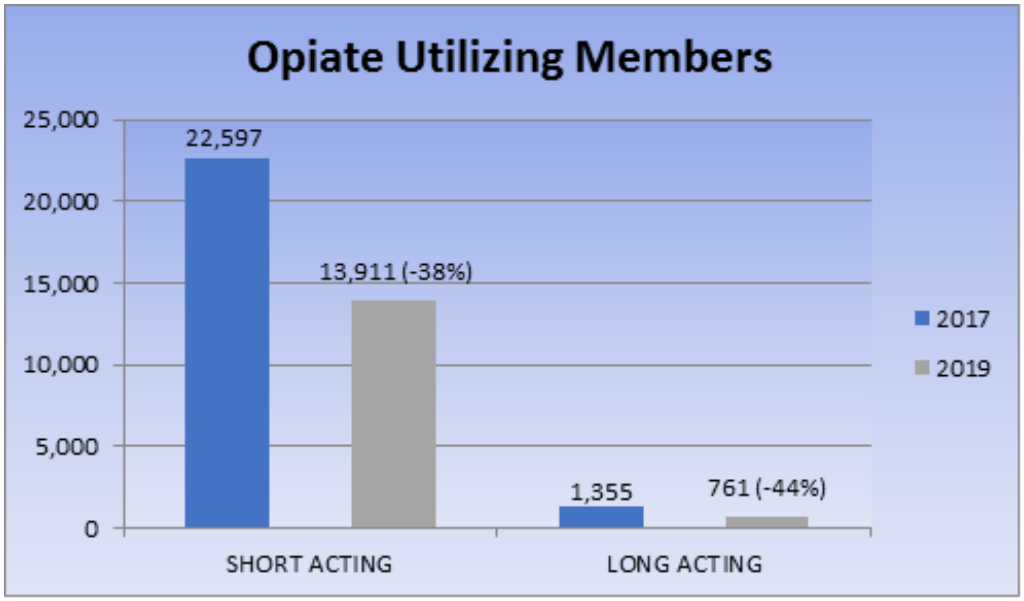
continues to grow, identifying new members and including more specialty medications as they come to market and usage increases.

Opioid Utilization

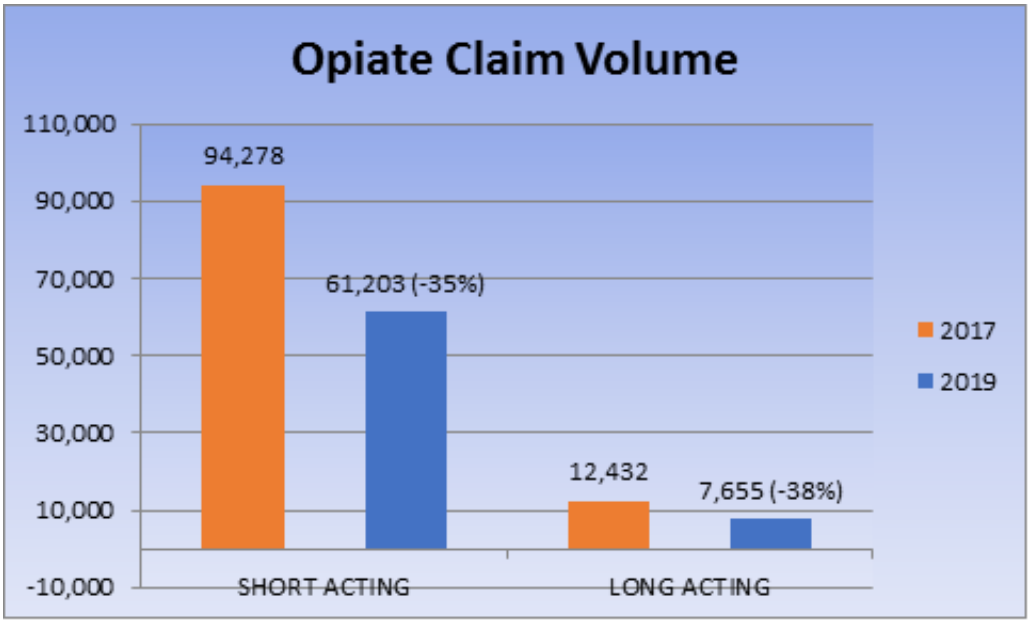
DVHA continues to see the highest spending on drugs used to treat substance-use disorder (opioid partial agonists), Hepatitis C, Attention Deficit Hyperactivity Disorder (stimulants, amphetamines), inflammatory conditions such as Rheumatoid Arthritis and Crohn's Disease, Diabetes, Depression, and neuropathic pain disorders.

Like SFY 2018, opioid partial agonists including Suboxone® are on the top of the charts by both spend and utilization. The number of claims for all buprenorphine containing drugs increased by 7% for SFY2019 and increased a total of 15.3% for the last two fiscal years supporting the trend toward more patients with Opiate Use Disorder accessing treatment. At the same time, we have seen the number of members using short-acting opioids decrease by 38% and those using chronic opioids decrease by 44% over the last two fiscal years. The number of prescriptions for short-acting and long-acting opioids declined by 35% and 38% respectively. There continues to be a significant focus on initiatives to tackle the opioid crisis. Vermont has put into place better prescribing guidelines, edits, and rules limiting the quantities of opioids that are prescribed. Educational initiatives and awareness around treating chronic pain differently without the use of opioids is also a contributing factor. Vermont is recognizing and treating opioid addiction as a chronic medical condition. This has expanded access for those who seek treatment and, in some counties, greatly decreased wait times for those patients. The Hub and Spoke program continue to be a valuable resource for improved access and treatment.

Number of Members Using Opioids: 3-yr Trend



Number of Prescriptions for Opioids: 3-yr Trend



Continuous Glucose Monitoring (CGM) Systems and Supplies

In order to improve patient access and lower DVHA's cost, Preferred Continuous Glucose Monitoring (CGM) systems and supplies are now available through retail pharmacy channels in addition to current DME provider channels. Prescribers may send prescriptions electronically to the pharmacy or hand write prescriptions for patients. Claims will adjudicate in "real time" through the Pharmacy Point of Sale (POS) system which will allow for faster and easier access for patients. Prior Authorization (PA) is required.

Changes to Vaccine Administration

Pharmacist administration reimbursement for influenza vaccine changed from $16.71 to $13.97 in November 2019. This adjustment was made to align with changes to the physician fee schedule for other providers for vaccine administration to adults. Additionally, pharmacist vaccine administration reimbursement of $13.97 now applies to all adult vaccines recommended by The Advisory Committee on Immunization Practices (ACIP). Prior to this change, DVHA only reimbursed pharmacists for Influenza vaccine administration.

DVHA-enrolled pharmacies may be reimbursed for vaccinations administered by pharmacists to adults 19 years and older who are enrolled in Vermont's publicly funded programs. Pharmacists must be certified to administer vaccines in the State of Vermont and must be compliant with all Vermont laws governing vaccine administration. Reimbursement will be based on either a written prescription or a non-patient specific written protocol based on a collaborative practice agreement per state law. There is no dispensing fee paid for pharmacist-administered vaccines.

vi. Choices for Care & Traumatic Brain Injury Programs

Key updates:

- Finalized consumer validation surveys for HCBS federal regulations.
- Initiated stakeholder feedback for an improved quality plan for Adult Family Care & Traumatic Brain Injury (TBI) services.
- 27% of TBI rehab participants returned to work.

<u>Nursing Facility Acuity</u>

DAIL identified an unexpected spike of approximately $2.9 million in nursing facility expenditures due to higher than anticipated case mix acutity. This adjustment was presented to the legislature at SFY2019 Budget Adjustment testimony in December 2019 and January 2020. The higher acuity can be attributed to nursing facilities serving more people with complex nursing, behavioral and rehabiltiative needs as more people with lighter needs seek community-based services alternatives.

Choices for Care Regulations

DAIL held a public hearing on October 4, 2019. Two people appeared in person at the hearing and no people participated by phone. DAIL also received three written comments submitted by Vermont Legal Aide, VNAs of Vermont and the Vermont Health Care Association. DAIL resolved most comments regarding language recommendations with no impact on the rules. Other comments were acknowledged with an explanatory response from DAIL. All comments and responses can be found on this web page. DAIL plans to submit final proposed regulations to the Legislative Committee on Administrative Rules in January 2020 with an anticipated public hearing in front of the committee in February 2020.

Conflict Free Case Management

DAIL initiated Phase II of the Conflict Free Case Management project in September 2019 for Choices for Care and the TBI program. Phase II includes an outreach plan for feedback from key stakeholder, a mailing to all program participants along with a survey, and some in-person listening sessions with consumers. DAIL expects to have public feedback completed by the end of February 2020.

Money Follows the Person (MFP)

On the wake of continued MFP funding from CMS that was awarded later than typical for CY2019, DAIL resurrected the MFP program in May 2019. As of December 2019, DAIL had transitioned 53 MFP eligible people with limited CMS funding. During this quarter, DAIL respectfully expressed concern to CMS partners regarding the challenges in managing the Vermont MFP sustainability plan given the timing of unpredictable CMS funding on a year to year basis. DAIL has chosen to continue MFP participation and has submitted a CY2020 budget to CMS for approval. DAIL plans to engage with stakeholders to examine ways to manage MFP into the future.

Wait Lists

- There is currently no wait list for the High Needs Group.
- There continues to be provider wait lists for Moderate Needs Group, estimated at almost 760 people statewide. Because the eligibility criteria for Moderate Needs services is so broad, Vermont does not expect to eliminate the wait list in the near future. However, the state is planning to revise the wait list procedures from chronological to priority-based in order to serve applicants with the greatest needs first.
- There is currently no wait list for the TBI program.

vii. Developmental Disabilities Services Division

Key updates:

- Vermont implements 2% rate increase
- Conflict Free Case Management System Evaluation in full swing

New Payment Model in Development

The Developmental Disabilities Services Division (DDSD) and DVHA have initiated a project to explore a new payment model for Developmental Disabilities home and community-based services (HCBS). The program has grown significantly over the years from several hundred to several thousand participants. This has provided the impetus for modernization to allow for more efficient oversight of the program. Overall, the goal of this payment reform project is to create a transparent, effective, and administrable payment model for Developmental Disabilities Services that aligns with the broader payment reform and health care reform goals of AHS. The State has engaged stakeholders including recipients, families, advocacy organizations, and providers to participate in workgroups for the development and implementation of the new payment model.

DVHA has engaged a Medicaid reimbursement consultant firm to assist the State in completing a provider rate study. The rate study has collected detailed information from providers regarding actual costs to deliver the defined categories of service under HCBS. The rate study is complete and new rates for services have been proposed. The information gathered will be utilized initially in developing the new payment model. It will later be decided whether these new rates can be adopted in the program. In addition to the provider rate study, the project is examining alternative assessment tools, resource allocation methods and options for more efficiently capturing encounter data for these services. A new methodology has been established for providers to report encounter data regarding services being delivered to participants. Provider agencies are currently adapting their electronic health records and business processes to prepare to report the data using the new method that will lead to increased transparency and accountability in the use of funds. The State is also in the process of developing an RFP for a contractor to conduct needs assessments using a standardized assessment tool, the Supports Intensity Scale. Design of the new payment model is continuing. . Ongoing work will be required, including seeking any needed CMS approval.

HCBS Rules Implementation

DDSD continues to work on implementing the HCBS rules to ensure compliance with all requirements by 2022. The Division has currently completed site visits to validate survey information submitted by providers. Providers are mostly in compliance with the setting requirements with minor changes being required. It is anticipated that all providers will be able to comply with the setting requirements and none will need to transition recipients to other settings. In addition, DDSD is developing policy guidance for providers to ensure compliance with the rules. The DDSD Quality Management Unit has incorporated oversight of HCBS rule requirements into their overall quality review process to ensure ongoing compliance with the rules.

The State is also engaged in developing its plan to comply with the requirement to provide conflict-free case management. A significant stakeholder engagement process was utilized to gather ideas regarding how the State can come into compliance with the part of the HCBS rule. The proposed plan will be included in the next waiver application.

Wait List

DDSD collects information from service providers on individuals who request funding for Home and Community-Based Services (HCBS) and other services including Targeted Case Management (TCM), Family Managed Respite (FMR), Flexible Family Funding (FFF) or Post-Secondary Education Initiative (PSEI). The information is gathered by the State from providers to determine individuals with developmental disabilities (DD) who are waiting for DD services but are not currently eligible. HCBS funding priorities are the method by which Vermont prioritizes who will receive caseload funding allocated annually by the legislature. Individuals are placed on the waiting list if they meet the following criteria:

1. HCBS Applicants: Individuals with DD who are clinically and financially eligible but who do not meet a funding priority for HCBS and have been denied services in whole or in part.
2. Individuals who are clinically and financially eligible for TCM, FMR, FFF or PSEI, but for whom there are insufficient funds.

There were no individuals who met a HCBS funding priority who were waiting for services that helps address the need related to the funding priority. As of 6/30/19, there were 276 people who requested HCBS services but were denied because they did not meet a funding priority. 23 people were waiting for FMR and 13 were waiting for FFF. There was no one waiting for TCM or PSEI. The waiting list is monitored by providers to determine if people have a change in circumstance that makes them eligible to receive HCBS. The waiting list is also reviewed when additional funds become available for other programs.

viii. All-Payer Model: Vermont Medicaid Next Generation Program

Key updates:

- Executed a contract extension with OneCare for a 2020 performance year of the program.
- Developed a new, more inclusive attribution methodology in one participating Health Service Area
- Continue to support Vermont's broader efforts to develop an integrated health care delivery system under an All Payer Model through future program planning and implementation.

In 2016, the Department of Vermont Health Access (DVHA) sought to establish service agreements with one (or more) Accountable Care Organization(s) (ACOs) for participation in a population-based payment model that is based on the CMS *Next Generation* ACO Model. As an evolution of the *Vermont Medicaid Shared Savings Program* (VMSSP), this new program offering creates a structure for provider organizations and other suppliers to join together under an ACO to voluntarily contract with DVHA to assume accountability for the cost and quality of care for Vermont's Medicaid beneficiaries, and for ACOs to distribute payments to their contracted network providers for any covered services rendered on behalf of Vermont Medicaid beneficiaries using alternatives to fee-for-service reimbursement. The goal of this agreement is to improve the quality and value of the care provided to the citizens served by the State of Vermont's public health care programs.

DVHA and OneCare entered into an agreement for the 2017 performance year as a pilot year with four possible one-year extensions to the program. Four risk-bearing hospital communities participated in the *Vermont Medicaid Next Generation* (VMNG) model for the pilot year: the University of Vermont Medicaid Center, Central Vermont Medical Center, Northwestern Medical Center, and Porter Hospital,

with additional participation from FQHCs, independent practices, home health providers, Designated Agencies, and skilled nursing agencies in the four communities.

DVHA issues a prospective Per-Member-Per-Month (PMPM) payment to the ACO; the ACO distributes payments to providers participating in the program per contractual arrangements between the ACO and providers. The ACO is paid for each attributed beneficiary according to their Medicaid Eligibility Group, and the ACO is accountable for the cost and quality of care of each attributed beneficiary. Payments for services not included in the ACO contract continue to be paid fee-for-service, as are payments made to Medicaid providers not participating in the ACO's network.

DVHA and OneCare executed a contract amendment to extend the VMNG program into a 2020 performance year in Q4. The most notable programmatic change was the development of a more inclusive attribution methodology that is a modified version of the 2019 geographic attribution pilot in one participating Health Service Area. This resulted in an expanded attribution methodology that was conducted in addition to the traditional attribution methodology that has been used since the 2017 performance year. Because the expanded attribution methodology represented a significant programmatic change, other adjustments were minimal. This ensures continued alignment across payer programs as part of the Vermont All Payer ACO Model, while allowing the VMNG program the opportunity to test an adjusted attribution methodology with the potential to scale to other payers in future performance years.

The VMNG program saw provider participation expand to all geographic regions of the state for the 2020 performance year, which, coupled with an expanded attribution methodology, led to a significant increase in scale for the program. The number of risk-bearing hospital communities increased from thirteen to fourteen for the 2020 performance year, with continued participation from other providers within the communities. The number of attributed lives for the 2020 performance year increased from approximately 79,140 lives to approximately 114,335 lives (85,937 lives through the traditional methodology and an additional 28,398 lives through the expanded attribution methodology).

DVHA and OneCare continue discussions of potential modifications for future program years, while remaining focused on aligning programs across payers in support of broader All Payer Model efforts.

ix. Substance Use Disorder Program

Key updates:

- Reporting on metrics will not be available until the first quarter report of 2020 (QE0320).
- Recovery Coaches in the Emergency Room Program launched in eight communities.
- The Substance Use Disorder Treatment Standards and Compliance Assessment Tool were updated and reissued.
- Reimbursement methodology change to residential treatment providers from a per diem payment to an "episodic payment", effective January 1, 2019. Vermont is planning to develop a value-based payment model for residential programs to align with its All Payer Model Agreement with CMS.

Executive Summary

During 2019 the State of Vermont continued to have all ASAM levels of care available and no ongoing waitlist to access to Medication Assisted Treatment. The Vermont Department of Health's Division of Alcohol and Drug Abuse Programs (ADAP).

Substance Use Disorder Treatment Standards and corresponding compliance assessment tool were revised for a January 1, 2020 effective date.

ADAP continued to develop the value-based payment model for residential programs, to align with its All Payer Model Agreement with CMS, for implementation in 2020. The utilization and reimbursement data were reviewed. As a result of the review the rates for the episodic payments were adjusted for a January 1, 2020 effective date. ADAP continued to elicit feedback from the residential providers on the design of the quality withhold and the performance measures under consideration.

ADAP's centralized intake and resource center was branded "VT Helplink: Alcohol and Drug Support Center". Contract work with Health Resources in Action (HRiA) is expected to result in the service being made available for public use during winter 2020. Major components include: 1) a call center staffed by certified Screening & Intake Specialists and licensed clinicians, 2) a website with information related to SUD and a self-screen tool, and 3) an appointment board to connect callers in need of treatment with appointments to ADAP's Preferred Provider Network.

The Substance Misuse Prevention Oversight and Advisory Council (SMPC) was established within the Vermont Department of Health and encompasses all substances of misuse including alcohol; cannabis; controlled substances such as opioids, cocaine and methamphetamines; and tobacco products, tobacco substitutes and substances containing nicotine.

Vermont launched the Recovery Coaches in the Emergency Department Program on July 1, 2018. With eight sites reporting, 1,820 individuals were seen in the EDs from July 1, 2018 – December 30, 2019. Three sites are planned to open during the first part of 2020, one of which is currently serving one hospital.

The plan for the SUD Mid-Point Assessment was determined. An internal team was established and is executing the plan. A survey of Preferred Providers was administered to collect their input regarding implementation of milestones #2 and #3.

<u>Assessment of Need and Qualification for SUD Services</u>

Prompts	Demonstration Year (DY) and quarter first reported	Related metric (if any)	Summary
Metric Trends			
Discuss any relevant trends that the data shows related to assessment of need and qualification for SUD services. At a minimum, changes (+ or -) greater than two percent should be described.			
[Add rows as needed]			
☒ The state has no metrics trends to report for this reporting topic.			

Implementation Update			
Compared to the demonstration design details outlined in the STCs and implementation plan, have there been any changes or does the state expect to make any changes to: A) the target population(s) of the demonstration? B) the clinical criteria (e.g., SUD diagnoses) that qualify a beneficiary for the demonstration?			There are no planned changes to the target population or clinical criteria.
Are there any other anticipated program changes that may impact metrics related to assessment of need and qualification for SUD services? If so, please describe these changes.			There are no anticipated program changes.
☒ The state has no implementation update to report for this reporting topic.			

Milestone 1: Access to Critical Levels of Care for OUD and other SUDs

This reporting topic focuses on access to critical levels of care for OUD and other SUDs to assess the state's progress towards meeting Milestone 1.

Prompts	Demonstration Year (DY) and quarter first reported	Related metric (if any)	Summary
Milestone 1 Metric Trends			
Discuss any relevant trends that the data shows related to assessment of need and qualification for SUD services. At a minimum, changes (+ or -) greater than two percent should be described.			
[Add rows as needed]			
☒ The state has no metrics trends to report for this reporting topic.			
Milestone 1 Implementation Update			

Prompts: Compared to the demonstration design and operational details outlined the implementation plan, have there been any changes or does the state expect to make any changes to: a. Planned activities to improve access to SUD treatment services across the continuum of care for Medicaid beneficiaries (e.g. outpatient services, intensive outpatient services, medication assisted treatment, services in intensive residential and inpatient settings, medically supervised withdrawal management)? SUD benefit coverage under the Medicaid state plan or the Expenditure Authority, particularly for residential treatment, medically supervised withdrawal management, and medication assisted treatment services provided to individuals in IMDs? **Summary**: There are no planned changes to access SUD treatment or the SUD benefit coverage.			
Are there any other anticipated program changes that may impact metrics related to access to critical levels of care for OUD and other SUDs? If so, please describe these changes.			There are no anticipated program changes.
☒ The state has no implementation update to report for this reporting topic.			

Milestone 2: Use of Evidence-based, SUD-specific Patient Placement Criteria

This reporting topic focuses on use of evidence-based, SUD-specific patient placement criteria to assess the state's progress towards meeting Milestone 2.

Prompts	Demonstration Year (DY) and quarter first reported	Related metric (if any)	Summary
Milestone 2 Metric Trends			
☒ The state is not reporting any metrics related to this reporting topic.			
Milestone 2 Implementation Update			
Prompts: Compared to the demonstration design and operational details outlined the implementation plan, have there been any changes or does the state expect to make any changes to: a. Planned activities to improve providers' use of evidence-based, SUD-specific placement criteria? b. Implementation of a utilization management approach to ensure: i. Beneficiaries have access to SUD services at the appropriate level of care? ii. Interventions are appropriate for the diagnosis and level of care? iii. Use of independent process for reviewing placement in residential treatment settings? **Summary:** The current version of the Substance Use Disorder Treatment Standards is being used. The Compliance Assessment Tool has been utilized with 25 substance use disorder treatment providers. The Substance Use Disorder Treatment Standards and corresponding compliance assessment tool were revised for a January 1, 2020 effective date. **Milestone 2 - Table 1**			

Action	Revised Completion Date	Responsible	Status

Finalize Substance Use Disorder Treatment Standards	August 1, 2018	Director of Quality Management and Compliance	Completed
Update Compliance Assessment Tool with revised Substance Use Disorder Treatment Standards and all residential ASAM criteria	August 15, 2018	Director of Quality Management and Compliance	Completed
Updated online recertification survey to reflect new revision of Substance Use Disorder Treatment Standards	October 31, 2018	Director of Quality Management and Compliance	Completed
Use the Compliance Assessment Tool to certify ASAM Level 3.5 Level of Care provider (Valley Vista Vergennes)	December 31, 2018	Director of Clinical Services; Director of Quality Management and Compliance	Completed
Use the Compliance Assessment Tool to certify ASAM Level 3.5 Level of Care provider (Valley Vista Bradford)	December 31, 2018	Director of Clinical Services; Director of Quality Management and Compliance	Completed
Implement the Compliance Assessment Tool	October 3, 2018	Director of Clinical Services; Director of Quality Management and Compliance	Completed
Use of the Compliance Assessment Tool to certify ASAM Level 3.3 Level of Care Provider (Recovery House)	March 31, 2019	Director of Clinical Services; Director of Quality Management and Compliance	Completed
Use of the Compliance Assessment Tool to certify ASAM Level 3.2-WM Level of Care Provider (Act 1/Bridge)	March 31, 2019	Director of Clinical Services; Director of Quality Management and Compliance	Completed

Vermont continues to develop a value-based payment model for residential programs to align with its All Payer Model Agreement with CMS. The value-based portion of the new model is anticipated to be implemented in 2020. The utilization and reimbursement data were reviewed. As a result of the review the rates for the episodic payments were adjusted for a January 1, 2020 effective date. ADAP continued to elicit feedback from the residential providers on the design of the quality withhold and the performance measures under consideration.

Milestone 2 – Table 2

Action	Date	Responsible
Develop the criteria for the differential case rate	Completed	ADAP Director of Clinical Services
Model the methodology using the identified criteria for the Vermont team to review	Completed	Payment Reform Team
Work with financial colleagues to finalize budget and rate decisions for the model	Completed	Payment Reform Team, ADAP Director of Clinical Services, VDH Business Office
Residential providers to provide feedback	Completed	ADAP Director of Clinical Services
Work with the Medicaid fiscal agent to identify and complete the necessary system's changes required for the Medicaid billing system	Completed	ADAP Director of Clinical Services, Payment Reform Team, DXC (Fiscal Agent)
Work with the residential providers to provide technical assistance and education around the necessary billing changes	Completed	ADAP Clinical Team
Regional Managers will partner with the compliance and quality team to determine the appropriate frequency with which the Regional Managers will perform the between audit chart reviews	Completed	ADAP Clinical Team and ADAP Quality Team

Are there any other anticipated program changes that may impact metrics related to the use of evidence-based, SUD-specific patient placement criteria (if the state is reporting such metrics)? If so, please describe these changes.			

☐ The state has no implementation update to report for this reporting topic.

Milestone 3: Use of Nationally Recognized SUD-specific Program Standards to Set Provider Qualifications for Residential Treatment Facilities

This reporting topic focuses on the use of nationally recognized SUD-specific program standards to set provider qualifications for residential treatment facilities to assess the state's progress towards meeting Milestone 3.

Prompts	Demonstration Year (DY) and quarter first reported	Related metric (if any)	Summary
Milestone 3 Metric Trends			
☒ The state is not reporting any metrics related to this reporting topic.			
Milestone 3 Implementation Update			
Prompts: Compared to the demonstration design and operational details outlined the implementation plan, have there been any changes or does the state expect to make any changes to: a. Implementation of residential treatment provider qualifications that meet the ASAM Criteria or other nationally recognized, SUD-specific program standards? b. State review process for residential treatment providers' compliance with qualifications standards? c. Availability of medication assisted treatment at residential treatment facilities, either on-site or through facilitated access to services off site? **Summary**: The current version of the Substance Use Disorder Treatment Standards is being used. The Compliance Assessment Tool has been utilized with 25 substance use disorder treatment providers. The Substance Use Disorder Treatment Standards and corresponding compliance assessment tool were revised for a January 1, 2020 effective date.			
Are there any other anticipated program changes that may impact metrics related to the use of nationally recognized SUD-specific program standards to set provider qualifications for residential treatment facilities (if the state is reporting such metrics)? If so, please describe these changes.			
☐ The state has no implementation update to report for this reporting topic.			

Milestone 4: Sufficient Provider Capacity at Critical Levels of Care including for Medication Assisted Treatment for OUD

This reporting topic focuses on provider capacity at critical levels of care including for medication assisted treatment (MAT) for OUD to assess the state's progress towards meeting Milestone 4.

Prompts	Demonstration Year (DY) and quarter first reported	Related metric (if any)	Summary
Milestone 4 Metric Trends			
Discuss any relevant trends that the data shows related to assessment of need and qualification for SUD services. At a minimum, changes (+ or -) greater than two percent should be described.			
[Add rows as needed]			
☒ The state has no metrics trends to report for this reporting topic.			
Milestone 4 Implementation Update			
Prompts: Compared to the demonstration design and operational details outlined the implementation plan, have there been any changes or does the state expect to make any changes to planned activities to assess the availability of providers enrolled in Medicaid and accepting new patients in across the continuum of SUD care? **Summary**: Vermont continues to develop a value-based payment model for residential programs to align with its All Payer Model Agreement with CMS. The value-based portion of the new model is anticipated to be implemented in 2020. The utilization and reimbursement data were reviewed. As a result of the review the rates for the episodic payments were adjusted for a January 1, 2020 effective date. ADAP continued to elicit feedback from the residential providers on the design of the quality withhold and the performance measures under consideration. ADAP's centralized intake and resource center was branded "VT Helplink: Alcohol and Drug Support Center". Contract work with Health Resources in Action (HRiA) is expected to result in the service being made available for public use during winter 2020. Major components include: 1) a call center staffed by certified Screening & Intake Specialists and licensed clinicians, 2) a website with information related to SUD and a self-screen tool, and 3) an appointment board to connect callers in need of treatment with appointments to ADAP's Preferred Provider Network.			
Are there any other anticipated program changes that may impact metrics related to provider capacity at critical levels of care, including for medication assisted treatment (MAT) for OUD? If so, please describe these changes.			

☐ The state has no implementation update to report for this reporting topic.

Milestone 5: Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse and OUD

This reporting topic focuses on the implementation of comprehensive treatment and prevention strategies to address opioid abuse and OUD to assess the state's progress towards meeting Milestone 5.

Prompts	Demonstration Year (DY) and quarter first reported	Related metric (if any)	Summary
Milestone 5 Metric Trends			
Discuss any relevant trends that the data shows related to assessment of need and qualification for SUD services. At a minimum, changes (+ or -) greater than two percent should be described.			
[Add rows as needed]			
☒ The state has no metrics trends to report for this reporting topic.			
Milestone 5 Implementation Update			
Prompts: Compared to the demonstration design and operational details outlined the implementation plan, have there been any changes or does the state expect to make any changes to: a. Implementation of opioid prescribing guidelines and other interventions related to prevention of OUD? b. Expansion of coverage for and access to naloxone? **Summary**: There are no planned changes to the prescribing guidelines and other interventions.			
Are there any other anticipated program changes that may impact metrics related to the implementation of comprehensive treatment and prevention strategies to address opioid abuse and OUD? If so, please describe these changes.			
☒ The state has no implementation update to report for this reporting topic.			

Milestone 6: Improved Care Coordination and Transitions between Levels of Care

This reporting topic focuses on care coordination and transitions between levels of care to assess the state's progress towards meeting Milestone 6.

Prompts	Demonstration Year (DY) and quarter first reported	Related metric (if any)	Summary
Milestone 6 Metric Trends			
Discuss any relevant trends that the data shows related to assessment of need and qualification for SUD services. At a minimum, changes (+ or -) greater than two percent should be described.			
[Add rows as needed]			
☒ The state has no metrics trends to report for this reporting topic.			
Milestone 6 Implementation Update			
Prompts: Compared to the demonstration design and operational details outlined the implementation plan, have there been any changes or does the state expect to make any changes to implementation of policies supporting beneficiaries' transition from residential and inpatient facilities to community-based services and supports? **Summary**: Vermont launched the Recovery Coaches in the Emergency Department Program on July 1, 2018. With eight sites reporting, 1,820 individuals were seen in the EDs from July 1, 2018 – December 30, 2019. Three sites are planned to open during the first part of 2020, one of which is currently serving one hospital.			
Are there any other anticipated program changes that may impact metrics related to care coordination and transitions between levels of care? If so, please describe these changes.			
☐ The state has no implementation update to report for this reporting topic.			

SUD Health Information Technology (Health IT)

This reporting topic focuses on SUD health IT to assess the state's progress on the health IT portion of the implementation plan.

Prompts	Demonstration Year (DY) and quarter first reported	Related metric (if any)	Summary
Metric Trends			
Discuss any relevant trends that the data shows related to assessment of need and qualification for SUD services. At a minimum, changes (+ or -) greater than two percent should be described.			
[Add rows as needed]			
☒ The state has no metrics trends to report for this reporting topic.			
Implementation Update			

Prompts: Compared to the demonstration design and operational details outlined in STCs and implementation plan, have there been any changes or does the state expect to make any changes to:

a. How health IT is being used to slow down the rate of growth of individuals identified with SUD?
b. How health IT is being used to treat effectively individuals identified with SUD?
c. How health IT is being used to effectively monitor "recovery" supports and services for individuals identified with SUD?
d. Other aspects of the state's plan to develop the health IT infrastructure/capabilities at the state, delivery system, health plan/MCO, and individual provider levels?
e. Other aspects of the state's health IT implementation milestones?
f. The timeline for achieving health IT implementation milestones?
g. Planned activities to increase use and functionality of the state's prescription drug monitoring program?

Summary:

- Vermont has a requirement and funding in the current contract with Appriss to connect VPMS to RxCheck for interstate data sharing. RxCheck is developing functionality for direct integration with EHRs and other health systems. Appriss has provided a change order to connect to RxCheck.
- Funding through the Center for Disease Control and Prevention, and the Bureau for Justice Administration requires the connection to RxCheck. The MOU has been reviewed by the Agency of the Administration and Agency of Digital Services Security for initial approval and is currently circulating for final approvals.
- The current contract for the VPMS was put out to bid in 2019. The request for proposal (RFP) included priorities such as improved access and support for providers, integration and data management, and increased reporting functionality. The selection is currently under independent review prior to commencing contract negotiations with the successful vendor.
- VPMS, Dr. First and Appriss are in the process of testing and verifying Appriss's Gateway integration tool to enable direct population of VPMS data into Dr. First's prescription ordering section, eliminating the need for providers to navigate between systems.
- VPMS staff are engaged with the NESCSO State HIT Learning Community. This group works to create a shared understanding of Federal legislation, the current state of PDMP activities, and identifies opportunities for multi-state alignment.
- VPMS staff participated in interviews for the development of statewide data integration opportunities. These interviews were with the contractor tasked with developing the health

IT infrastructure plans for the HIE Steering Committee and were combined with other data systems needs and requirements for integration. • VDH promoted the availability of technical assistance at the prescriber level. Promotion was integrated into the implementation of prescriber insight reports. Insight reports include metrics for providers about the prescriptions dispensed that they prescribed and comparisons with other providers within their specialty. Vermont continues to offer prescriber reports on a quarterly basis. New enhancements to the report include metrics on stimulants and sedatives in addition to opioids. The scope of the providers receiving reports have been expanded and will now include those who have prescribed controlled substances other than opioids as well. • VDH conducted an impact evaluation of the 7/1/17 pain prescribing rule change to assess the impact of the new prescribing rules on prescribing patterns, determine if the new prescribing rules affect awareness/usage of VPMS and evaluate the impact of stricter prescribing rules on future prescription opioid misuse. Results are expected during the first part of 2020. • The centralized intake and resource Center, branded as VT Helplink: Alcohol & Drug Support Center, encompasses a call center, public-facing informational website, and a web-based appointment board. Contracted work with the vendor, Health Resources in Action, has continued. This service is anticipated to be available for public use during winter 2020.			
Are there any other anticipated program changes that may impact metrics related to SUD Health IT (if the state is reporting such metrics)? If so, please describe these changes.			
☐ The state has no implementation update to report for this reporting topic.			

Other SUD-Related Metrics

Prompts	Demonstration Year (DY) and quarter first reported	Related metric (if any)	Summary
9.2 Other SUD-Related Metrics			
9.2.1 Metric Trends			
Discuss any relevant trends that the data shows related to assessment of need and qualification for SUD services. At a minimum, changes (+ or -) greater than two percent should be described.			
[Add rows as needed]			
☒ The state has no metrics trends to report for this reporting topic.			
9.2.2 Implementation Update			
Are there any other anticipated program			

changes that may impact the other SUD-related metrics? If so, please describe these changes.			
☒ The state has no implementation updates to report for this reporting topic.			

Budget Neutrality

Prompts	Demonstration Year (DY) and quarter first reported	Related metric (if any)	Summary
10.2 Budget Neutrality			
10.2.1 Current status and analysis			
Discuss the current status of budget neutrality and provide an analysis of the budget neutrality to date. If the SUD component is part of a comprehensive demonstration, the state should provide an analysis of the SUD-related budget neutrality and an analysis of budget neutrality as a whole.			Updates on Budget Neutrality can be found in Attachment 1: *Budget Neutrality* of this report.
[Add rows as needed]			
☒ The state has no metrics trends to report for this reporting topic.			
10.2.2 Implementation Update			
Are there any anticipated program changes that may impact budget neutrality? If so, please describe these changes.			
[Add rows as needed]			
☒ The state has no implementation updates to report for this reporting topic.			

SUD-Related Demonstration Operations and Policy

Prompts	Demonstration Year (DY) and quarter first reported	Related metric (if any)	Summary
11.1 SUD-Related Demonstration Operations and Policy			
11.1.1 Considerations			
Highlight significant SUD (or if broader			

demonstration, then SUD-related) demonstration operations or policy considerations that could positively or negatively impact beneficiary enrollment, access to services, timely provision of services, budget neutrality, or any other provision that has potential for beneficiary impacts. Also note any activity that may accelerate or create delays or impediments in achieving the SUD demonstration's approved goals or objectives, if not already reported elsewhere in this document. See report template instructions for more detail.			
[Add rows as needed]			
☒ The state has no related considerations to report for this reporting topic.			
11.1.2 Implementation Update			
Compared to the demonstration design and operational details outlined in STCs and the implementation plan, have there been any changes or does the state expect to make any changes to: a. How the delivery system operates under the demonstration (e.g. through the managed care system or fee for service)? b. Delivery models affecting demonstration participants (e.g. Accountable Care Organizations,			

Patient Centered Medical Homes)? c. Partners involved in service delivery?			
Has the state experienced any significant challenges in partnering with entities contracted to help implement the demonstration (e.g., health plans, credentialing vendors, private sector providers)? Has the state noted any performance issues with contracted entities?			
What other initiatives is the state working on related to SUD or OUD? How do these initiatives relate to the SUD demonstration? How are they similar to or different from the SUD demonstration?			
[Add rows as needed]			
☒ The state has no implementation updates to report for this reporting topic.			

SUD Demonstration Evaluation Update

Prompts	Demonstration Year (DY) and quarter first reported	Related metric (if any)	Summary
12.1 SUD Demonstration Evaluation Update			
12.1.1 Narrative Information			
Provide updates on SUD evaluation work and timeline. The appropriate content will depend on when this report is due to CMS and the timing for the demonstration. See report template instructions for more details.			Updates on the SUD evaluation work, deliverables, and timeline can be found in Section IV: *Quality Assurance & Performance Improvement Activities* of this report.
Provide status updates on deliverables related to the demonstration evaluation and indicate			

whether the expected timelines are being met and/or if there are any real or anticipated barriers in achieving the goals and timeframes agreed to in the STCs.			
List anticipated evaluation-related deliverables related to this demonstration and their due dates.			
[Add rows as needed]			
☒ The state has no metrics trends to report for this reporting topic.			
12.1.2 Implementation Update			
Are there any anticipated program changes that may impact budget neutrality? If so, please describe these changes.			
[Add rows as needed]			
☐ The state has no SUD demonstration evaluation update to report for this reporting topic.			

Other Demonstration Reporting

Prompts	Demonstration Year (DY) and quarter first reported	Related metric (if any)	Summary
13.1 Other Demonstration Reporting			
13.1.1 General Reporting Requirements			
Have there been any changes in the state's implementation of the demonstration that might necessitate a change to approved STCs, implementation plan, or monitoring protocol?			
Does the state foresee the need to make future changes to the STCs, implementation plan, or monitoring protocol, based on expected or upcoming implementation changes?			
Compared to the details outlined in the STCs and the monitoring			Updates on the Monitoring Protocol work, deliverables, and timeline can be

protocol, has the state formally requested any changes or does the state expect to formally request any changes to: a. The schedule for completing and submitting monitoring reports? b. The content or completeness of submitted reports? Future reports?			found in Section IV: *External Quality Review* of this report.
Has the state identified any real or anticipated issues submitting timely post-approval demonstration deliverables, including a plan for remediation?			
[Add rows as needed]			
☐ The state has no updates on general reporting requirements to report for this reporting topic.			
13.1.2 Post Award Public Forum			
If applicable within the timing of the demonstration, provide a summary of the annual post-award public forum held pursuant to 42 CFR § 431.420(c) indicating any resulting action items or issues. A summary of the post-award public forum must be included here for the period during which the forum was held and in the annual report.			
[Add rows as needed]			
☒ There was not a post-award public forum held during this reporting period and this is not an annual report, so the state has no post award public forum update to report for this reporting topic.			

Notable State Achievements and/or Innovations

Prompts	Demonstration Year (DY) and quarter first reported	Related metric (if any)	Summary
14.1 Notable State Achievements and/or Innovations			
14.1 Narrative Information			
Provide any relevant summary of			

achievements and/or innovations in demonstration enrollment, benefits, operations, and policies pursuant to the hypotheses of the SUD (or if broader demonstration, then SUD related) demonstration or that served to provide better care for individuals, better health for populations, and/or reduce per capita cost. Achievements should focus on significant impacts to beneficiary outcomes. Whenever possible, the summary should describe the achievement or innovation in quantifiable terms, e.g., number of impacted beneficiaries.			

x. Global Commitment Register

Key updates:

- Since the Global Commitment Register (GCR) launched in November 2015, 222 final GCR policies have been publicly posted.
- The GCR listserv expanded to approximately 450 interested parties.

The GCR is a database of policy changes to and clarifications of existing Medicaid policy under Vermont's 1115 Global Commitment to Health waiver. It is based on the Federal Register and can be used as both a public notice and documentation tool for Medicaid policy. Like the Federal Register, the GCR can be used to publish proposed policy, including information on public comment submissions, final policy, notices, and policy clarifications. The GCR is available on the DVHA website to ensure that policy changes are transparent to Vermonters and to provide a forum for public comments.

The GCR listserv is a group of about 450 interested parties who have elected to receive periodic key updates about Vermont health care programs, which includes policy changes to all Medicaid programs as well as policy changes to Vermont's Health Benefit Exchange. A policy change in the GCR could be a change made under the authority of the waiver, a proposed waiver amendment or extension, an administrative rule change or a State Plan Amendment. The GCR also contains policy clarifications for when an issue is identified that is not clearly answered in current policy.

Health care policy stakeholders are notified via email every time a proposed or final policy is posted to the GCR; an email is also sent when policy clarifications are posted. Stakeholders have an opportunity to provide comments on proposed GCR policies before the policies are made final. Comments received are

posted in the GCR online. The GCR emails are also distributed to members of the Medicaid and Exchange Advisory Board.

Many policies were posted to the GCR in 2019. Of the 50 final policies issued, approximately six percent were notices of administrative rulemaking and 30 percent were State Plan Amendments (SPAs). Other final policies included reimbursement/rate changes, coding corrections, waiver amendment and public forums, and changes to covered services. There were two policy clarifications issued through the GCR in 2019.

The GCR can be found here: http://dvha.vermont.gov/global-commitment-to-health/global-commitment-register.

VI. Utilization Management

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

i. Clinical Utilization Review Board

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

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

The CURB has the following duties and responsibilities:

1) Identify and recommend to the Commissioner opportunities to improve quality, efficiencies, and adherence to relevant evidence-based clinical practice guidelines in the Department's medical programs by:
   a) Examining high-cost and high-use services identified through the programs' current medical claims data;
   b) Reviewing existing utilization controls to identify areas in which improved utilization review might be indicated, including use of elective, nonemergency, out-of-state outpatient and hospital services;
   c) Reviewing medical literature on current best practices and areas in which services lack sufficient evidence to support their effectiveness;
   d) Conferring with commissioners, directors, and councils within the Agency of Human Services and the Department of Financial Regulation, as appropriate, to identify specific opportunities for exploration and to solicit recommendations;

e) Identifying appropriate but underutilized services and recommending new services for addition to Medicaid coverage;
f) Determining whether it would be clinically and fiscally appropriate for the DVHA to contract with facilities that specialize in certain treatments and have been recognized by the medical community as having good clinical outcomes and low morbidity and mortality rates, such as transplant centers and pediatric oncology centers; and
g) Considering the possible administrative burdens or benefits of potential recommendations on providers, including examining the feasibility of exempting from prior authorization requirements those health care professionals whose prior authorization requests are routinely granted.

2) Recommend to the Commissioner the most appropriate mechanisms to implement the recommended evidence-based clinical practice guidelines. Such mechanisms may include prior authorization, prepayment, post service claim review, and frequency limits.

ii. Drug Utilization Review Board

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

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

Additionally, the Vermont Legislature enacted the Pharmacy Best Practices and Cost Control Program from the 2002 Appropriations Act, H. 485, which mandated that DVHA establish a pharmacy best practices and cost control program to reduce the cost of providing prescription drugs, while maintaining high quality in prescription drug therapies. It further specifies that the program adopt a preferred list of covered prescription drugs that identifies preferred choices within therapeutic classes including generic alternatives, DUR, utilization management including a prior authorization review process, and any other cost containment activity adopted by rule by the commissioner.

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

Executive order (No. 07-19), signed on September 5, 2019 by Governor Philip Scott was created to facilitate the alignment of DUR Board members terms. Based on this new Order, DUR Board member are now appointed to three-year terms with an option for a three-year extension. The Board is composed of 10-12 members of which at least one-third, but not more than half, of members are licensed and actively practicing physicians and at least one-third of its members are licensed and actively practicing pharmacists. In addition, there is one member at large who is typically a mid-level practitioner, currently a nurse practitioner. Board members are recommended for appointment by the DVHA Commissioner and approved by the Governor. Meetings of the DURB occur seven times per year.

The chart below lists some of the SFY2019 activities of the DUR Board.

Review Topic	SFY 2019 Total
Therapeutic Drug Classes: Periodic Review	43
Full New Drug Reviews	54
FDA Safety Alerts	10
New/Updated Clinical Guidelines	21
RetroDUR/ProDUR reviews	6
New Managed Therapeutic Drug Classes	4
BioSimilar Drug Reviews	2

.

iii. Appropriateness of Services

DVHA delegates to its IGA partners who provide care to the four identified special health care needs populations, the responsibility to develop mechanisms to assess the quality and appropriateness of care furnished to enrollees with special health care needs. DMH monitors the quality and appropriateness of care for enrollees in the Community, Rehabilitation and Treatment (CRT) Program through the biennial Minimum Standards Review and for children identified with severe emotional disturbance through Program Reviews. The Department of Disability, Aging and Independent Living (DAIL) monitors the quality and appropriateness of care to enrollees in the Developmental Services Program and the Traumatic Brain Injury Program through Quality Service Reviews. (For further descriptions of the delegated activities see the individual departments' quality plans.)

iv. Vermont Integrity Program

Key updates:

- DVHA's Program Integrity Unit underwent reorganization in 2018, resulting in two units now supporting Vermont's overall Integrity Program – Oversight & Monitoring Unit and Program Integrity Unit.
- Corrective action plans were put in place and actively pursued to ensure a reduction in repeat findings. Number of open items from audits open in 2017 or earlier reduced from twenty-one to ten. No audits OMU was responsible for in 2019 have repeat findings.
- Facilitated nine state and federal audits of DVHA programs from Federal and State regulators.
- DVHA continue to review existing Standard Operating Procedure (SOP) documents annually and continue to create new SOPs as needed to documents the risks and controls in each area and to provide leadership, regulators, examiners, and auditors with documentation to support the assessment that DVHA has a strong control environment. Being able to document a strong control environment (that stands up to audit testing) results in reduced testing and findings.

<u>Program Integrity Unit</u>

The Program Integrity Unit (PIU) is responsible for ensuring provider and beneficiary compliance with federal and state Medicaid regulations and has the responsibility to monitor, detect, prevent, and investigate inappropriate use of resources, fraud, waste and abuse.

The PIU works with providers, beneficiaries, federal and state partners such as the Centers for Medicare & Medicaid (CMS), Office of Inspector General (OIG), Medicaid Fraud & Residential Abuse Unit (MFRAU), fiscal agents, contractors, and many other various partners to ensure that federal and state regulatory requirements are met, and that compliance and integrity are fundamental in all aspects of the Vermont Medicaid program.

The Medicaid Management Information System (MMIS) is an integral component of the Program Integrity utilization review activities. The MMIS maintains Medicaid claims data, beneficiary eligibility and demographics, and provider enrollment information which allows for additional review and scrutiny of the Medicaid eligibility, enrollment, and claims data.

PIU staff examine beneficiary eligibility, provider enrollment and claims data to verify appropriate determinations in pre-& post payment reviews. Staff utilize data mining techniques and have developed a variety of algorithms to detect aberrant utilization. Medicaid policies, guidelines and claims data are utilized in the development of these algorithms. Reports generated from these reviews could result in supporting existing PI investigations or the creation of new investigations.

The PIU works to establish and maintain the integrity of the Medicaid program by engaging in activities to prevent, detect and investigate Medicaid provider fraud, waste and abuse. PIU receives referrals from a variety of sources and uses data mining and analytics to investigate allegations of fraud, waste and abuse. PIU works with Vermont Medicaid providers and partners to identify payment integrity issues and will provide education to providers when deficiencies and incorrect billing practices are identified. PIU works with providers to develop the appropriate resolution and recovers overpayments. Cases with credible allegations of fraud are referred to Medicaid Fraud Residential Abuse Unit (MFRAU). In addition, PIU assists other Medicaid program units to facilitate changes in policies, procedures, and program logic to ensure the integrity of the programs.

The PIU also has the responsibility to investigate, detect and prevent beneficiary healthcare eligibility and enrollment fraud in the Vermont Medicaid Program. The PIU works with the Health Access Enrollment & Eligibility Unit (HAEEU), as well as other state and federal partners to ensure Vermonters are receiving appropriate eligibility determinations based on their applications, and that income thresholds, residency and other means of determining coverage are correct. All other non-healthcare programs remain the responsibility of the Department for Children and Families (DCF), and PIU will work with DCF to evaluate and investigate allegations received with and joint nexus.

Outcomes

The Vermont PIU is regularly regarded by CMS, as well as other federal and state partners, as a leading and strong unit. The PIU takes pride in ensuring the appropriate use and spending of Medicaid federal and state dollars, which further allows for more flexibility in the budget to consider increased coverage options, increased budgetary appropriations, and potential increased rates.

In SFY 2019, the PIU reviewed approximately 177 cases related to potential provider fraud, waste and abuse allegations. Related to provider cases the PIU successfully settled, recovered and cost-avoided a collective $4,710,886. In addition, PIU cost-avoided and estimated $937,189 by investigating the Public Assistance Reporting Information System (PARIS) Interstate Match Report and removing beneficiaries from Vermont Medicaid that are active in Vermont and another state's Medicaid program simultaneously.

Oversight & Monitoring Unit

The Oversight & Monitoring Unit (OMU) is responsible for ensuring compliance, proper oversight, and appropriate use of Federal and State funds with minimal waste. OMU works to promote efficiency, accountability, compliance, and integrity within the DVHA Healthcare Program.

OMU includes Healthcare Program Oversight & Monitoring (O&M), Payment Error Rate Measurement (PERM) audit, HealthCare Quality Control (HCQC), and Promoting Interoperability/EHR Incentive Program (HIT Auditor).

Effective oversight & monitoring ensures:

- Compliance with Federal & State Medicaid Policies and regulations
- Transparent and appropriate responses to external audits
- Timely response to corrective action requests
- Clear documentation of policies and procedures (SOPs)
- Mitigation of potential fraud, waste and abuse

OMU works in partnership with the Program Integrity Unit, many Federal and State partners such as, the Centers for Medicare & Medicaid Services (CMS), the Office of Inspector General (OIG), the Medicaid Fraud & Residential Abuse Unit (MFRAU) of the Attorneys General (AG) Office, State's Attorney's Office, Medical Practice and Licensing Boards, Drug Enforcement Administration (DEA) and other Law Enforcement Offices. Additionally, there is always communication with Federal and State Regulators, AHS Departments, State Fiscal Agents, providers, beneficiaries, and more.

Oversight & Monitoring (O&M)

DVHA Oversight & Monitoring (O&M) was established to ensure the effectiveness and efficiency of departmental control environments, operational processes, financial and performance reporting in alignment with federal and state laws and regulations and the strategic direction of DVHA and AHS Leadership. This unit is the key liaison for DVHA Federal, State and independent examinations to ensure consistent, timely and professional response, and presentation of requested material.

O&M proactively evaluates units for audit readiness and provides consultation regarding auditor/regulator communications, proper response, follow up, escalation and reporting. Additionally, O&M acts as an intermediary and advocate for DVHA by establishing a basis of understanding and expectation for regulators, examiners, auditors, independent auditors and State senior leadership.

Outcomes

In calendar year 2019 the O&M unit made significant strides in coordinating DVHA participation in State, Federal, and independent audits and examinations, seeking to ensure that information shared is consistent, accurate, and timely. Specifically, O&M:

- Facilitated nine state and federal audits of DVHA programs
- Provided ongoing tracking and monitoring and follow-up of mitigation plans and other open Corrective Action Plans.
- Supported AHS and DVHA staff with documentation standards for better Standard Operating Procedures and policies.

The goal of the O&M group is to facilitate open communication, through a single voice, to ensure all expectations of auditors and regulators are met and that there are no repeat findings. Collectively, this transparency will promote further success of the program.

Payment Error Rate Measurement (PERM)

3-year cyclical audit conducted by CMS as required by federal law to determine improper payments in state Medicaid programs. This audit closely examines many aspects of Medicaid and CHIP claims: medical record documentation (MR), claims data processing (DP), and beneficiary eligibility (ER). The current audit is reviewing claims from 7/1/18 – 6/30/19.
O&M facilitates the PERM audit with the assistance of DVHA units such as HAEEU, LTC, Provider Relations, and the Business Office, and other state agencies whose claims are sampled in the audit, with the goal of timely and accurate response to CMS and the federal contractors administering the audit. As the cycle progresses, we will work with these same units to prepare corrective action plans addressing all errors identified in the audit.

Outcomes

- In 2019, the PERM audit sample (649 claims) was finalized by the statistical contractor (SC) and both the review contractor (RC) and eligibility review contractor (ERC) began their case reviews.
- Both the RC and ERC spent time at the state to learn from our Medicaid program experts and collect the case screen prints they need for the PERM reviews. Their reviews are ongoing. We continue to work closely with these contractors to provide them any additional documents and explanations needed to clarify audit questions.
- The medical record reviews are currently 97% complete and there are only a handful outstanding. We continue to outreach providers as necessary in an effort to eliminate any error findings based on missing/unsubmitted records.

Healthcare Quality Control Unit (HCQC)

HCQC was established to enhance DVHA's healthcare quality control program by performing independent monthly case reviews (post completion) for MAGI-based, VPharm, and Non-MAGI-based health care programs. Results of their reviews are shared with the Health Access Eligibility & Enrollment Unit (HAEEU), Long-Term Care (LTC), and Coordination of Benefits (COB) units. HCQC also is responsible for planning and conducting the federally mandated Medicaid Eligibility Quality Control (MEQC) audit every 3 years. This audit will cycle with PERM and happen in the year after PERM. The first MEQC audit is from 1/1/2020-12/31/2020.

Outcomes

- For FY 2018, 742 cases were reviewed.
- For FY 2019, 1007 cases have been reviewed.
- To date for FY 2020, 480 cases have been reviewed
- 1/1/2020 marks the first month of the review period for the MEQC audit.
- On 2/4/2020, the first sample was loaded into HCQC's new case management system
- Streamlined the Difference Resolution process to mirror the CMS DR process.

Promoting Interoperability Program (HIT Auditor)

The Promoting Interoperability Program (PIP), formerly known as the EHR Incentive Program (EHRIP), was established by the 2009 Health Information Technology for Economic and Clinical Health (HITECH) Act of the American Recovery & Reinvestment Act (ARRA). The program is designed to support providers during the period of health information technology transition and includes the requirement that States develop financial oversight and monitoring of expenditures for the Medicaid PIP/EHRIP. The post-

payment audit function of the program resides under the Oversight & Monitoring Unit and the pre-payment review function resides under the HIE Unit.

Outcomes

- Audits are performed following an Audit Plan, annually approved by CMS, to accommodate rule changes.
- Version 7.0 of the Audit Plan was approved by CMS in July of 2019.
- Approximately ten percent of individual providers and fifty percent of hospitals are selected for audit each program year.
- This year, twenty-two individual and one hospital audit have been completed. One individual failed audit and filed a Request for Reconsideration, which was denied. They currently have the option to file an Appeal.
- While 12/31/21 is the last day for incentive payments to be issued, HITECH 90/10 administrative funding for audit, appeals, and related activities, goes thru 9/30/23. The program's MAPIR application and support from the vendor (DXC) will need to continue through 2023 to allow for audits to occur and to process adjustments.

v. *Inpatient, Outpatient, and Emergency Department Utilization*

Methods

Utilization statistics for inpatient, outpatient, and emergency department services provided under Global Commitment during FFY 2017-19 were compiled by the DVHA's Data Unit in February 2020 using paid claims data. The scope of analysis included institutional services provided under the Medicaid program between 10/1/2016 and 9/30/2019, excluding crossover claims.[2] The following areas of utilization were the focus of this analysis:

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

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

Findings

The following table (Table 5) presents discharge counts and average length-of-stay by age for inpatient services provided in FFY 2017-19.

Table 5. Inpatient Utilization by Fiscal Year and Age Group

Total Inpatient:

	Sum LOS Days			Discharges			Average LOS Days		
Age	**2017**	**2018**	**2019**	**2017**	**2018**	**2019**	**2016**	**2018**	**2019**
<1	10,882	10,658	11,119	2,879	2,794	2,667	3.8	3.8	4.2
1-9	2,355	2,606	2,834	399	461	544	5.9	5.7	5.2
10-19	8,091	8,979	8,718	1,053	1,194	1,069	7.7	7.5	8.2
20-44	29,171	31,704	29,487	6,022	6,184	5,889	4.8	5.1	5

[2] Crossover claims or claims for which the State of Vermont was the payer of last resort and paid the remainder of cost for services covered by Medicare.

45-64	21,785	23,809	25,801	3,782	3,934	3,764	5.8	6.1	6.9
65+	1,050	590	1,067	139	85	66	7.6	6.9	16.2
Overall	**73,334**	**78,346**	**79,026**	**14,274**	**14,652**	**13,999**	**5.1**	**5.3**	**5.7**

A) Inpatient Medical (Alcohol/Substance + Mental Health + Other Medical):

	Sum LOS Days			Discharges			Average LOS Days		
Age	**2017**	**2018**	**2019**	**2017**	**2018**	**2019**	**2017**	**2018**	**2019**
<1	10,671	10,549	10783	2,848	2774	2640	3.7	3.8	4.1
1-9	1,972	2,216	2493	341	384	464	5.8	5.8	5.4
10-19	7,273	8,020	8133	892	1010	921	8.2	7.9	8.8
20-44	23,705	25,398	23089	4,794	4919	4672	4.9	5.2	4.9
45-64	14,934	17,315	19294	2,705	2882	2782	5.5	6	6.9
65+	883	526	958	116	74	58	7.6	7.1	16.5
Overall	**59,438**	**64,024**	**64750**	**11,696**	**12043**	**11537**	**5.1**	**5.3**	**5.6**

A1) Alcohol/Substance Inpatient Medical:

	Sum LOS Days			Discharges			Average LOS Days		
Age	**2017**	**2018**	**2019**	**2017**	**2018**	**2019**	**2017**	**2018**	**2019**
<1	4	-	-	1	-	-	4	-	-
1-9	-	-	-	-	-	-	-	-	-
10-19	120	63	47	7	13	12	17.1	4.8	3.9
20-44	1,724	1558	1774	399	401	399	4.3	3.9	4.5
45-64	1,290	1955	1613	262	367	325	4.9	5.3	5
65+	-	4	-	-	1	-	-	4	-
Overall	**3,138**	**3580**	**3434**	**669**	**782**	**736**	**4.7**	**4.6**	**4.7**

A2) Mental Health Inpatient Medical:

	Sum LOS Days			Discharges			Average LOS Days		
Age	**2017**	**2018**	**2019**	**2017**	**2018**	**2019**	**2017**	**2018**	**2019**
<1	5	-	27	2	-	3	2.5	-	9
1-9	951	1,239	1,323	56	74	83	17	16.7	15.9
10-19	5,525	6,261	6,388	423	572	519	13.1	10.9	12.3
20-44	11,553	13,200	10,909	1,185	1,261	1,174	9.7	10.5	9.3
45-64	4,115	4,965	6,718	352	429	402	11.7	11.6	16.7
65+	120	149	274	4	6	6	30	24.8	45.7
Overall	**22,269**	**25,814**	**25,639**	**2,022**	**2,342**	**2,187**	**11**	**11**	**11.7**

A3) Other Inpatient Medical:

	Sum LOS Days			Discharges			Average LOS Days		
Age	**2017**	**2018**	**2019**	**2017**	**2018**	**2019**	**2017**	**2018**	**2019**
<1	10,662	10,549	10,756	2,845	2,774	2,637	3.7	3.8	4.1
1-9	1,021	977	1170	285	310	381	3.6	3.2	3.1
10-19	1,628	1,696	1698	462	425	390	3.5	4	4.4
20-44	10,428	10,640	10,406	3,210	3,257	3,099	3.2	3.3	3.4
45-64	9,529	10,395	10,963	2,091	2,086	2,055	4.6	5	5.3
65+	763	373	684	112	67	52	6.8	5.6	13.2
Overall	**34,031**	**34,630**	**35,677**	**9,005**	**8,919**	**8,614**	**3.8**	**3.9**	**4.1**

B) Inpatient Surgery:

	Sum LOS Days	Discharges	Average LOS Days

Age	2017	2018	2019	2017	2018	2019	2017	2018	2019
<1	211	109	336	31	20	27	6.8	5.5	12.4
1-9	383	390	341	58	77	80	6.6	5.1	4.3
10-19	818	959	574	161	184	146	5.1	5.2	3.9
20-44	5,466	6,306	6,355	1,228	1,265	1,205	4.5	5	5.3
45-64	6,851	6,494	6,507	1,077	1,052	982	6.4	6.2	6.6
65+	167	64	109	23	11	8	7.3	5.8	13.6
Overall	**13,896**	**14,322**	**14,222**	**2,578**	**2,609**	**2,448**	**5.4**	**5.5**	**5.8**

The following table (Table 6) presents visit counts by age for outpatient services provided in FFY2017-19, first for all outpatient clinic services, emergency department services, other outpatient services, and then the combination of ED and other outpatient.

Table 6. Outpatient Utilization by Fiscal Year and Age Group

FFY17			**EXCLUDING Clinic**	
Age	**ED**	**Other**	**ED & Other**	**%ED**
<1	2,447	3,044	5,491	45%
1-9	13,774	19,248	33,022	42%
10-19	15,128	31,296	46,424	33%
20-44	37,621	106,020	143,641	26%
45-64	15,136	90,974	106,110	14%
65+	173	1,378	1,551	11%
Overall	**84,279**	**251,960**	**336,239**	**25%**
FFY18			**EXCLUDING Clinic**	
Age	**ED**	**Other**	**ED & Other**	**%ED**
<1	2,473	2,958	5,431	46%
1-9	13,764	19,581	33,345	41%
10-19	15,181	32,037	47,218	32%
20-44	36,322	104,607	140,929	26%
45-64	15,572	88,145	103,717	15%
65+	162	1,303	1,465	11%
Overall	**83,474**	**248,631**	**332,105**	**25%**
FFY19			**EXCLUDING Clinic**	
Age	**ED**	**Other**	**ED & Other**	**%ED**
<1	2,505	2,816	5,321	47%
1-9	13,358	19,618	32,976	41%
10-19	14,687	32,290	46,977	31%
20-44	34,750	102,742	137,492	25%
45-64	14,958	84,431	99,389	15%
65+	154	1,165	1,319	12%
Overall	**80,412**	**243,062**	**323,474**	**25%**

Discussion

In FFY2018, Global Commitment, Medicaid, paid for 13,999 inpatient stays and 323,474 outpatient visits for Vermonters. The total number of inpatient visits decreased 1.9% from FFY17 through FFY19. Eighty-

two percent of inpatient discharges were for medicine and 18% were for surgery. Outpatient visits have decreased largely due to an end to provider-based billing where hospital owned practices bill for separate professional fees.

Alcohol/substance-abuse inpatient stays were somewhat shorter duration, inpatient surgeries were moderately longer, and psychiatric stays were much longer duration than other inpatient medical stays. Psychiatric inpatient medical services constituted 16% of the total inpatient stays and medical treatment for alcohol and substance abuse were 5% of the total inpatient stays. Total bed days increased for both psychiatric and alcohol/substance abuse stays during FFY17 to FFY19. Average length of stay alcohol/substance abuse was about the same duration with an average of 4.7 days in FFY19 and inpatient psychiatric medical average length of stay was about 12 days.

Among outpatient visits, emergency department visits constituted roughly 25% of the emergency and other outpatient visits throughout the three-year period. Outpatient clinic facility visits were treated separately in this report due to fluctuations in billing practices.

VII. Policy and Administrative Difficulties

Fiscal & Operational Management:
For all CY2019, AHS paid DVHA 1/12 of the legislative budget for Global Commitment on the first business day of every month during the year. This payment serves as the proxy by which to draw down federal funds for Global Commitment. For each quarter in CY2019, the State prepared the CMS-64 based upon actual allowable Medicaid expenditures (program, investments, and administrative). (Please note administrative costs are now claimed outside of GC neutrality.) After each quarterly submission, AHS reconciled what was claimed on the CMS-64 versus the monthly payments made to DVHA.

For CY2019, the Supplemental Budget Neutrality Test for SUD Expenditures shows that SUD IMD expenses for ABD Adult, ABD Dual and non-ABD Adult have exceeded the without waiver limits by $391,071 gross; however, there is ample headroom in the overall without waiver budget neutrality limit to accommodate this overage. In addition, the SUD expenses for the New Adult MEG have exceeded the without waiver limit by $1,026,423 gross; similarly, there is ample headroom in the non-SUD IMD New Adult budget neutrality to accommodate this overage. The overall Budget Neutrality is in a favorable position.

It should also be noted that per STC#41, the State stayed below the CY2019 funding limit of $7.8M for state-funded marketplace subsidies with a cumulative total of $5.9M. Also, the State's CY2019 annual investment expenditures of $119.1M complied with the STC#84 annual limit.

AHS submitted the calendar year 2020 PMPM Medicaid rates during the 1219 quarter.

Also, in the 1219 quarter, AHS and CMS successfully negotiated an amendment to the Waiver which allows for expenditure authority for SMI/SED IMD expenses. This amendment will be effective January 1, 2020. AHS, DVHA and DMH are working to operationalize the reporting requirements for these expenditures.

VIII. Capitated Revenue Spending

The PMPM rates as set for 1/1/19-12/31/19 are listed below.

Medicaid Eligibility Group	DY 14 PMPM CY2019
ABD - Non-Medicare - Adult	$1,623.47
SUD - IMD ABD	$ 3,553.24
ABD - Non-Medicare - Child	$3,180.06
ABD - Dual	$2,795.58
SUD - IMD Dual	$ 2,799.44
ANFC - Non-Medicare - Adult	$708.86
SUD - IMD ANFC	$ 2,852.36
ANFC - Non-Medicare - Child	$587.93

New Adult Group	$ 562.71
SUD - IMD - New Adult	$ 3,006.05

[i] http://www.jabfm.org/content/30/1/25.full?sid=f635119b-7243-4bfe-bbd2-3241c11377f4; https://www.ncbi.nlm.nih.gov/pubmed/28379819; http://medicaleconomics.modernmedicine.com/medical-economics/content/tags/affordable-care-act/integrating-primary-care-and-mental-health-key-im?page=full

Attachments

Attachment 1 - Budget Neutrality

State of Vermont Global Commitment to Health
Budget Neutrality PMPM Projection vs 64 Actuals Summary
January 30, 2020

ELIGIBILITY GROUP	DY 12	DY 13	DY 14	DY 15	DY 16	Total
	JAN - DEC 2017	JAN - DEC 2018	JAN - DEC 2019	JAN - DEC 2020	JAN - DEC 2021	
Without Waiver (Caseload x pmpms)						
ABD - Non-Medicare - Adult	$ 142,860,455	$ 130,050,973	$ 132,168,316	$ -	$ -	$ 405,079,745
ABD - Non-Medicare - Child	$ 85,359,001	$ 78,434,428	$ 75,707,688	$ -	$ -	$ 239,501,117
ABD - Dual	$ 664,153,383	$ 693,539,886	$ 717,809,894	$ -	$ -	$ 2,075,503,163
ANFC - Non-Medicare - Adult	$ 101,757,250	$ 96,887,008	$ 73,374,099	$ -	$ -	$ 272,018,356
ANFC - Non-Medicare - Child	$ 392,665,288	$ 406,444,058	$ 413,279,514	$ -	$ -	$ 1,212,388,861
Total Expenditures Without Waiver	**$ 1,386,795,376**	**$ 1,405,356,354**	**$ 1,412,339,512**	**$ -**	**$ -**	**$ 4,204,491,242**
With Waiver						
ABD Non Medicare Adult	$ 162,602,154	$ 162,728,372	$ 168,382,861	$ -	$ -	$ 493,713,386
ABD - Non-Medicare - Child	$ 66,593,208	$ 60,077,015	$ 58,176,676	$ -	$ -	$ 184,846,898
ABD - Dual	$ 445,847,909	$ 461,739,496	$ 484,543,363	$ -	$ -	$ 1,392,130,768
ANFC - Non-Medicare - Adult	$ 84,040,228	$ 83,558,956	$ 66,315,388	$ -	$ -	$ 233,914,572
ANFC - Non-Medicare - Child	$ 305,543,574	$ 335,706,591	$ 350,804,595	$ -	$ -	$ 992,054,761
Premium Offsets	$ (655,991)	$ (772,935)	$ (774,152)	$ -	$ -	$ (2,203,077)
Moderate Needs Group	$ 1,488,408	$ 1,378,915	$ 1,429,868	$ -	$ -	$ 4,297,191
Marketplace Subsidy	$ 6,355,286	$ 6,242,717	$ 5,915,336	$ -	$ -	$ 18,513,340
VT Global Rx	$ 13,824,166	$ 15,300,919	$ 10,692,124	$ -	$ -	$ 39,817,209
VT Global Expansion VHAP	$ 414,824	$ 716,198	$ 906,394	$ -	$ -	$ 2,037,417
CRT DSHP	$ 10,331,787	$ 9,240,772	$ 6,787,058	$ -	$ -	$ 26,359,617
Investments	$ 142,332,671	$ 148,500,000	$ 119,133,232	$ -	$ -	$ 409,965,903
Total Expenditures With Waiver	**$ 1,238,718,223**	**$ 1,284,417,019**	**$ 1,272,312,742**	**$ -**	**$ -**	**$ 3,795,447,984**
Supplemental Test: New Adult (Gross)						
Limit New Adult	$ 370,689,611	$ 375,735,593	$ 368,916,052	$ -	$ -	$ 1,115,341,256
Without Waiver SUD - IMD New Adult Expenditures		$ 2,704,249	$ 4,842,747	$ -	$ -	$ 7,546,995
With Waiver New Adult Expenditures	$ 295,620,340	$ 312,104,578	$ 315,241,704	$ -	$ -	$ 922,966,621
With Waiver SUD - IMD New Adult Expenditures		$ 2,826,119	$ 5,869,169	$ -	$ -	$ 8,695,288
Surplus (Deficit)	*$ 75,069,271*	*$ 63,509,145*	*$ 52,647,926*	*$ -*	*$ -*	$ 191,226,342
Supplemental Test: IMD SUD (Gross)						
SUD - IMD ABD - Non-Medicare - Adult		$ 268,039	$ 529,433	$ -	$ -	$ 797,472
SUD - IMD ABD - Dual		$ 214,495	$ 442,312	$ -	$ -	$ 656,807
SUD - IMD ANFC - Non-Medicare - Adult		$ 533,391	$ 633,224	$ -	$ -	$ 1,166,615
Limit SUD IMD Without Waiver		**$ 1,015,926**	**$ 1,604,968**	**$ -**	**$ -**	**$ 2,620,894**
SUD - IMD ABD Non Medicare Adult		$ 249,820	$ 646,440	$ -	$ -	$ 896,261
SUD - IMD ABD - Dual		$ 199,224	$ 545,837	$ -	$ -	$ 745,061
SUD - IMD ANFC - Non-Medicare - Adult		$ 540,841	$ 803,762	$ -	$ -	$ 1,344,604
Limit SUD IMD With Waiver		**$ 989,886**	**$ 1,996,039**	**$ -**	**$ -**	**$ 2,985,925**
Surplus (Deficit)		*$ 26,040*	*$ (391,071)*	*$ -*	*$ -*	$ (365,031)
Waiver Savings Summary						
Annual Savings	$ 148,077,153	$ 120,939,335	$ 140,026,770	$ -	$ -	$ 409,043,258
Shared Savings Percentage	30%	25%	25%	25%	25%	
Shared Annual Savings	$ 44,423,146	$ 30,234,834	$ 35,006,692	$ -	$ -	$ 109,664,672
Total Savings	$ 44,423,146	$ 30,234,834	$ 35,006,692	$ -	$ -	$ 109,664,672
Cumulative Savings	***$ 44,423,146***	***$ 74,657,980***	***$ 109,664,672***	***$ 109,664,672***	***$ 109,664,672***	***$ 109,664,672***
	11%	9%	10%			

New Adult Waiver Savings Not Included in Waiver Savings Summary
See Budget Neutrality New Adult tab (STC#64)
See CY2019 Investments tab
See EG MM CY 2019 Tab for Member Month Reporting

Budget Neutrality New Adult

New Adult (w/ and w/o Child) Medical Costs Only	**DY 12 – PMPM**				**DY 13 – PMPM**				**DY 14 – PMPM**			
	QE 0317	**QE 0617**	**QE 0917**	**QE 1217**	**QE 0318**	**QE 0618**	**QE 0918**	**QE 1218**	**QE 0319**	**QE 0619**	**QE 0919**	**QE 1219**
(A) New Adult Group PMPM Projection	$518.26	$518.26	$518.26	$518.26	$540.03	$540.03	$540.03	$540.03	$562.71	$562.71	$562.71	$562.71
(B-1) eligible member months w/ Child	55,223	57,077	56,789	55,632	55,583	55,408	55,889	57,002	57,969	58,486	58,513	57,840
(B-2) eligible member months w/o Child	124,999	124,981	121,338	119,219	120,870	119,755	116,895	114,366	110,736	106,972	103,760	101,330
(C-1 = (A x B-1) Supplemental Cap 1 w/ Child	$ 28,619,871.98	$ 29,580,726.02	$ 29,431,467.14	$ 28,831,840.32	$ 30,016,487.49	$ 29,921,982.24	$ 30,181,736.67	$ 30,782,790.06	$ 32,619,735.99	$ 32,910,657.06	$ 32,925,850.23	$ 32,547,146.40
(C-2 = (A x B-2) Supplemental Cap 1 w/o Child	$ 64,781,981.74	$ 64,772,653.06	$ 62,884,631.88	$ 61,786,438.94	$ 65,273,426.10	$ 64,671,292.65	$ 63,126,806.85	$ 61,761,070.98	$ 62,312,254.56	$60,194,214.12	$58,386,789.60	$57,019,404.30
(D-1) New Adult FMAP w/ Child	54.46%	54.46%	54.46%	53.47%	53.47%	53.47%	53.47%	53.89%	53.89%	53.89%	53.89%	53.86%
(D-2) New Adult FMAP w/o Child	86.89%	86.89%	86.89%	86.69%	89.95%	89.95%	89.95%	89.99%	93.00%	93.00%	93.00%	93.00%
(E-1 = C-1 x D-1) Federal Share of Supplemental Cap 1 w/ Child	$ 15,586,382.28	$ 16,109,663.39	$ 16,028,377.00	$ 15,416,385.02	$ 16,049,815.86	$ 15,999,283.90	$ 16,138,174.60	$ 16,588,845.56	$ 17,578,775.73	$ 17,735,553.09	$ 17,743,740.69	$ 17,529,893.05
(E-2 = C2 x D-2) Federal Share of Supplemental Cap 1 w/o Child	$ 56,289,063.93	$ 56,280,958.24	$ 54,640,456.64	$ 53,562,663.92	$ 58,713,446.78	$ 58,171,827.74	$ 56,782,562.76	$ 55,578,787.77	$ 57,950,396.74	$ 55,980,619.13	$ 54,299,714.33	$ 53,028,046.00
Subtotal Federal Share Supplemental Cap 1	$ 71,875,446.21	$ 72,390,621.63	$ 70,668,833.64	$ 68,979,048.94	$ 74,763,262.64	$ 74,171,111.64	$ 72,920,737.36	$ 72,167,633.34	$ 75,529,172.47	$ 73,716,172.22	$ 72,043,455.02	$ 70,557,939.05
Total FFP reported for New Adult Group	$ 62,816,665.28	$ 61,830,391.33	$ 54,643,069.28	$ 51,158,852.52	$ 62,183,045.44	$ 63,756,150.76	$ 62,666,336.47	$ 61,269,677.13	$ 67,854,834.87	$ 68,588,592.26	$ 63,276,555.83	$ 54,245,264.74
Supplemental Budget Neutrality Test 1 over/(under) - report any negative # under main GC budget neutrality	$ 9,058,780.94	$ 10,560,230.30	$ 16,025,764.37	$ 17,820,196.41	$ 12,580,217.20	$ 10,414,960.88	$ 10,254,400.88	$ 10,897,956.21	$ 7,674,337.60	$ 5,127,579.96	$ 8,766,899.18	$16,312,674.31

Report to
The Vermont Legislature

Medicaid Program Enrollment and Expenditures Quarterly Report

In Accordance with 33 V.S.A. § 1901f

Submitted to: The General Assembly

Submitted by: Mike Smith, Secretary
Agency of Human Services

Prepared by: Cory Gustafson, Commissioner
Department of Vermont Health Access

Report Date: December 1st, 2019
(revised December 2nd, 2019)

VERMONT
AGENCY OF HUMAN SERVICES
DEPARTMENT OF VERMONT HEALTH ACCESS

TABLE OF CONTENTS

BACKGROUND 2

KEY TERMS 2

MEDICAID PROGRAM ENROLLMENT AND EXPENDITURES 4

BACKGROUND

In accordance with 33 V.S.A. § 1901f, a quarterly report on enrollment and total expenditures by Medicaid eligibility group for all programs paid for by the Department of Vermont Health Access shall be submitted to the General Assembly by March 1, June 1, September 1, and December 1 of each year. To the extent such information is available, total expenditures for Medicaid-related programs paid for by other departments within the Agency of Human Services shall be included.

KEY TERMS

Caseload: Average monthly member enrollment

PMPM: Per Member Per Month

MEG: Medicaid Eligibility Group

- **ABD Adult**: Beneficiaries age 19 or older; categorized as aged, blind, disabled, and/or medically needy
- **ABD Dual**: Beneficiaries eligible for both Medicare and Medicaid; categorized as aged, blind, disabled, and/or medically needy
- **General Adult**: Beneficiaries age 19 or older; pregnant women or parents/caretaker relatives of minor children receiving cash assistance and those receiving transitional Medicaid after the receipt of cash assistance
- **New Adult Childless**: Beneficiaries age 19 or older and under 65; who are at or below 133% of the FPL who do not have dependent children
- **New Adult w/Child:** Beneficiaries age 19 or older and under 65; who are at or below 133% of the FPL who have dependent children
- **BD Child:** Beneficiaries under age 19; categorized as blind, disabled, and/or medically needy
- **General Child:** Beneficiaries under age 19, and below the protected income level, categorized as those eligible for cash assistance including Reach Up (Title V) and foster care payments (Title IV-E)
- **Underinsured Child:** Beneficiaries under age 19 with household income 237-312% FPL with other (primary) insurance

CHIP: Children's Health Insurance Program; Beneficiaries under age 19 with household income 237-312% FPL with no other insurance

Sunsetted Programs: Expenditures still being incurred for programs no longer active such as VHAP, VHAP ESI, and Catamount.

Vermont Premium Assistance: Individuals enrolled in qualified health plans (QHP) with incomes at or below 300% FPL

Vermont Cost Sharing: Individuals enrolled in qualified health plans (QHP) with incomes at or below 300% FPL

Pharmacy Only: Assistance to help pay for prescription medicines based on income, disability status, and age

Choices for Care (Traditional): Vermont's Long-Term Care Medicaid Program for Vermonters in nursing homes, home-based settings, and/or enhanced residential care (ERC)

Choices for Care (Acute): Long-Term Care Medicaid for Vermonters who would otherwise qualify for Choices for Care (Traditional), but who are currently receiving a lower level of care

MEDICAID PROGRAM ENROLLMENT AND EXPENDITURES

The Department of Vermont Health Access
Caseload and Expenditure Report
All AHS and AOE YTD SFY'20

	SFY'20 As Passed			SFY'20 Actuals Thru September 30, 2019			% of Expenses to
Medicaid Eligibility Group	Caseload	Budget	PMPM	Caseload	Expenses	PMPM	Budget Line Item
ABD Adult	6,031	$ 140,899,312	$ 1,946.88	6,359	$ 34,945,235	$ 1,831.70	24.80%
ABD Dual	17,804	$ 232,065,960	$ 1,086.21	17,375	$ 58,594,191	$ 1,124.09	25.25%
General Adult	12,867	$ 88,653,500	$ 574.17	8,281	$ 15,353,923	$ 618.04	17.32%
New Adult Childless	39,273	$ 229,699,189	$ 487.40	34,274	$ 54,066,622	$ 525.83	23.54%
New Adult w/Child	18,813	$ 90,771,890	$ 402.08	19,341	$ 26,065,791	$ 449.24	28.72%
BD Child	2,112	$ 59,706,690	$ 2,355.85	1,889	$ 12,822,604	$ 2,262.68	21.48%
General Child	59,708	$ 343,868,454	$ 479.93	57,396	$ 75,987,765	$ 441.31	22.10%
Underinsured Child	584	$ 1,474,509	$ 210.40	546	$ 236,723	$ 144.52	16.05%
CHIP	4,697	$ 10,270,816	$ 182.22	4,332	$ 3,344,770	$ 257.37	32.57%
Sunsetted Programs		$ -			$ 144,935		
Vermont Premium Assistance	19,951	$ 6,914,219	$ 28.88	16,326	$ 1,444,114	$ 29.49	20.89%
Vermont Cost Sharing	4,052	$ 1,314,872	$ 27.04	3,735	$ 293,989	$ 26.23	22.36%
Pharmacy Only	10,125	$ 7,465,318	$ 61.44	10,177	$ 324,282	$ 10.62	4.34%
Choices for Care - Traditional	4,390	$ 213,712,634	$ 4,056.81	4,300	$ 54,936,617	$ 4,258.65	25.71%
Choices for Care - Acute	4,390	$ 34,265,489	$ 650.45	4,300	$ 8,428,523	$ 653.37	24.60%
Total Medicaid	196,355	$ 1,461,082,851	$ 620.09	180,596	$ 346,990,083	$ 640.45	23.75%

The Department of Vermont Health Access

Caseload and Expenditure Report

All AHS YTD SFY'20

Medicaid Eligibility Group	SFY'20 As Passed Caseload	SFY'20 As Passed Budget	SFY'20 As Passed PMPM	SFY'20 Actuals Thru September 30, 2019 Caseload	SFY'20 Actuals Thru September 30, 2019 Expenses	SFY'20 Actuals Thru September 30, 2019 PMPM	% of Expenses to Budget Line Item
ABD Adult	6,031	$ 147,857,367	$ 2,043.02	6,359	$ 34,725,681	$ 1,820.20	23.49%
ABD Dual	17,804	$ 262,468,117	$ 1,228.51	17,375	$ 58,547,262	$ 1,123.19	22.31%
General Adult	12,867	$ 102,161,665	$ 661.65	8,281	$ 15,286,896	$ 615.34	14.96%
New Adult Childless	39,273	$ 218,326,967	$ 463.27	34,274	$ 54,043,556	$ 525.60	24.75%
New Adult w/Child	18,813	$ 73,651,050	$ 326.24	19,341	$ 26,065,434	$ 449.23	35.39%
BD Child	2,112	$ 50,844,420	$ 2,006.17	1,889	$ 10,017,014	$ 1,767.60	19.70%
General Child	59,708	$ 304,317,884	$ 424.73	57,396	$ 68,540,933	$ 398.06	22.52%
Underinsured Child	584	$ 1,215,226	$ 173.41	546	$ 194,854	$ 118.96	16.03%
CHIP	4,697	$ 14,649,058	$ 259.90	4,332	$ 3,010,560	$ 231.65	20.55%
Sunsetted Programs		$ -			$ 144,935		
Vermont Premium Assistance	19,951	$ 6,914,219	$ 28.88	16,326	$ 1,444,114	$ 29.49	20.89%
Vermont Cost Sharing	4,052	$ 1,314,872	$ 27.04	3,735	$ 293,989	$ 26.23	22.36%
Pharmacy Only	10,125	$ 7,465,318	$ 61.44	10,177	$ 324,282	$ 10.62	4.34%
Choices for Care - Traditional	4,390	$ 213,712,634	$ 4,056.81	4,300	$ 54,936,617	$ 4,258.65	25.71%
Choices for Care - Acute	4,390	$ 28,719,705	$ 545.17	4,300	$ 8,428,523	$ 653.37	29.35%
Total Medicaid	196,355	$ 1,433,618,501	$ 608.43	180,596	$ 336,004,650	$ 620.18	23.44%

The Department of Vermont Health Access

Caseload and Expenditure Report

DVHA Only YTD SFY'20

Medicaid Eligibility Group	SFY'20 As Passed Caseload	SFY'20 As Passed Budget	SFY'20 As Passed PMPM	SFY'20 Actuals Thru September 30, 2019 Caseload	SFY'20 Actuals Thru September 30, 2019 Expenses	SFY'20 Actuals Thru September 30, 2019 PMPM	% of Expenses to Budget Line Item
ABD Adult	6,031	$ 53,364,028	$ 737.36	6,359	$ 13,239,919	$ 693.99	24.81%
ABD Dual	17,804	$ 56,831,305	$ 266.00	17,375	$ 14,609,510	$ 280.27	25.71%
General Adult	12,867	$ 72,488,541	$ 469.47	8,281	$ 12,130,836	$ 488.30	16.73%
New Adult Childless	39,273	$ 195,378,448	$ 414.57	34,274	$ 45,035,891	$ 438.00	23.05%
New Adult w/Child	18,813	$ 78,136,341	$ 346.11	19,341	$ 22,789,087	$ 392.77	29.17%
BD Child	2,112	$ 19,287,093	$ 761.01	1,889	$ 5,723,152	$ 1,009.91	29.67%
General Child	59,708	$ 150,490,908	$ 210.04	57,396	$ 37,980,833	$ 220.58	25.24%
Underinsured Child	584	$ 490,900	$ 70.05	546	$ 141,926	$ 86.65	28.91%
CHIP	4,697	$ 8,439,212	$ 149.73	4,332	$ 2,415,446	$ 185.86	28.62%
Sunsetted Programs					$ 144,935		
Vermont Premium Assistance	19,951	$ 6,914,219	$ 28.88	16,326	$ 1,444,114	$ 29.49	20.89%
Vermont Cost Sharing	4,052	$ 1,314,872	$ 27.04	3,735	$ 293,989	$ 26.23	22.36%
Pharmacy Only	10,125	$ 7,465,318	$ 61.44	10,177	$ 324,282	$ 10.62	4.34%
Choices for Care - Traditional	4,390	$ -	$ -	4,300	$ -	$ -	0.00%
Choices for Care - Acute	4,390	$ 28,269,908	$ 536.63	4,300	$ 7,306,579	$ 566.40	25.85%
Total Medicaid	196,355	$ 678,871,092	$ 288.11	180,596	$ 163,580,499	$ 301.93	24.10%

VERMONT
AGENCY OF HUMAN SERVICES
DEPARTMENT OF VERMONT HEALTH ACCESS

State of Vermont
Department of Vermont Health Access
280 State Drive, NOB 1 South
Waterbury, VT 05671-1010

Agency of Human Services
[Phone] 802-879-5900
http://dvha.vermont.gov

Questions, Complaints and Concerns Received by Health Access Member Services
October 1, 2019 – December 31, 2019

The following information represents the monthly documentation of Green Mountain Care Member Questions, Complaints, and Concerns as reported to Green Mountain Care Member Services (1-800-250-8427) per quarter. Calls are addressed per guidelines (policy, scripts, multi-tier resolver groups) developed by the Department of Vermont Health Access and in collaboration with Maximus. The nature of each call is assessed by the customer service representative (CSR) and the appropriate action (appeal rights, fair hearings, policy explanation, etc.) is then applied. If the call requires an action or advice that is beyond the scope of information available to the CSR, the member is then afforded a warm transfer to the appropriate subject matter expert within DVHA (e.g. Provider and Member Relations, Health Access Eligibility & Enrollment Unit, etc.). Each documented question, complaint, or concern is captured in order to ensure that the member's needs are met and that proper resolution is guaranteed.

October 2019:

- Caller wanted to submit negative feedback about her provider. Caller states the facility treats them like a number instead of a person. Caller states facility needs to change on how they treat their customers and need to alleviate the number of people there because they take on so many clients. When the caller's daughter was very ill she was seen by several PCPs who were prescribing her different treatments. Caller states they are treating the express care like a walk-in only. Caller states her daughter is unable to see her PCP because of overflow of patients. Caller states the system there needs to be changed. Caller stated that this happened within the last few months. Caller stated it's unacceptable to be sitting there for 2 1/2 hours in order to be seen. CSR apologized for their frustration, offered to try to help find a new PCP and offered the complaint form as well as to document their feedback about this provider's office.

November 2019:

- Caller wants to submit feedback regarding our covered services. Caller states they require internet to run certain DME. Their internet bill continues to be raised and they are unable to afford it. Caller states it would be a good idea if Dept. of Health works out a discount

with internet providers during times in which internet is required for DME. Caller states they are sure there will be more DME that is coming that will also require internet and that other states have agreements worked out with internet providers for DME use. CSR apologized for their frustration and offered to document their feedback.

- Caller wanted to submit feedback about Medicaid providers. Caller states it's impossible to find a doctor that will accept Medicaid. Caller states that the doctor's he has seen previously that accept Medicaid didn't even follow general accepted principles like using sterile gloves etc. CSR apologized for their frustration and offered to assist them in finding a new provider. Also documented their feedback.
- Caller wanted to submit negative feedback about the transportation benefit. Caller is frustrated that they are unable to get a ride due to having a car in their household and able to drive. Caller feels it is unfair for their ride to be denied as they are a working individual and it seems everyone else who doesn't work can get rides no problem. CSR apologized for their frustrations, explained the benefit to them and ways it could be covered. Also, offered to document their feedback.
- Caller wanted to submit negative feedback as they feel that we should offer vision coverage plans. CSR apologized for their frustration and offered to document their feedback.

December 2019:

- Caller wanted to submit feedback because they think Medicaid is over paying for Enteral Supplies. Enteral Supplies are feeding their son through a tube in his stomach. The company that they get the supplies from is Bio Scripts. There are four items that Bio Scripts would bill Medicaid for. The first one is food. Four cases every month of 2 Cal HM. Bio Scripts is billing $980.00 for four of those cases. Caller states they purchased the same items from the supplier for $155.00. The next item Medicaid bought are the syringes and they can be reused. Caller gets more than they need each month and Bio Scripts sent 30 tubes/syringes and charged Medicaid $18.00 per syringe. Caller purchases syringes online for $2.00 a piece as needed. Caller feels this should be brought to the states attention. CSR apologized for their frustration with this and offered to document their feedback.

VERMONT

Agency of Human Services

Grievance and Appeal Quarterly Report
Medicaid Managed Care Model
All Departments Combined Data
October 1, 2019 – December 31, 2019

The Medicaid Managed Care Model is composed of various administrative areas within the Agency of Human Services (AHS). These include: the Department of Vermont Health Access (DVHA), the Department for Children and Families (DCF), the Department of Mental Health (DMH), the Department of Disabilities, Aging and Independent Living (DAIL), and the Department of Health (VDH). Also, included in the Medicaid Managed Care Model are the Designated Agencies (DA) and Specialized Service Agencies (SSA) that provide service authorizations for DMH and DAIL. Each entity should have at least one assigned grievance and appeal coordinator who enters data into the centralized grievance and appeals database. This report is based on data compiled on February 16, 2020 from the centralized database that were filed from October 1, 2019 through December 31, 2019.

Grievances: A grievance is an expression of dissatisfaction about any matter that is not an action taken by the Medicaid Managed Care Model.

During this quarter, there were 23 grievances filed; thirteen were addressed and two were withdrawn during the quarter. Grievances must be addressed within 90 days of filing, so having pending cases at the end of the quarter is to be expected. Acknowledgement letters of the receipt of a grievance must be sent within five days; the average was three days. Of the grievances filed, 87% were filed by the beneficiary, 9% were filed by the beneficiary's representative and 4% were filed by another source. Of the 23 grievances filed, DMH had 91%, DCF had 4% and DAIL had 4%. There were no grievances filed for DVHA or VDH during this quarter.

Grievances were filed for service categories case management, counseling services, and mental health services.

There were no Grievance Reviews filed this quarter.

Appeals: Health Care Administrative Rule 8.100 defines adverse benefit determinations that the Managed Care Model makes that are subject to an internal appeal. These actions are:

1. denial or limitation of authorization of a requested covered service or eligibility for service, including the type, scope or level of service;
2. reduction, suspension or termination of a previously authorized covered service or a service plan;
3. denial, in whole or in part, of payment for a covered service;
4. failure to provide a clinically indicated, covered service, when the Managed Care provider is a DA/SSA;
5. failure to act in a timely manner when required by state rule;
6. denial of a beneficiary's request to obtain covered services outside the network.

During this quarter, there were 32 appeals filed. Of these 32 appeals, 19 were resolved (57%), 10 were still pending (31%), 1 was filed too late (3%) and 3 were withdrawn (9%).

Of the 19 appeals that were resolved this quarter, 74% were resolved within the statutory time frame of 30 days. Five appeal were resolved after the 30-day timeframe, one of these appeals was extended at the request of the beneficiary. The average number of days it took to resolve these cases was 26 days. Acknowledgement letters of the receipt of an appeal must be sent within five days; the average was two days.

Of the 32 appeals filed, DVHA had 22 appeals filed (69%), DAIL had 8 (25%), VDH had 2 (6%) and DMH none.

The appeals filed were for service categories; disability determinations, orthodontics, surgical, personal care, chiropractic, transportation, long term care, community supports, prescriptions, community/social supports, home health services, imaging, prescriptions and case management.

Beneficiaries must exhaust the internal appeal process before they can file a fair hearing if their appeal is not decided in their favor. There were three fair hearing filed this quarter.

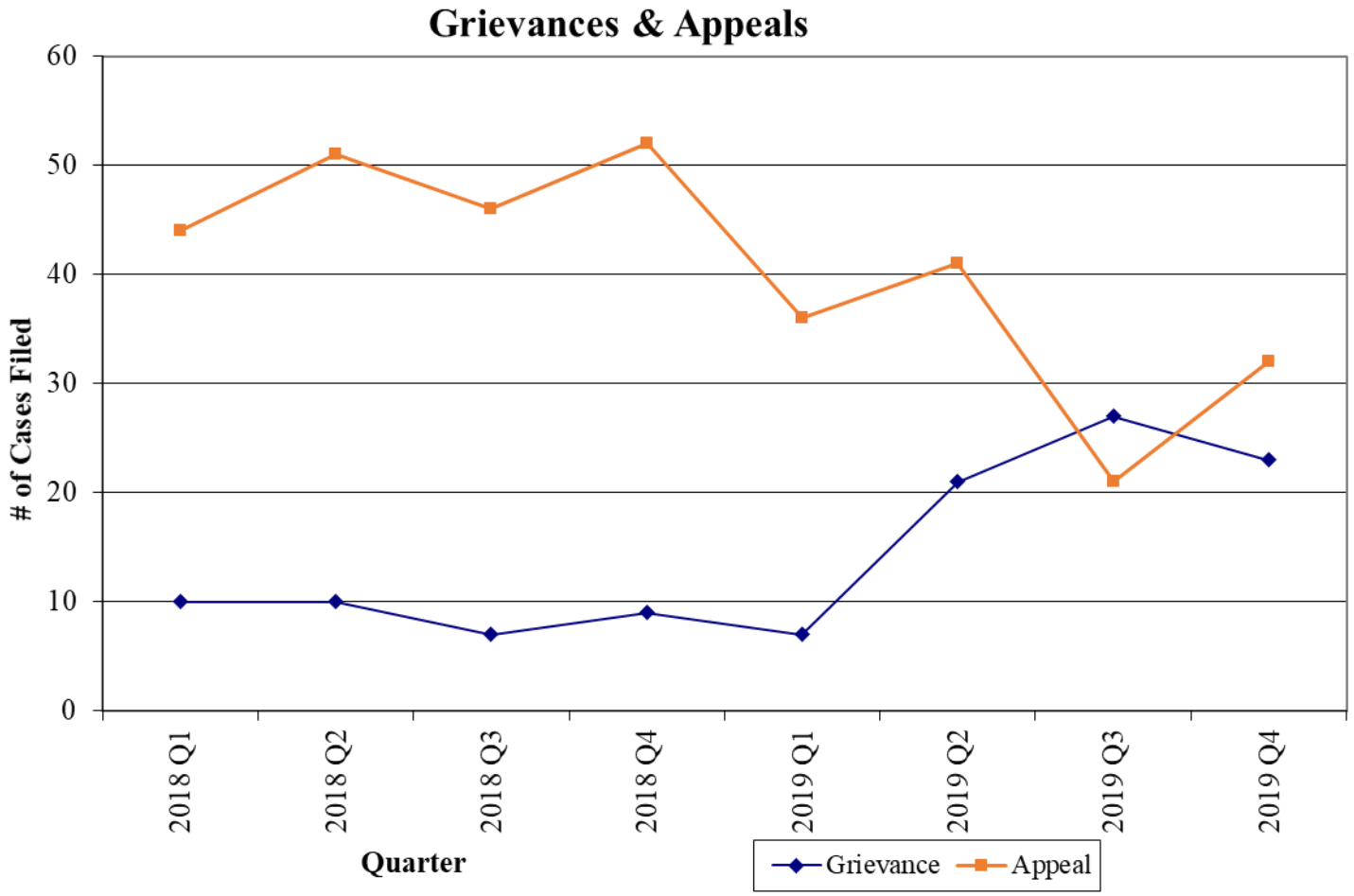
2019 Summary:

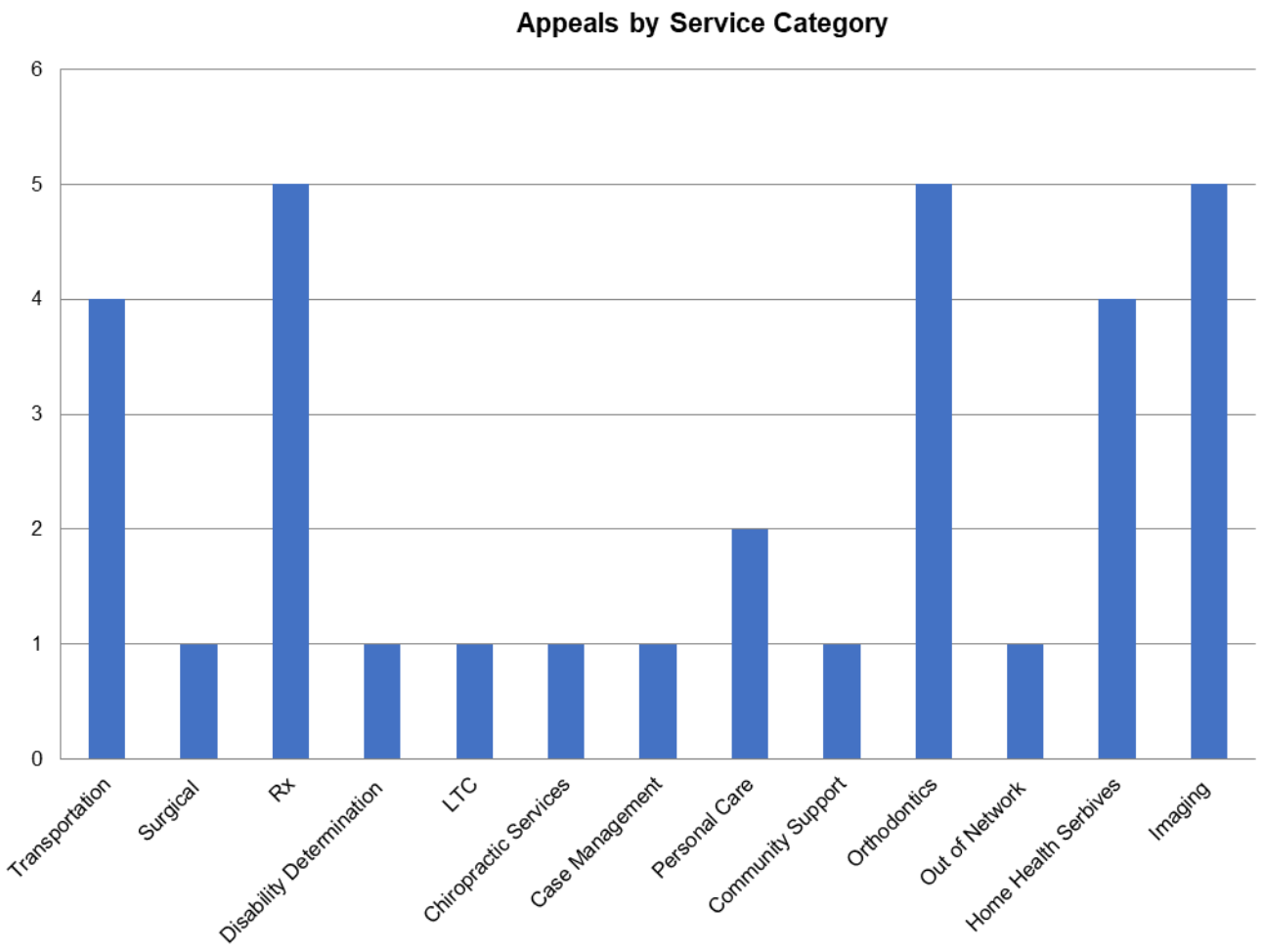
Grievances: There were 114 Grievances filed in 2019. Of those 114 grievances filed, DAIL had 17%, DMH had 73%, DVHA had 9% and DCF had 1%.

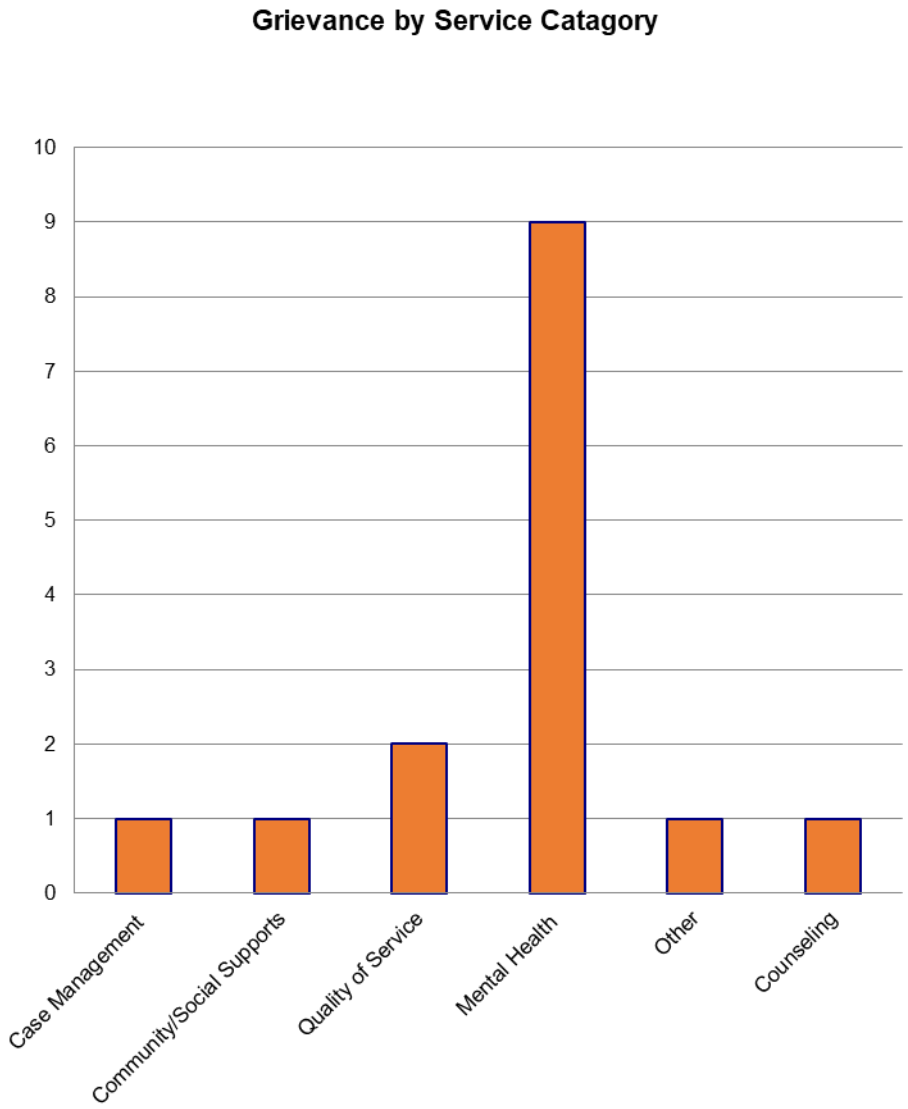
The top service categories for grievances filed were for mental health, community/social supports and case management.

Appeals: There were 172 appeals filed in 2019. Of those appeals filed, DAIL had 44%, DMH had 4%, DVHA had 47%, VDH had 6%, and DCF had 3%.

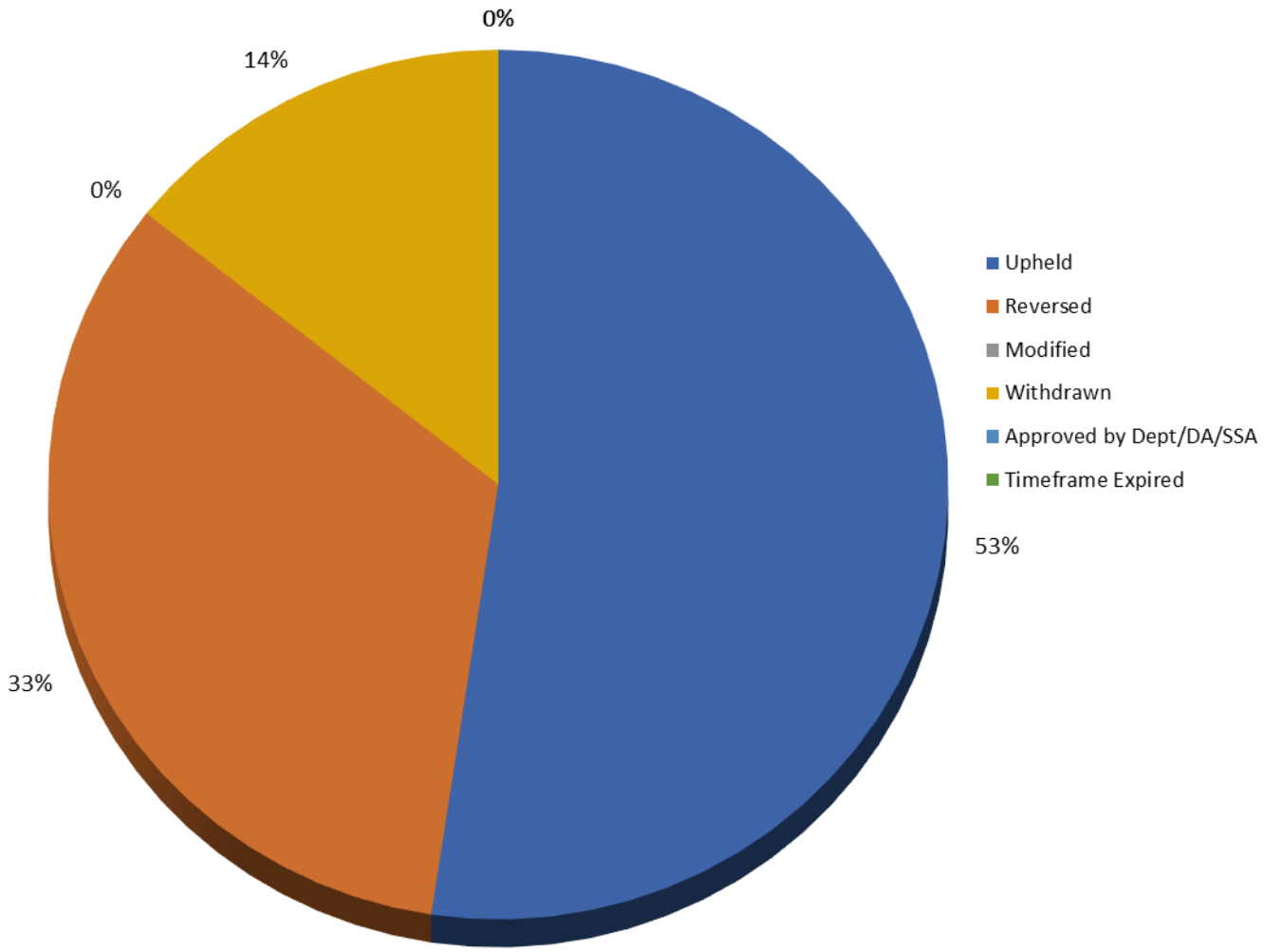
The top reasons for appeal were, orthodontic services, prescriptions, transportation services, community/social supports, imaging, case management long-term care and personal care services.


Grievances & Appeals
60
50
40
30
20
10
0
# of Cases Filed
2018 Q1
2018 Q2
2018 Q3
2018 Q4
2019 Q1
2019 Q2
2019 Q3
2019 Q4
Quarter
Grievance
Appeal


Appeals by Service Category
6
5
4
3
2
1
0
Transportation
Surgical
Rx
Disability Determination
LTC
Chiropractic Services
Case Management
Personal Care
Community Support
Orthodontics
Out of Network
Home Health Serbives
Imaging


Grievance by Service Catagory
10
9
8
7
6
5
4
3
2
1
0
Case Management
Community/Social Supports
Quality of Service
Mental Health
Other
Counseling

Appeal Resolutions
10/1/2019 thru 12/31/2019



Vermont Legal Aid

Office of the Health Care Advocate

Quarterly Report

October 1, 2019 - December 31, 2019

to the

Agency of Administration

submitted by

Michael Fisher, Chief Health Care Advocate

Office of the Health Care Advocate

January 17, 2020

TABLE OF CONTENTS

Introduction **3**

Individual Consumer Assistance **6**

Case Examples 6

Priorities **8**

Consumer Protection Activities **13**

A. Rate Review 13

B. Oversight of Accountable Care Organizations 133

C. Certificate of Need Applications 133

D. Other Green Mountain Care Board Activities 133

E. Other Activities 144

Outreach and Education **17**

A. Increasing Reach and Education through the Website 17

B. Other Outreach and Educational Activities 188

C. Promoting Plain Language in Health Communications 21

Introduction

The Office of the Health Care Advocate (HCA) advocates for all Vermonters through both individual consumer assistance and systemic advocacy on health care issues. We work to increase access to high quality, affordable health care for all Vermonters through individual advocacy and representing the public before the Green Mountain Care Board, state agencies, and the state legislature.

The HCA advocates focused on Open Enrollment during this quarter for both Medicare and Vermont Health Connect. During the annual Medicare enrollment, beneficiaries can change Part D prescription drug plans or decide to sign up for a Medicare Advantage Plan. We had 89 cases involving Medicare consumer education. We also talked to 25 households about Medicare Part D plans, and 22 households about Low Income Subsidy, a federal program that lowers out of pocket prescription costs for low income Part D enrollees. We also advised 23 consumers like Spencer (see panel at right) about VPharm, the state pharmacy assistance program that helps with premiums and copayments.

During the Vermont Health Connect (VHC) Open Enrollment, we advised 91 households on Premium Tax Credit eligibility. We advised 59 households on special enrollment periods for Vermont Health Connect and another 40 households on buying VHC plans.

The HCA held two health care town hall meetings in Bennington and Rutland counties this quarter to hear directly from Vermonters about local access to health care issues. At these events, legislators, health care leaders, and community members heard impassioned voices about what is working well and what needs to be changed.

Spencer's Story:

Spencer called the HCA because he could not afford to pick up his prescription. He was enrolled in a Medicare Part D prescription drug plan as well as VPharm 2. VPharm is the state pharmacy assistance program that works with Part D plans. It helps with the monthly premium and reduces copayments to $1 or $2. There are three levels of VPharm: 1, 2 and 3. VPharm 1 reduces copayments for all covered medications. VPharm 2 & 3 reduce copayments only for maintenance medications for chronic conditions and diabetic supplies. Spencer's VPharm 2 helps with his maintenance medications. For all other prescriptions, he owed the full amount set by his Part D plan. The previous time he had filled this prescription, the cost was $2, but now the cost was over $100. When the HCA advocate investigated, she found that the medication was no longer being considered a maintenance medication, and that was why Spencer was not getting the VPharm copayment rate. The HCA advocate learned that Spencer's provider had previously submitted a prior authorization (PA) requesting that the medication be treated as a maintenance medication. However, that PA had expired. The HCA advocate worked with Spencer's provider to get a new PA request submitted. The new PA was approved, and Spencer was able to pick up the prescription for $2.

The HCA represents Vermonters through individual, administrative, and legislative advocacy. Our policy priorities reflect our daily work with Vermonters struggling with a health care system that often does not meet their needs. We work to control unnecessary costs and make the health care system sustainable, and to ensure that Vermont consumers are heard by providers and policy-makers.

Overview

The HCA provides assistance to consumers through our statewide hotline (**1-800-917-7787**) and through the Online Help Request feature on our website, Vermont Law Help (*https://vtlawhelp.org/health)*. We have a team of advocates located in Vermont Legal Aid's Burlington office that provides this help to any Vermont resident free of charge, regardless of income.

The HCA received 921 calls[1] this quarter. We divided these calls into broad categories. The figures below are based on the All Calls data. The percentage and number of calls in each issue category, based on the caller's primary issue, were as follows:

- **23.24%** (214) about **Access to Care**
- **10.10%** (93) about **Billing/Coverage**
- **4.23%** (39) about **Buying Insurance**
- **11.62%** (107) **about Complaints**
- **12.16 %** (112) about **Consumer Education**
- **27.58%** (254) about **Eligibility** for state and federal programs
- **9.01%** (83) were categorized as **Other**, which includes Medicare Part D, communication problems with providers or health benefit plans, access to medical records, changing providers or plans, confidentiality issues, and complaints about insurance premium rates, as well as other issues.

We have a customized case management system that allows us to track more than one issue per case. This enables us to see the total number of calls that involved a particular issue. For example, although 254 of our cases had eligibility for state and federal healthcare programs listed as the primary issue, an additional 454 cases had eligibility listed as a secondary concern.

In each section of this narrative, we indicate whether we are referring to data based on just primary issues, or primary and secondary issues combined. Determining which issue is the "primary" issue is sometimes difficult when there are multiple causes for a caller's problem. This has proven to be particularly true for Vermont Health Connect (VHC) cases. See the breakdowns of the issue numbers in the individual data reports for a more detailed look at how many callers had questions about issues in addition to the "primary" reason for their call.

The most accurate information about eligibility for state programs is in the All Calls data report because callers who had questions about Vermont Health Connect and Medicaid programs fell into all three insurance status categories.

The full quarterly report for October-December 2019, includes:

- This narrative, which contains sections on **Individual Consumer Assistance**, **Consumer Protection Activities,** and **Outreach and Education**
- Seven data reports, including three based on the caller's insurance status:
  - **All Calls/All Coverages**: 921 calls (compared to 934 calls last quarter)
  - **Department of Vermont Health Access (DVHA) beneficiaries**: 314 calls (313 calls last quarter)

[1] The term "call" includes cases we get through the intake system on our website.

- **Commercial Plan Beneficiaries**: 184 calls (165 calls last quarter)
- **Uninsured Vermonters**: 73 calls (89 calls last quarter)
- **Vermont Health Connect (VHC)**: 203 calls (209 calls last quarter)
- **Reportable Activities (Summary & Detail)**: 34 activities and 4 documents (51 activities, 7 documents)

Individual Consumer Assistance

Case Examples

These case summaries illustrate the types of problems we helped Vermonters resolve this quarter:

Mia's Story

Mia called the HCA because she could not afford her prescription. When she had gone to the pharmacy to pick it up, the cost was over $100. The HCA advocate discovered that Mia had been enrolled on VPharm, the state pharmacy assistance program that helps reduce out of pocket costs for Medicare Part D and keeps copayments in the $1 to $2 range. The HCA advocate found out that Mia's VPharm had closed for non-payment. When the HCA advocate investigated, though, she discovered that Mia's coverage had been closed in error. First, Mia had made her monthly payment on time, but it had not been applied correctly. In addition, the closure notice that Mia received was inadequate. When a health care program is closing, the State of Vermont must send a notice describing what is closing, and when and why it is closing. Mia's notice did not list the program that was closing, which is why she did not realize what was happening. Because of the mistakes, Vermont Health Connect reinstated the VPharm, and Mia was able to pick up her prescription with the regular low copayment.

Reed's Story

Reed had just moved to Vermont, and was living with his grandparents. His grandparents had become his new guardians, but they did not have any information about his prior insurance coverage from his past guardian. They called the HCA because Reed needed a prescription. They also wanted to take him to the doctor, so they wanted to establish coverage as soon as possible. The HCA advocate assisted Reed's grandparents with the application, and was able to get it submitted to Vermont Health Connect. The application was expedited, and Reed was approved for Medicaid the same day the application was submitted. This meant Reed's grandparents were able to pick his prescriptions and make appointments with providers.

Kara's Story

Kara called the HCA because she had moved to Vermont and was having trouble signing up for coverage. Kara was on Medicare, and had previously been on a Medicare Savings Program to help pay for Medicare costs. Medicare Savings Programs (MSP) pay for Part B premiums, and in some cases, Medicare cost-sharing. By the time she called the HCA, she had been in Vermont for several months and had not been able to get any help with the Medicare costs. The HCA advocate advised Kara that she should be eligible for a Medicare Savings Program to help pay her monthly Medicare costs and for Medicaid for Aged Blind and Disabled (MABD) that would also help with the cost-sharing. The advocate helped Kara with the application and submitted it to Vermont Health Connect. Kara was approved for an MSP and MABD, and she now felt comfortable making appointments to see new providers.

Hayley's Story

Hayley called the HCA because she was worried about the costs related to her pregnancy care. Hayley was already on a Vermont Health Connect (VHC) plan that cost several hundred dollars a month. Under the Affordable Care Act, pregnancy coverage is an essential health benefit, and it is included as a

covered benefit within the Qualified Health Plans (QHPs) on VHC. Also, the deductible on QHPs is waived for preventive care related to the pregnancy. Hayley was having a high risk pregnancy and expected to need a lot of care. The HCA advocate studied Hayley's household income and found that if she could reduce her taxable income, she would be able to qualify for Dr. Dynasaur for pregnancy. Dr. Dynasaur for pregnancy has no monthly premium, no copayments, and includes dental benefits. Hayley was able to make a contribution to a traditional IRA and reduce her taxable income. This made her eligible for Dr. Dynasaur going forward and saved her thousands in dollars in premiums and costs over the entire pregnancy.

Beth's Story

Beth called because she had been terminated from her Qualified Health Plan (QHP) on VHC for non-payment, and she did not understand why. Beth received Advance Premium Tax Credit (APTC) to help pay for her premium. Because she received APTC, she was entitled to a three-month grace period, which meant that if she fell behind on her premium payments, she had three months to catch up. She should have received grace period notices for each of the three months prior to the termination. In addition, in the second and third months of the grace period, claims are "pended." This means that they are not paid until the person gets out of the grace period. When the HCA advocate studied Beth's case, she found that she did not receive all three of her grace period notices. She also continued to have claims paid during the second and third months of the grace period, so she did not realize she was in a grace period and in danger of losing her coverage. Because of the failure to send the required grace period notices, VHC agreed to reinstate the coverage.

Abigail's Story

Abigail called the HCA because she was having trouble scheduling a Medicaid ride to her provider. Without the ride, she was going to miss her appointment. Vermont Medicaid includes coverage of transportation to provider appointments. However, to be eligible for Medicaid transportation, you need to show that you do not have access to a vehicle in your Medicaid household. Abigail was being told that she could not schedule the ride because someone in her Medicaid household had a vehicle. The HCA advocate quickly pointed out that Abigail was the only person in her Medicaid household, and she did not have access to any vehicles, so this was not a valid reason for denying her ride. The Medicaid transportation broker agreed and scheduled the ride.

Zach's Story

Zach was turning 26 and was about to age out of his parent's health insurance plan. Under the Affordable Care Act, children are able to stay on their parents' plans until they turn 26. He called the HCA because he was unsure about his next steps and worried about affording coverage. He had a job, but was not eligible for employer coverage for several months. The HCA advocate explained that because his coverage through his parents' plan was ending, he would be eligible for a Special Enrollment Period to enroll in a Vermont Health Connect Plan. The advocate helped Zach complete and submit the application. Because he was not yet eligible for his employer plan, Zach was eligible for Advance Premium Tax Credit (APTC) to help pay his monthly premium. With the APTC, Zach's monthly premium was less than $100. Also the HCA advocate explained that Zach could get off the VHC plan once he became eligible for his employer plan.

Priorities

A. The HCA presented a joint training with the Division of Vocational Rehabilitation.

The HCA presented a joint training with the Division of Vocational Rehab for attorneys and paralegals at Vermont Legal Aid and Legal Services Vermont. The HCA focused specifically on the eligibility rules for Medicaid for the Working Disabled. It also focused on SSDI and Medicare, and health care options for those who have been found disabled but are not yet eligible for Medicare. Staff from the Division of Vocational Rehabilitation discussed different programs and services for consumers, and answered questions. We discussed how the organizations could streamline referrals to ensure that consumers were getting the assistance that they were eligible for. The HCA plans a follow up training with Voc Rehab later this year.

B. The HCA continues to work on making Hospital Patient Financial Assistance Policies more accessible.

The HCA continued to advocate for improvements to Vermont hospitals' patient financial assistance policies (FAPs). The HCA closely reviewed the FAPs of the five largest Vermont hospitals and provided those hospitals with our analysis of their policies' compliance with federal regulations. During the hospital budget review process, hospitals committed to working with us to improve their policies. This project transitioned into a work group effort with UVMMC, RMC, VAHHS, and the HCA, to develop a plain language summary template that will be a resource for all Vermont hospitals. In addition, we have started to advocate for best practices improvements to financial assistance policies and patient financial counseling practices at all Vermont hospitals. We advised 29 households on applying for Patient Financial Assistance. This work is ongoing.

C. Overall HCA call volume stayed nearly the same.

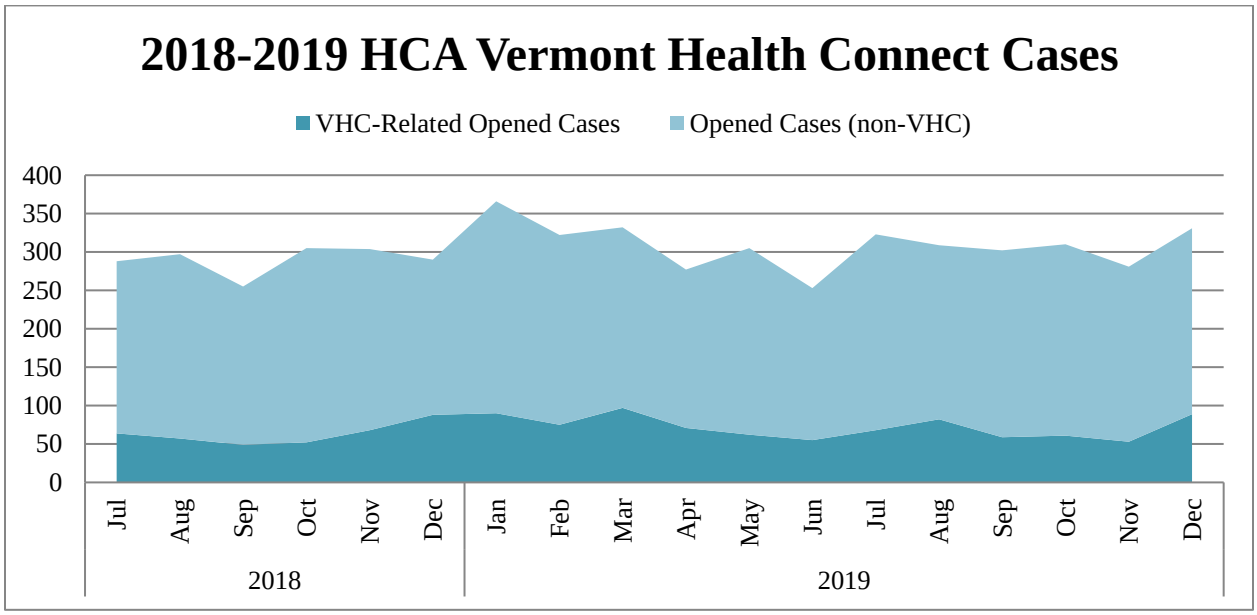
The HCA had 921 calls this quarter, compared to 934 calls last quarter. The HCA talked to many consumers about Medicare Part D open enrollment and Vermont Health Connect Open Enrollment during this quarter. About 11% of this quarter's calls involved getting consumers onto new coverage, preventing the loss of coverage, or obtaining coverage for services. We also helped 51 households estimate their eligibility for insurance programs. We saved consumers $28,010.26 this quarter.

D. Calls concerning Vermont Health Connect remained steady this quarter.

The volume of calls concerning Vermont Health Connect stayed nearly the same (203 calls this quarter compared to 209 calls last quarter). The top VHC issue remained eligibility for MAGI Medicaid. This was the primary issue in 72 cases and secondary issue in 56 cases. This quarter, 55 VHC cases required complex interventions that took more than two hours of an advocate's time to resolve, and another 35 cases required a direct intervention to resolve the case.

The HCA continues to resolve its cases by working directly with Tier 3 Health Access Eligibility Unit (HAEU) workers, who are trained to resolve all aspects of complex cases. In addition, the HCA meets with VHC as needed to discuss cases, and has regular email contact with Tier 3. This quarter we had 47 escalated cases (39 last quarter). Of the 47 escalated cases, 41 were resolved within the quarter.

Tier 3 also now works on resolving Green Mountain Care cases (VPharm, Medicaid for Aged Blind and Disabled (MABD), Medicare Saving Programs, and Medicaid Spend Downs). This quarter we continued to receive significant numbers of consumers calling with questions about Medicare Savings Programs (68), MABD (74), Medicaid Spend Down (11) and VPharm eligibility (23).



E. Medicaid eligibility calls represented 31% of all our cases (282 cases/921 total cases). Consumers need assistance with all types of Medicaid.

Medicaid eligibility was again the top issue generating calls. We had 128 calls about eligibility for Medicaid for Children and Adults (MCA) Medicaid, 74 about eligibility for Medicaid for the Aged Blind and Disabled (MABD), 11 about Medicaid Spend Downs, and 15 about Medicaid for Working Disabled, and 4 about Katie Beckett Medicaid. We also had 50 calls about Long Term Care Medicaid. MAGI Medicaid and MABD Medicaid have different eligibility and income rules, and HCA advocates assess and advise on eligibility for both programs. Consumers frequently have questions about what counts as income, who should be counted in their household, what expenses can be used to meet a Spend Down, how to complete renewal paperwork, and whether their eligibility decision is correct.

F. The top issues generating calls

The listed issues in this section include both primary and secondary issues, so some of these may overlap.

All Calls 921 (compared to 934 last quarter)

1. MAGI Medicaid eligibility 128 (127)
2. Premium Tax Credit eligibility 91 (82)
3. Medicare Consumer Education 89 (67)
4. Complaints about providers 86 (107)
5. Information/applying for DVHA programs 86 (74)
6. Medicaid eligibility (non-MAGI) 74 (68)
7. Buy-in programs/Medicare Savings Programs 68 (57)
8. Access to Prescription Drugs/Pharmacy 67 (70)
9. Termination of Insurance 67 (51)
10. Information about HCA 66 (55)
11. Eligibility for Special Enrollment Periods 59 (73)
12. Not health related 56 (74)
13. Long Term Care Medicaid & Choices for Care Eligibility 50 (25)
14. Nursing Home & Home Health access 44 (43)
15. Buying QHPs through VHC 38 (20)

Vermont Health Connect Calls 203 (compared to 209 last quarter)

1. Premium Tax Credit eligibility 86 (76)
2. MAGI Medicaid eligibility 79 (80)
3. Termination of Insurance 43 (42)
4. Eligibility for Special Enrollment Periods 42 (57)
5. Buying QHPs through VHC 37 (20)
6. Information about DVHA 34 (38)
7. ACA Tax Issues 21 (12)
8. Premiums billing 19 (17)
9. Complaints about VHC – Invoices or Payment 18 (25)
10. Complaints about VHC – Eligibility Error 18 (14)

DVHA Beneficiary Calls 314 (compared to 313 last quarter)

1. MAGI Medicaid eligibility 61 (56)
2. Information about DVHA 36 (25)
3. Medicaid eligibility (non-MAGI) 35 (31)
4. Access to Prescription Drugs/Pharmacy 27 (27)
5. Buy In Programs/MSPs eligibility 25 (19)
6. Termination of Insurance 24 (9)
7. Complaints about providers 24 (26)
8. Information about Medicare 20 (23)
9. Information about HCA 19 (19)
10. Access to dental care 18 (11)

11. Access to transportation 18 (21)
12. Long Term Care Medicaid & Choices for Care Eligibility 18 (10)

Commercial Plan Beneficiary Calls 184 (compared to 165 last quarter)

1. Premium Tax Credit eligibility 50 (38)
2. Buying QHPs through VHC 25 (12)
3. Information about Medicare 23 (7)
4. MAGI Medicaid eligibility 22 (19)
5. Termination of Insurance 21 (16)
6. Information about ACA (20) (13)
7. Information about HCA 20 (10)
8. Premiums billing 19 (13)
9. Information about DVHA 19 (10)
10. Termination of Insurance 17 (16)

The HCA received 921 total calls this quarter. Callers had the following insurance status:

- **DVHA program beneficiaries** (Medicaid, Medicare Savings Program also called Buy-In program, VPharm, or both Medicaid and Medicare also known as "dual eligible"): 34% (314 calls) compared to 33.1% (309 calls) last quarter
- **Medicare**[2] **beneficiaries (**Medicare only, Medicare Advantage Plans, Medicare and a Medicare Supplemental Plan aka Medigap, Medicare and Medicaid also known as "dual eligible," Medicare and Medicare Savings Program also called Buy-In program, Medicare and Part D, or Medicare and VPharm): 27% (247 calls) compared to 26.7% (250 calls) last quarter
- **Commercial plan beneficiaries** (employer-sponsored insurance, small group plans, or individual plans 20% (184 calls) compared to 17.3% (162 calls) last quarter
- **Uninsured:** 8.0% (73 calls) compared to 9.5% (89 calls).

Case Results

A. Dispositions of Closed Cases

All Calls

We closed 914 cases this quarter, compared to 917 last quarter:

- 39% (359 cases) were resolved by brief analysis and advice
- 32% (289) were resolved by brief analysis and referral
- 15% (141) of the cases were complex interventions involving complex analysis, usually direct intervention, and more than two hours of an advocate's time
- 10% (88) were resolved by direct intervention, including calling an insurance company, calling providers, writing letters, gathering supporting medical documentation, etc.
- In the remaining cases, 32 clients withdrew, resolved the issue on their own, or had some other outcome.

[2] Because Medicare beneficiaries can also have commercial or DVHA coverage, these Medicare numbers overlap with the figures for those categories.

Appeals: The HCA worked on 41 cases related to appeals: 25 Fair Hearings; 6 Commercial Insurance appeals; 6 Medicare Part A, B, or C appeals; 0 Medicare Part D appeals; and 4 Medicaid MCO Internal appeals.

DVHA Beneficiary Calls

We closed 310 DVHA cases this quarter, compared to 324 last quarter:

- 28% (87 cases) were resolved by brief analysis and/or advice
- 19% (59) were considered complex intervention, which involves complicated analysis, usually direct intervention, and more than two hours of an advocate's time
- 36% (111) were resolved by brief analysis and/or referral
- 14% (44) were resolved by direct intervention on the caller's behalf, including advocacy with the carrier and providers, writing letters, and gathering medical information
- In the remaining cases, 7 clients resolved the issue on their own, or had some other outcome.

Commercial Plan Beneficiary Calls

We closed 183 cases involving individuals on commercial plans, compared to 183 last quarter:

- 45% (82 cases) were resolved by brief analysis and/or advice
- 21% (38) were considered complex intervention, which involves complicated analysis, usually direct intervention, and more than two hours of an advocate's time
- 17% (32) were resolved by brief analysis and/or referral
- 12% (22) were resolved by direct intervention on the caller's behalf, including advocacy with the carrier and providers, writing letters, and gathering medical information
- In the remaining cases, 3 clients withdrew, resolved the issue on their own, or had some other outcome.

B. All Calls Case Outcomes

The HCA helped 532 people with advice and education about health insurance questions or problems. We obtained insurance for 65 households. We assisted 9 people with applications for or enrollment in insurance plans and prevented 18 insurance terminations or reductions. We obtained coverage for services for 19 people. We got 9 claims paid, written off, or reimbursed. We estimated VHC insurance program eligibility for 51 more. We provided other billing assistance to 15 individuals. We obtained other access or eligibility outcomes for 70 additional people.

Consumer Protection Activities

A. Rate Review

The HCA analyzes all commercial insurance carrier requests to the Green Mountain Care Board (Board) to change premium prices. Insurers typically request an increase in the premium prices that Vermonters must pay.

The Board decided two filings during the quarter from October 2019 through December 2019.

MVP Health Plan, Inc. (MVP) submitted the two filings decided by the Board this quarter, namely, the MVP 2020 Large Group POS Riders and the MVP 2020 Large Group HMO (collectively Filings). The Filings were closely related and were analyzed and decided together, as the Board always has. Approximately 1,800 Vermonters who obtain coverage through their employers were impacted by the Filings. MVP filed for an average annual premium price increase of 16.7% for the portion of the rate determined by the rating formula. For groups renewing in 1Q20 the average proposed premium increase was 16.7% and for groups renewing in 2Q20 the average proposed premium increase was 8.4%.

The HCA appeared on behalf of Vermonters, filed questions to the carrier, filed various motions, and submitted a Memorandum In Lieu of Hearing in these matters. The Board reduced MVP's average premium price increase for groups renewing in 1Q20 to approximately 15% and for groups renewing in 2Q20 to 7%.

There are no premium price increase requests pending at the end of this quarter.

B. Oversight of Accountable Care Organizations

The HCA represents Vermonters in the Board's annual ACO budget review process which took place this quarter. The Board reviewed the budget of OneCare Vermont, the state's only ACO. The HCA reviewed OneCare's 2020 budget materials which included responses to questions from the HCA, submitted a set of written questions to OneCare after reviewing its initial budget materials, reviewed all responses to Board and HCA questions, and participated in OneCare's budget hearing before the Board. We met regularly with the Board's ACO budget staff throughout this process to discuss the budget submissions and responses to questions, and we met with OneCare to discuss questions the HCA continued to have following the hearing. Finally, we submitted formal comments on OneCare's 2020 Budget. Our comments expressed our concerns about OneCare's transparency and population health management and our suggestions for improving the ACO regulatory process.

C. Certificate of Need Applications

This quarter, the HCA continued to monitor new certificate of need applications and updates from previously approved certificate of need projects submitted to the Board. We intervene for any projects where we have significant consumer protection concerns.

D. Other Green Mountain Care Board Activities

The HCA continues to attend the weekly Board meetings. At the November 13, 2019 Board meeting, we made a verbal public comment about Vermont Information Technology Leader's move to an opt out patient consent policy. After having significant initial concerns about the project, we stated that we are now cautiously optimistic about how this is unfolding and applaud the inclusion of representatives of

vulnerable populations in the planning process. The Chief Advocate also attended the Board's Advisory Committee meeting in November and we attended the December Hospital CFO meeting.

E. Other Activities

Administrative Advocacy

✧ **Rural Health Task Force**

The Rural Health Task Force was formed as directed by Act 26 of 2019. This taskforce is made up of a broad range of provider groups who focus on rural health care delivery in Vermont. The HCA was an active participant in this workgroup. The members of this group met a number of times this quarter focusing on workforce, care management, telemedicine, distribution of healthcare infrastructure, and financial sustainability. The culmination of this effort was the creation of a presentation to the legislature.

✧ **Definition of Primary Care Work Group**

The HCA participated in the Primary Care work group defined in Act 107 of 2019. The work group's membership includes Vermont Association of Hospitals and Health Systems, BiState primary Care, Green Mountain Care Board, the Agency of Human Services, Department of Vermont Health Access, the Blueprint for Health, OneCare Vermont, Vermont Medical Society, Blue Cross/Blue Shield, MVP Healthcare, and the office of the Health Care Advocate. After reviewing both state and national definitions of primary care, the group compared those standards to determine the best standard for Vermont. The group reached significant consensus around a broadly-inclusive definition of primary care. This standard may not be particularly useful as a tool to compare Vermont primary care spending to other states or countries, due to significant variations in the definition of primary care. It will, however, provide a useful benchmark to measure expansion or contraction of primary care spending in Vermont over the years. This workgroup continued to meet a few times this quarter followed by a review of proposed drafts of a report to the legislature.

✧ **Vermont Health Information Exchange Consent Policy**

The HCA advocated for meaningful informed consent for patient participation in Vermont's Health Information Exchange. The HCA engaged with state partners to assure that there is a robust outreach and communications plan to ensure that Vermonters understand how and why their health information will be shared. In December, the HCA advocacy team participated in a training with VITL in preparation for new VHIE consent policy. Further, related to the consent policy, DVHA recently formed a committee to evaluate the implementation of the new consent policy. We were invited to be a member of this committee and are participating. In December, we attended an orientation for the evaluation committee. The committee will meet monthly to both review data related to the implementation of the consent policy and establish consent policy evaluation methods.

✧ **Gender Affirming Surgery**

This quarter, the HCA testified in the October 2019 LCAR hearing in support of HCAR 4.238. LCAR voted to approve the rule, which increases access to medically necessary surgery for transgender and non-binary Vermonters on Medicaid. In the year leading up to this approval, the HCA coordinated outreach

with local, regional, and national stakeholder organizations, attended the public hearing**,** and submitted written comments during this comment period. After the approval, the HCA coordinated dissemination of the improved coverage guidelines to stakeholders and community members through local organizations and medical providers. Throughout the HCA's work on this issue, our priorities are ensuring that Medicaid is accurately determining medical necessity while decreasing onerous barriers to access to care for Vermonters with gender dysphoria.

✧ **Global Commitment Register Comments**

The HCA continues to monitor Global Commitment rule and policy changes. This quarter we reviewed several proposed rule and policy changes.

✧ **Vermont Health Connect Escalation Path**

The HCA and VHC continue to collaborate to resolve complex VHC issues. The VHC escalation path now also works to resolve issues regarding Medicaid for Aged, Blind and Disabled (MABD), Medicare Savings Programs, Medicaid Spend Downs, and V-Pharm. We communicate with VHC multiple times per day and meet as needed to discuss the most difficult cases.

✧ **Comments on Vermont Health Connect Notices**

At VHC's request, the HCA commented on 6 notices, in an effort to make them more readable and consumer-friendly. See **Promoting Plain Language in Health Communications** below.

✧ **Medicaid and Exchange Advisory Board**

This quarter, the Chief Health Care Advocate continued to co-chair and actively participate in Vermont's Medicaid and Exchange Advisory Board (MEAB). This quarter, the MEAB membership had a particular focus on Success Beyond Six, Health Information Technology, and Electronic Visit Verification. The Chief attended and co-chaired two meetings of the MEAB this quarter.

Legislative Activities

The HCA participated in various legislatively-defined work groups including, the Rural Health Services Task Force, Vermont Health Information Exchange Opt-Out Consent Policy implementation, Definition of Primary Care work group, Dental Access and Reimbursement Working Group and the Price Transparency Billing Processes stakeholder group, Health Insurance Affordability Report, and the Merged Insurance Markets report.

The Chief Advocate met with a number of health care committee members in their communities this quarter to update them on the summer and fall regulatory activities and to be responsive to legislative requests. The HCA was available and responsive to numerous legislator inquiries about policy issues and constituent access to care issues during this quarter. In addition, the Chief Health Care Advocate initiated meetings with various key legislators to discuss the coming session.

Collaboration with Other Organizations

The HCA regularly collaborates with other organizations to advance consumer-oriented policy objectives and to conduct outreach and education. We worked with the following organizations this quarter:

- American Civil Liberties Union of Vermont
- Bi-State Primary Care
- Bennington Free Clinic
- Blue Cross Blue Shield of Vermont
- Community Catalyst
- Families USA
- Health Policy Institute, Georgetown University
- Healthcare Value Hub
- IRS Taxpayer Advocate Service
- The Janet S. Munt Family Room
- MVP Health Care
- National Center for Transgender Equality
- Network for Public Health Law
- NHeLP, National Health Law Program
- OneCare Vermont
- Out in the Open (formerly Green Mountain Crossroads)
- Outright Vermont
- Pride Center of Vermont
- Planned Parenthood of Northern New England
- QueerConnect Bennington
- Rights and Democracy Vermont
- Rutland County Free Clinic
- Rutland Regional Medical Center
- SHIP, State Health Insurance Assistance Program
- University of Vermont Medical Center
- Vermont Association of Hospitals and Health Systems
- Vermont Businesses for Social Responsibility
- Vermont Care Partners
- Vermont CARES
- Vermont Department of Health
- Vermont Department of Taxes
- Vermont Developmental Disabilities Council
- Vermont Health Connect
- Vermont Medical Society
- Vermont Program for Quality in Health Care
- Vermont Workers' Center
- You First

Outreach and Education

Quarterly report – website stats – Oct - Dec 2019

*Note: Office pageviews of the health web pages are included in the numbers here. The **only** numbers where office traffic is **excluded** are the Online Help Tool numbers.*

A. Increasing Reach and Education through the Website

VTLawHelp.org is a statewide website maintained by Vermont Legal Aid and Legal Services Vermont. The site includes a substantial Health section (*https://vtlawhelp.org/health*) with more than 180 pages of consumer-focused health information maintained by the HCA.

HCA advocates work diligently to keep the site updated in order to provide the latest and most accurate information to Vermont consumers.

Popular Web Pages

- The total number of **health pageviews increased by 18%** in the reporting quarter ending December 31, 2019 (14,529 pageviews), compared with the same quarter in 2018 (12,354 pageviews).

- The **top-20 health pages** on our website this quarter with change over last year:
  1. *Income Limits – Medicaid* – 2,752 pageviews (18% ↓)
  2. *Health* – section home page – 1,329 (28% ↓)
  3. *Medicaid* – 647 (171% ↑)
  4. *Dental Services* – 642 (58% ↑)
  5. *Resource Limits – Medicaid* – 423 (1%↓)
  6. *Medicaid, Dr. Dynasaur & Vermont Health Connect* – 398 (290% ↑)
  7. *Services Covered by Medicaid* – 388 (20% ↓)
  8. *Supplemental Plans Medicare* – 358 (165% ↑)
  9. *Vermont Health Connect main page* – 355 (66% ↑)
  10. *Medicare Savings / Buy-In Programs* – 325 (84% ↑)
  11. *HCA Help Request Form* – 318 pageviews (34% ↑) and 116 online help requests (73% ↑)
  12. *Long-term Care* – 312 (100% ↑)
  13. *Choices for Care* – 268 (18% ↓)
  14. *Medicaid and Medicare Dual Eligible* – 235 (46% ↑)
  15. *Medical Decisions: Advance Directives* – 232 (78% ↑)
  16. *Prescription Help – State Pharmacy Programs* – 227 (91% ↑)
  17. *Medicare* – 218 (506% ↑)
  18. *Dr. Dynasaur* – 217 pageviews (58% ↑)
  19. *Open Enrollment 2020 news item* – 206 (100% ↑)
  20. *Medicaid Transportation* – 206 (78% ↑)

- Besides the pages listed above, other **spikes in interest** in our pages included:
  - *Medicare Part D Plans* – 126 (186% ↑)
  - *Premium Tax Credits* – 105 (184% ↑)
  - *How to Get Durable Medical Equipment* – 101 (45% ↑)
  - *Moving from VHC to Medicare* – 114 (124% ↑)

Popular Downloads

19 different health care-related PDF, Word or other files were downloaded from the VTLawHelp.org website. The top downloads were:

- *Advance Directive, short form* (97 downloads)
- *Advance Directive, long form* (76 downloads)
- *Vermont Dental Clinics Chart* (39 downloads)
- *VHC to Medicare flyer* (33 downloads)
- *Vermont Medicaid Coverage Exception Standards flyer* (23 downloads)
- *5 Step Guide to DME* (22 downloads)

The *Advance Directive Short Form* is the **third most downloaded of all PDFs** downloaded from the entire VTLawHelp.org website. The *Long Form* is the **fifth most downloaded**. The *Vermont Dental Clinics Chart* is the **11th most downloaded**.

Online Help Tool Adds to Our Reach

Health is one of the topics in the online help tool on our website. It can be accessed from most pages of our website *https://vtlawhelp.org/triage/vt_triage*.

The website visitor answers a few questions to find specific health care information they need. The tool addresses some of the most popular questions that are posed to the HCA. In addition to our deep collection of health-related web pages, the online help tool adds a new way to access helpful information — at all hours of the day and night. The website user can also call us or fill in our online form to get personal help from an advocate.

Website visitors used this tool to access health care information **244 times** during this quarter. That's up from the same quarter last year as well as the previous quarter of this year.

Of the 58 health care topics that were accessed using this tool, the top topics were:

- Medicaid – I want to apply for Medicaid or Dr. Dynasaur for myself or for my children.
- Medicaid – I have questions about my Medicaid coverage.
- Dental Services – I need help finding a low-cost dentist and paying for dental care.
- Long-Term Care – I want to go over my long-term care options.
- VHC – I want to apply for Vermont Health Connect for myself or my children

B. Other Outreach and Educational Activities

- **Central Vermont Young Professionals Health Insurance Workshop, October 16, 2019.** The HCA presented on a panel in Barre, VT, to reach young adults and small business owners between 20 to 40 years old. Approximately 15 young professionals learned about navigating thorny health insurance questions, discussed general eligibility resources for young professionals with variable income, and received an overview of eligibility for state and federal health care financial help.

- **Rutland Health Care Town Hall, October 23, 2019.** We co-hosted the Health Care Town Hall with the Rutland County Free Clinic. Over 40 community members showed up at the Rutland Free Library to share experiences, including many legislators. Tony Morgan, Executive Director of the Rutland Free Clinic, co-facilitated with Mike Fisher, Chief Health Care Advocate. High heath care costs, complex red-tape, and supportive community organizations including 2-1-1

and VCIL were themes across the discussion. The HCA also distributed brochures to the Rutland Planned Parenthood clinic location. The HCA distributed brochures and information about the HCA HelpLine services.

- **Guen Gifford Advocacy Training, October 23, 2019.** The HCA presented to an audience of approximately 50 social workers, case managers, and other community partners. We gave a comprehensive overview of state and federal health care programs available to Vermonters. We also distributed brochures and explained how to refer clients to the HCA.

- **Vermont Health Connect Assister Conference, October 24, 2019.** The HCA participated in discussions about Vermont's health care eligibility and in-person assisters, introduced the HCA and shared information about the HCA's services with all attendees, and distributed brochures and business cards.

- **Here to Help Clinic, October 26 and November 23, 2019.** The HCA handed out business cards and shared general information with potential clients. We also connected with community partners and distributed brochures and information about referring clients to the HCA and which services the HCA provides.

- **Outreach at the Janet S. Munt Family Room, November 7 and December 5, 2019.** The HCA provided information about our HelpLine services, shared general information about health care program eligibility, and distributed brochures and business cards to approximately 30 families. We also shared referral information with five additional staff and volunteers.

- **LGBTQ Town Hall at Pride Center of Vermont, November 14, 2019.** The HCA distributed information about our HelpLine services, answered general health insurance questions, and shared information about policy advocacy and legislative advocacy including recent gender affirming surgery, the Vermont Health Information Exchange, and other regulations. The HCA reached 40 members of Vermont's LGBTQ community.

- **Bennington Health Care Town Hall, November 20, 2019.** The HCA co-hosted the Health Care Town Hall in with the Bennington Free Clinic at the Bennington Free Library. Sue Andrews, Bennington Free Clinic Executive, co-facilitated with Mike Fisher, Chief Health Care Advocate. Over 55 community members shared stories of needing universal health care, not being able to afford health care, and the difficulty of transportation to specialist care in a rural setting. The HCA distributed brochures and information about the HCA HelpLine services.

- **Mexican Consulate's Visit to Middlebury, December 7, 2019.** The HCA distributed handouts in English and Spanish to potential Spanish-speaking clients and connected with community organizations including Migrant Justice, WomenSafe, and the Open Door Clinic, at the Mexican Consulate's visit to Middlebury.

- **Rural Vermont Meeting, December 13, 2019.** The HCA handed out business cards and shared general information on referring clients. We established overlaps in our client population, and planned future outreach for 2020, and began working on an outreach document.

- **Social Media Outreach.** The HCA published 13 posts on Facebook, with a total of 11,175 views. The HCA published 15 posts on Twitter.

- **Email Newsletter** The HCA distributed an email with open enrollment information, HCA HelpLine information, and other HCA updates reaching approximately 250 Vermonters.

C. Promoting Plain Language in Health Communications

During this quarter, the HCA provided feedback and revisions to promote the use of plain language and increase consumers' accessibility to and understanding of important communications from the state and other health organizations regulated by the state. The HCA made plain language edits and edits/comments to improve comprehension of message and ability to resolve the problem being addressed in the following notices/letters:

- Open Enrollment: Approval for MCA
- Open Enrollment: Pending for MCA
- 1095-B Companion letter
- Comments on Rights & Responsibilities Section of Health Care Application
- Notice on Pursuit of Unearned Income
- Follow up Notice on Pursuit of Unearned Income.

Office of the Health Care Advocate

Vermont Legal Aid
264 North Winooski Avenue
Burlington, Vermont 05401
800.917.7787

https://vtlawhelp.org/health

CY 2019 Investment Expenditures

Department	STC #	Receiver Suffix	Investment Description	QE 0319	QE 0619	QE 0919	QE 1219	CY 2019 Total
AHSCO	41	9091	Investments (STC-79) - 2-1-1 Grant (41)	113,067	113,067	113,101	113,118	**452,353**
AHSCO	54	9090	Investments (STC-79) - Designated Agency Underinsured Services (54)	3,309,488	2,352,569	1,684,460	1,654,744	**9,001,261**
AOE	11	n/a	Non-state plan Related Education Fund Investments					**-**
DCF	55	9402	Investments (STC-79) - Medical Services (55)	23,713	16,960	27,382	13,946	**82,002**
DCF	1	9403	Investments (STC-79) - Residential Care for Youth/Substitute Care (1)	2,232,488	2,163,050	2,364,167	99,832	**6,859,537**
DCF	56	9405	Investments (STC-79) - Aid to the Aged, Blind and Disabled CCL Level III (56)	1,047,295	697,313	1,373,316	1,018,227	**4,136,151**
DCF	57	9406	Investments (STC-79) - Aid to the Aged, Blind and Disabled Res Care Level III (57)	27,795	18,726	37,520	27,110	**111,151**
DCF	58	9407	Investments (STC-79) - Aid to the Aged, Blind and Disabled Res Care Level IV (58)	68,004	44,134	89,955	63,970	**266,063**
DCF	59	9408	Investments (STC-79) - Essential Person Program (59)	209,725	209,216	207,565	212,937	**839,444**
DCF	60	9409	Investments (STC-79) - GA Medical Expenses (60)	70,191	83,423	46,007	87,371	**286,992**
DCF	61	9411	Investments (STC-79) - Therapeutic Child Care (61)	285,108	303,798	344,393	312,397	**1,245,695**
DCF	2	9412	Investments (STC-79) - Lund Home (2)	366,961	697,058	679,793	723,382	**2,467,194**
DCF	33	9413	Investments (STC-79) - Prevent Child Abuse Vermont: Shaken Baby (33)	-	-	-	-	**-**
DCF	34	9414	Investments (STC-79) - Prevent Child Abuse Vermont: Nurturing Parent (34)	44,660	101,852	60,572	60,572	**267,656**
DCF	9	9415	Investments (STC-79) - Challenges for Change: DCF (9)	48,807	20,545	44,742	92,394	**206,488**
DCF	26	9416	Investments (STC-79) - Strengthening Families (26)	308,531	272,857	329,223	191,161	**1,101,771**
DCF	62	9417	Investments (STC-79) - Lamoille Valley Community Justice Project (62)	68,790	65,921	45,782	49,847	**230,340**
DCF	35	9418	Investments (STC-79) - Building Bright Futures (35)	206,047	148,849	115,376	295,117	**765,389**
DDAIL	63	9602	Investments (STC-79) - Mobility Training/Other Svcs.-Elderly Visually Impaired (63)	120,100	66,080	122,709	94,428	**403,317**
DDAIL	64	9603	Investments (STC-79) - DS Special Payments for Medical Services (64)	353,476	856,447	83,779	174,758	**1,468,459**
DDAIL	27	9604	Investments (STC-79) - Flexible Family/Respite Funding (27)	289,997	193,985	-	171,232	**655,214**
DDAIL	42	9605	Investments (STC-79) - Quality Review of Home Health Agencies (42)	-	-	-	-	**-**
DDAIL	43	9606	Investments (STC-79) - Support and Services at Home (SASH) (43)	232,386	282,202	318,148	177,364	**1,010,100**
DDAIL	77	9607	Investments (STC-79) - HomeSharing (77)	86,397	86,312	84,939	68,512	**326,160**
DDAIL	78	9608	Investments (STC-79) - Self-Neglect Initiative (78)	110,761	69,406	66,292	39,910	**286,369**
DDAIL	65	9609	Investments (STC-79) - Seriously Functionally Impaired: DAIL (65)	16,175	17,153	16,734	14,563	**64,625**
DMH	28	9501	Investments (STC-79) - Special Payments for Treatment Plan Services (28)	38,771	33,410	11,930	44,796	**128,906**
DMH	66	9502	Investments (STC-79) - MH Outpatient Services for Adults (66)	665,517	645,037	728,097	777,228	**2,815,879**
DMH	79	9504	Investments (STC-79) - Mental Health Consumer Support Programs (79)	130,269	111,612	112,321	116,193	**470,395**
DMH	16	9505	Investments (STC-79) - Mental Health CRT Community Support Services (16)	(5,624,184)	(834,225)	(2,309,280)	5,795,606	**(2,972,083)**
DMH	12	9506	Investments (STC-79) - Mental Health Children's Community Services (12)	1,096,710	662,760	656,147	982,196	**3,397,813**
DMH	29	9507	Investments (STC-79) - Emergency Mental Health for Children and Adults (29)	2,723,842	1,595,744	1,258,706	1,895,051	**7,473,343**
DMH	67	9508	Investments (STC-79) - Respite Services for Youth with SED and their Families (67)	465,823	158,672	194,375	238,438	**1,057,308**
DMH	22	9510	Investments (STC-79) - Emergency Support Fund (22)	287,906	75,706	107,393	130,634	**601,639**
DMH	3	9511	Investments (STC-79) - Institution for Mental Disease Servcies: DMH (3) - VPCH	5,513,064	4,779,527	5,587,349	6,407,607	**22,287,546**
DMH	3	9512	Investments (STC-79) - Institution for Mental Disease Servcies: DMH (3) - BR	1,390,537	2,610,673	927,225	998,099	**5,926,534**
DMH	68	9514	Investments (STC-79) - Seriously Functionally Impaired: DMH (68)	11,939	41,947	18,760	18,772	**91,417**
DMH	13	9516	Investments (STC-79) - Acute Psychiatric Inpatient Services (13)	43,293	436,132	143,984	366,172	**989,580**
DOC	4	n/a	Return House	117,936	135,666	134,109	122,850	**510,561**
DOC	5	n/a	Northern Lights	98,438	98,438	98,438	98,438	**393,752**
DOC	6	n/a	Pathways to Housing - Transitional Housing	278,587	383,103	137,049	258,589	**1,057,328**
DOC	14	n/a	St. Albans and United Counseling Service Transitional Housing (Challenges for Change)	130,237	62,365	135,464	27,463	**355,529**
DOC	15	n/a	Northeast Kingdom Community Action	-	-	-	-	**-**
DOC	69	n/a	Intensive Substance Abuse Program (ISAP)	-	-	-	-	**-**
DOC	70	n/a	Intensive Domestic Violence Program	-	-	-	-	**-**
DOC	71	n/a	Community Rehabilitative Care	-	1,364,230	788,919	696,159	**2,849,309**
DOC	80	n/a	Intensive Sexual Abuse Program	2,500	2,720	-		**5,220**
DVHA	8	9101	Investments (STC-79) - Vermont Information Technology Leaders/HIT/HIE/HCR (8)	-	-			**-**
DVHA	51	9102	Investments (STC-79) - Vermont Blueprint for Health (51)	770,216	823,697	681,434	813,105	**3,088,452**
DVHA	52	9103	Investments (STC-79) - Buy-In (52)	14,170	10,699	8,808	10,725	**44,401**
DVHA	53	9104	Investments (STC-79) - HIV Drug Coverage (53)	682	682	682	663	**2,709**
DVHA	18	9106	Investments (STC-79) - Patient Safety Net Services (18)	-	-	-	-	**-**
DVHA	7	9107	Investments (STC-79) - Institution for Mental Disease Services: DVHA (7)	2,306,138	2,716,620	2,801,713	2,035,619	**9,860,089**
DVHA	72	9108	Investments (STC-79) - Family Supports (72)	-	-	-		**-**
DVHA	81	9109	DSR Investment (STC-83) – One Care VT ACO Quality & Health Management (81)	-	-	-	973,770	**973,770**
DVHA	82	9110	DSR Investment (STC-83) – One Care VT ACO Advanced Community Care Coordination (82)	-	-	-	(268,750)	**(268,750)**
DVHA	83	9111	DSR Investment (STC-83) - One Care VT ACO Primary Prevention Development (83)	-	-	-	1,100,000	**1,100,000**
GMCB	45	n/a	Green Mountain Care Board	437,029	717,531	601	(601)	**1,154,560**
UVM	10	n/a	Vermont Physician Training	844,804	844,805	337,288	505,932	**2,532,829**
VAAFM	36	n/a	Agriculture Public Health Initiatives	-	-	-	-	**-**
VDH	19	9201	Investments (STC-79) - Emergency Medical Services (19)	123,846	116,394	130,864	126,668	**497,772**
VDH	74	9203	Investments (STC-79) - TB Medical Services (74)	10,095	15,236	9,467	2,764	**37,562**
VDH	40	9204	Investments (STC-79) - Epidemiology (40)	174,421	322,332	267,704	290,195	**1,054,652**
VDH	39	9205	Investments (STC-79) - Health Research and Statistics (39)	270,241	304,300	283,771	320,536	**1,178,849**
VDH	31	9206	Investments (STC-79) - Health Laboratory (31)	810,186	959,944	738,077	768,984	**3,277,191**
VDH	50	9207	Investments (STC-79) - Tobacco Cessation: Community Coalitions (50)	210,907	818,988	360,567	356,235	**1,746,697**
VDH	76	9208	Investments (STC-79) - Statewide Tobacco Cessation (76)	-	-	-	-	**-**
VDH	75	9209	Investments (STC-79) - Family Planning (75)	406,196	400,950	415,808	414,370	**1,637,324**
VDH	25	9210	Investments (STC-79) - Physician/Dentist Loan Repayment Program (25)	18,722	-	515,294	233,627	**767,643**
VDH	73	9211	Investments (STC-79) - Renal Disease (73)	-	-	-	-	**-**
VDH	37	9213	Investments (STC-79) - WIC Coverage (37)	808,915	1,054,030	593,183	1,245,645	**3,701,772**
VDH	21	9214	Investments (STC-79) - Area Health Education Centers (AHEC) (21)	268,800	-	125,000	24,800	**418,600**
VDH	47	9217	Investments (STC-79) - Patient Safety - Adverse Events (47)	12,065	15,299	13,500	-	**40,864**
VDH	30	9219	Investments (STC-79) - Substance Use Disorder Treatment (30)	473,797	512,894	471,088	336,177	**1,793,956**
VDH	17	9220	Investments (STC-79) - Recovery Centers (17)	310,887	327,846	61,033	464,199	**1,163,964**
VDH	46	9221	Investments (STC-79) - Enhanced Immunization (46)	90,214	21,081	32,994	118,770	**263,059**
VDH	48	9222	Investments (STC-79) - Poison Control (48)	26,246	28,252	28,252	26,295	**109,045**
VDH	23	9223	Investments (STC-79) - Public Inebriate Services, C for C (23)	279,443	475,636	273,485	55,845	**1,084,409**
VDH	38	9224	Investments (STC-79) - Fluoride Treatment (38)	14,144	15,440	14,368	13,936	**57,888**
VDH	24	9225	Investments (STC-79) - Medicaid Vaccines (24)	-	-	-	-	**-**
VDH	49	9226	Investments (STC-79) - Healthy Homes and Lead Poisoning Prevention Program (49)	58,791	48,459	47,031	45,226	**199,506**
VDH	44	9228	Investments (STC-79) - VT Blueprint for Health (44)	466,192	283,982	244,284	236,789	**1,231,247**
VSC	32	n/a	Health Professional Training	204,730	-	204,731	-	**409,461**
VVH	20	n/a	Vermont Veterans Home					**-**
				26,423,019	**32,079,537**	**25,647,968**	**34,982,707**	**119,133,232**

(129,089)	129,089	138,500,000 CY19 limit
737,462		19,366,768 remaining

(5,284) CY 18 adjustment - QE 1218 PQA D'

19,372,052 adjusted CY 19 limit

VERMONT
AGENCY OF HUMAN SERVICES
DEPARTMENT OF VERMONT HEALTH ACCESS

P Institution for Mental Disease (IMD)

Investment IMD

Budget Information

SFY 2019 Costs: $9,682,795

SFY 2018 Costs: $7,897,961

SFY 2017 Costs: $8,034,408

What We Do

The Brattleboro Retreat is considered an Institute for Mental Disease (IMD) and is a key provider for psychiatric and detoxification inpatient care in the state. DVHA purchases services identified as cost-effective alternatives to traditional state plan services. In SFY 2019, there were a total of 1730 (ACO and non-ACO) adult psychiatric hospital admissions across the state. Of those 1730 admissions, 881 of them (or 50.7%) were at the Brattleboro Retreat. Continued funding is necessary to ensure access to needed care.

DVHA does not expect these investment expenditures to continue past 1/1/2020, at which point the funds move to program costs due to the approved serious mental illness (SMI) waiver.

Who We Serve

Medicaid beneficiaries (adults and children) with mental illness and/or substance use disorder.

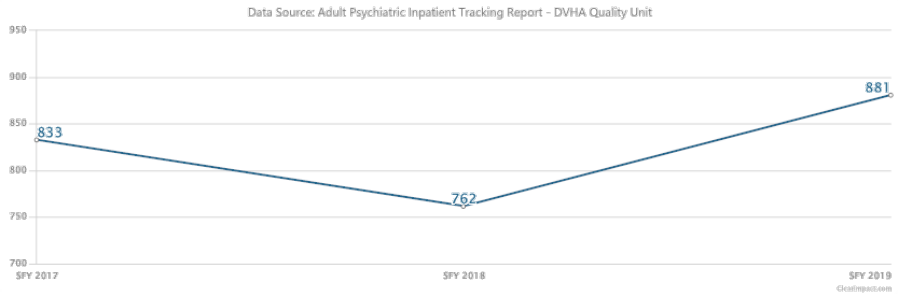
How We Impact

Investment Objective:

Increase the access of quality health care to uninsured, underinsured, and Medicaid beneficiaries.

Performance Measures

	Most Recent Period	Current Actual Value
PM DVHA # of adult psychiatric admissions to the Brattleboro Retreat	SFY 2019	881
	SFY 2018	762
	SFY 2017	833



Notes on Methodology

Institution for Mental Disease (IMD)			
Adult psychiatric admissions to the Brattleboro Retreat			
	SFY17	**SFY18**	**SFY19**
ACO	33	152	254
Non-ACO	800	610	627
Total	**833**	**762**	**881**

Story Behind the Curve

This performance measure includes both ACO and non-ACO admissions; they are broken out in the grid above.

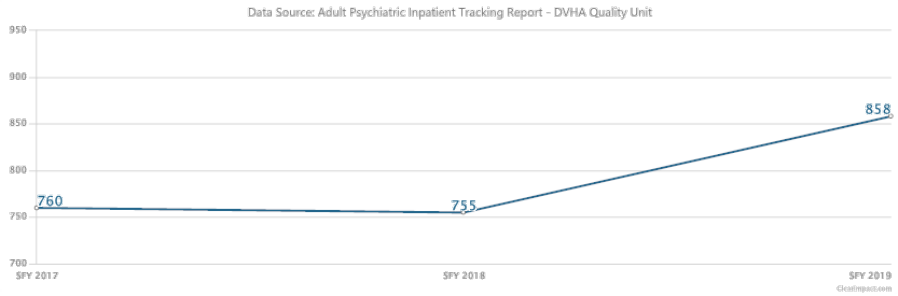
Please note that the non-ACO admissions are authorized by both the Department of Vermont Health Access (DVHA) and the Department of Mental Health (DMH) utilization review clinicians but DO NOT include DMH Level 1 admissions. The UR Teams review all admission notifications within 1 business day of receipt. The UR Teams did not provide utilization review for ACO members in SFY17, SFY18, or SFY19.

DVHA participates in an Accountable Care Organization program as part of Vermont's All Payer Model Agreement with CMS. Through the procurement process, in 2017 DVHA contracted with an ACO, OneCare Vermont, to participate in the Vermont Medicaid Next Generation (VMNG) program. The number of Medicaid members attributed to the VMNG has increased year-to-year as the ACO has expanded its provider network and more members become eligible for attribution. Attribution increased from 28,593 members in 2017 to 42,342 members in 2018, to 79,004 members in 2019 and then to 114,335 members for the 2020 performance year.

Last updated: February 2020

PM DVHA # of adult psychiatric admissions to all other Vermont facilities to whom DVHA issues prior authorizations*

SFY 2019	**858**
SFY 2018	**755**
SFY 2017	**760**



Notes on Methodology

***The VT facilities included in the measure are:**

- Central Vermont Medical Center (CVMC)
- Champlain Valley Physician's Hospital (CVPH)
- Dartmouth Hitchcock Medical Center (DHMC)
- Rutland Regional Medical Center (RRMC)
- University of Vermont Medical Center (UVMC)
- Walden

- Windham - Springfield Hospital

Institution for Mental Disease (IMD)			
Adult psychiatric admissions to all other VT facilities			
	SFY17	SFY18	SFY19
ACO	38	147	217
Non-ACO	722	608	641
Total	760	755	858

Story Behind the Curve

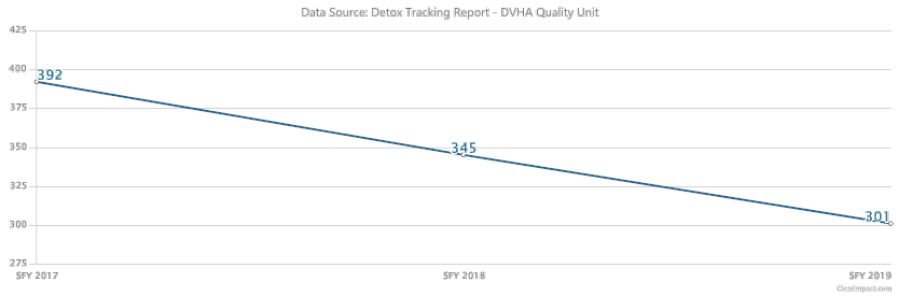
This performance measure includes both ACO and non-ACO admissions; they are broken out in the grid above.

Please note that the non-ACO admissions are authorized by both the Department of Vermont Health Access (DVHA) and the Department of Mental Health (DMH) utilization review clinicians but DO NOT include DMH Level 1 admissions. The UR Teams review all admission notifications within 1 business day of receipt. The UR Teams did not provide utilization review for ACO members in SFY17, SFY18, or SFY19.

DVHA participates in an Accountable Care Organization program as part of Vermont's All Payer Model Agreement with CMS. Through the procurement process, in 2017 DVHA contracted with an ACO, OneCare Vermont, to participate in the Vermont Medicaid Next Generation (VMNG) program. The number of Medicaid members attributed to the VMNG has increased year-to-year as the ACO has expanded its provider network and more members become eligible for attribution. Attribution increased from 28,593 members in 2017 to 42,342 members in 2018, to 79,004 members in 2019 and then to 114,335 members for the 2020 performance year.

Last updated: February 2020

PM DVHA # detoxificiation admissions to the Brattleboro Retreat **SFY 2019** **301**



SFY 2018	**345**
SFY 2017	**392**

Notes on Methodology

Institution for Mental Disease (IMD)			
Detoxification admissions to the Brattleboro Retreat			
	SFY17	**SFY18**	**SFY19**
ACO	17	75	122
Non-ACO	375	270	179
Total	**392**	**345**	**301**

Story Behind the Curve

This performance measure includes both ACO and non-ACO admissions; they are broken out in the grid above.

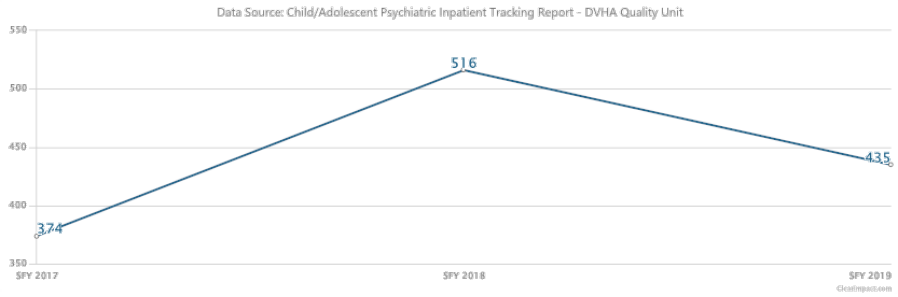
Please note that the non-ACO admissions are authorized by both the Department of Vermont Health Access (DVHA) and the Department of Mental Health (DMH) utilization review clinicians but DO NOT include DMH Level 1 admissions. The UR Teams review all admission notifications within 1 business day of receipt. The UR Teams did not provide utilization review for ACO members in SFY17, SFY18, or SFY19.

DVHA participates in an Accountable Care Organization program as part of Vermont's All Payer Model Agreement with CMS. Through the procurement process, in 2017 DVHA contracted with an ACO, OneCare Vermont, to participate in the Vermont Medicaid Next Generation (VMNG) program. The number of Medicaid members attributed to the VMNG has increased year-to-year as the ACO has expanded its provider network and more members become eligible for attribution. Attribution increased from 28,593 members in 2017 to 42,342 members in 2018, to 79,004 members in 2019 and then to 114,335 members for the 2020 performance year.

Last updated: February 2020

PM DVHA # of child psychiatric admissions to the Brattleboro Retreat

SFY 2019	435
SFY 2018	516
SFY 2017	374



Notes on Methodology

Institution for Mental Disease (IMD)			
Child psychiatric admissions to the Brattleboro Retreat			
	SFY17	SFY18	SFY19
ACO	33	132	225
Non-ACO	341	384	210
Total	374	516	435

Story Behind the Curve

This performance measure includes both ACO and non-ACO admissions; they are broken out in the grid above.

Please note that the non-ACO admissions are authorized by both the Department of Vermont Health Access (DVHA) and the Department of Mental Health (DMH) utilization review clinicians but DO NOT include DMH Level 1 admissions. The UR Teams review all admission notifications within 1 business day of receipt. The UR Teams did not provide utilization review for ACO members in SFY17, SFY18, or SFY19.

DVHA participates in an Accountable Care Organization program as part of Vermont's All Payer Model Agreement with CMS. Through the procurement process, in 2017 DVHA contracted with an ACO, OneCare Vermont, to participate in the Vermont Medicaid Next Generation (VMNG) program. The number of Medicaid members attributed to the VMNG has increased year-to-year as the ACO has expanded its provider network and more members become eligible for attribution. Attribution increased from 28,593 members in 2017 to 42,342 members in 2018, to 79,004 members in 2019 and then to 114,335 members for the 2020 performance year.

Last updated: February 2020

Actions

Name	Assigned To	Status	Due Date	Progress

Integrating Family Services

CMS IFS

What We Do

CMS GC Investment Goal: Provide public health approaches and other innovative programs to improve the health outcomes, health status and quality of life for uninsured, underinsured and Medicaid-eligible individuals in Vermont

Background on IFS: The initial IFS implementation site in Addison County began on July 1, 2012, and the second pilot region in Franklin/Grand Isle counties began on April 1, 2014. These pilots included consolidation of over 30 state and federal funding streams into one unified whole through one AHS Master Grant agreement. The State created an annual aggregate spending cap for two providers in Addison County (the Designated Agency and the Parent Child Center) and one in Franklin/Grand Isle (this provider is both the Designated Agency and Parent Child Center). This has created a seamless system of care to ensure no duplication of services for children and families. The overarching goal of IFS was to ensure families received support.

***These are the baseline measures. In calendar year 2019, one of the IFS grantees (CSAC) underwent a transition to a new Electronic Health Record on November 1, 2019.**

This means they are unable to get quality data that cuts across the calendar year. Due to this fact, this report focuses on FY data like last year.

Who We Serve

IFS offers families an expanded array of service domains, including; mental and behavioral health, developmental disabilities, and substance use. Services include the following Medicaid State Plan and Demonstration services: Section 1115 Demonstration Services: specialized mental health services for children under 22 with a severe emotional disturbance; specialized developmental disability services for individuals under 18. State Plan Services: mental health clinic services including mental health outpatient therapy, targeted case management, specialized rehabilitation services (early childhood development and mental health), intensive family-based services, extended nursing visits for pregnant and postpartum women.

Moving Forward: On January 1, 2019, the IFS sites became aligned with larger payment reform efforts occurring across AHS including having incentives tied to them in alignment with statewide implementation. At the same time, IFS regions have additional requirements for performance measurement in accordance with the broader scope of services included in those regions.

How We Impact

Goals of IFS: The goals of IFS are: a) to improve the delivery of services and ultimately the health and well-being of pregnant/postpartum women, infants, children and young adults and b) advance maternal and child health and safety, family stability, and optimal healthy development through the transition to adulthood. This is achieved by:

- Providing flexible funding that allows service providers to meet family needs as they become known.
- Bringing children's, youth and family services together in an integrated and seamless continuum.
- Offering families supports and services based on need rather than program eligibility criteria.
- Shifting the focus from counting clients and service units to measuring the impact of those services.

IFS propels individuals, organizations and systems at the state and community level to work together more collaboratively, use resources more flexibly, and make supports and services more family-friendly so children, youth and families are better off as a result of their interaction with AHS and its community partners.

How we do it: The Integrating Family Services (IFS) bundled payment model supports Medicaid services for pregnant women and children birth through age 21 across service domains, including: mental and behavioral health, developmental disabilities, and substance use. Services reach across the continuum of prevention, diagnosis, and treatment.

The bundled rate allows IFS providers to bill once a month for Medicaid services after a single unit of service. That single payment supports services regardless of how frequently or intensively services occurred in a month for an individual. The bundled rate further supports IFS delivery of service in the most natural setting for the child and family, including in the home, and allows the provider to focus on the plan of care and supporting individuals in meeting goals. A unique case rate is established for each provider. The provider case rate represents reimbursement for specific Medicaid-covered services to the target population (pregnant women and children age 0 through 21 years). The specific Medicaid services within each IFS provider's case rate differ, based on the array of services provided by that provider.

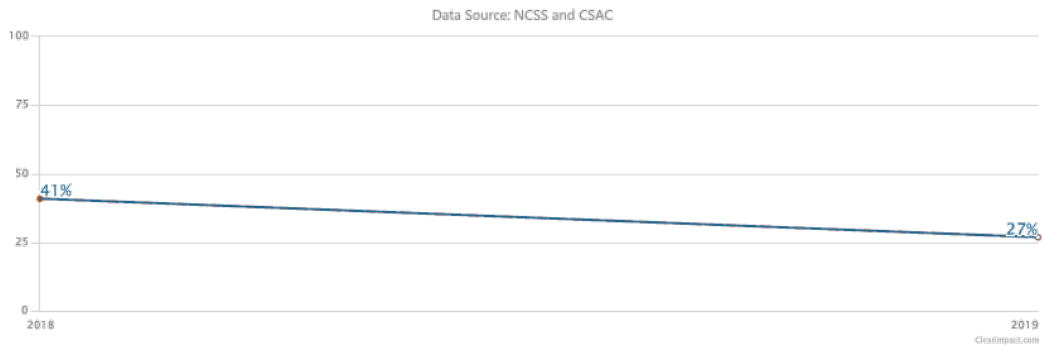
IFS providers are expected to serve a minimum caseload for the target population each year.

Should the IFS provider incur verifiable service costs that, because of the pilot, are not reimbursable, but would be reimbursable under practices in place for non-pilot sites at the time the services were provided, they may request a review and payment by the State. The request must be accompanied by documentation of the expense, the services delivered, and the reason the costs are above and beyond the IFS aggregate annual cap and/or the case rate. All IFS-related revenue and expense detail is reported by the provider to the State monthly through an electronic financial reporting system. In moving from a fee-for-service, or uncapped payment model, to a bundled model, the grantee incurs risk in exchange for administrative streamlining and delivery system flexibility. However, grantees must continue to meet EPSDT mandates and fulfill other contractual expectations within this cap.

Providers are required to electronically submit encounter data to the State for all services delivered using the Department of Mental Health Monthly Service Report (MSR). Minimum required encounter data elements include: Medicaid ID, date of referral, date of first contact, date of service, place of service, type of service, and person delivering service. Ad hoc reports are developed by the State to examine demographic, program and/or policy trends that may be reflected in service delivery data. IFS is a service delivery and payment reform model that uses the same terms of performance and rate setting methodology for all providers. Rather than the previous fee-for-service model utilized for these services, a Results-Based Accountability approach is used to determine if children, youth and families are improving. This model allows for flexibility of service that focuses on providing the right amount of service and support being tied to accountability through specific performance measures and progress monitoring, which all providers are subject to. Performance measures are used to monitor quality of care, but results are not considered when developing the case rate or annual budget. IFS grantees are required to reach 90% of their target caseload to draw down their full allocation. If they do not hit their caseload targets or provide the required services, they would not get reimbursed.

Performance Measures

	Most Recent Period	Current Actual Value	Current Target Value	Current Trend
PM CMS % of clients seen within 5 days of their first call requesting services.	2019	27%	27%	↘ 1
	2018	41%	41%	→ 0



Story Behind the Curve

This measure is used to monitor from an access perspective. When a family calls requesting services, IFS regions are looking to provide them supports and services as quickly as possible. Important to note is that while we are looking for quick access, families are also being asked when they would like services which may impact the timeline for services beginning.

The decrease for CSAC is largely attributable to staff vacancies which contributed to fewer clinicians to provide intake assessments. They also tried a new intake system that has since changed—the attempt had streamlined some parts of the intake process but did not allow enough appointments to meet the 5-day requirement.

At NCSS, IFS is a program within Children and Youth Services, so they have a centralized intake and do not track this for individual programs but as a children's system of care within the Designated Agency system. The data for IFS specifically must be pulled manually and continues to be a training issue because of the way the centralized workflow is set up.

- 17% seen within 5 calendar days
- 42% were offered an appointment within 5 calendar days

Another important factor to consider with this performance measure is that the majority of services provided to families are home and community-based (at NCSS that accounts for 92% of their services) which can also impact how quickly clients are seen upon their first call. Families are often provided support by phone and that does not get counted in this measure.

Target: IFS grantees will demonstrate a 2% decrease in the average wait time (in days) between first call requesting services and first appointment offered.

The definition of first call is when contact with the client/family themselves has been made and they have stated they would like or need services

Partners

NCSS and CSAC

Notes on Methodology

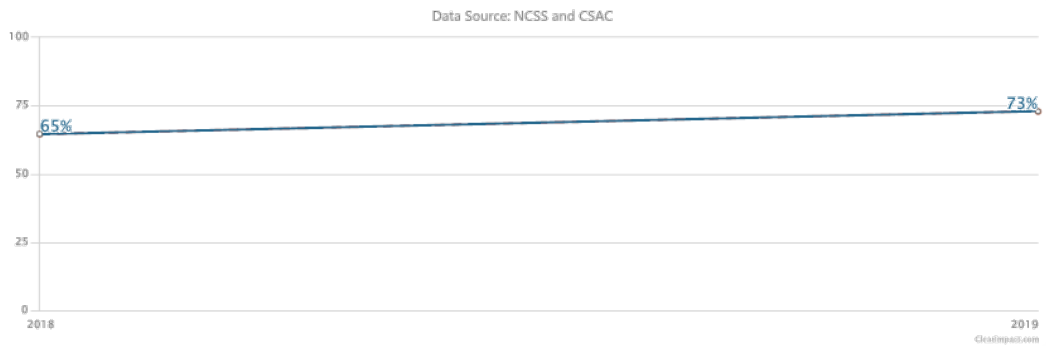
Numerator: Time in days between first call requesting services and appointment offered.

Denominator: Total number of inactive clients requesting services.

Average wait time increased by 14.05%

PM CMS % of eligible clients with a CANS administered

2019	73%	73%	↗ 1
2018	65%	65%	→ 0



Story Behind the Curve

The CANS is a comprehensive tool that integrates client-level data in one place, while revealing areas that need intense or immediate action, moderate action, or watchful waiting. The simple scoring and clear visual representations help to inform treatment plans and services, by allowing children and caregivers to identify and envision their needs and strengths and communicate them easily to multiple providers. One unique feature of the CANS is that it also focuses on the strengths of children and their caregivers; this positive lens can prove instrumental in a personalized treatment plan.

Vermont began implementation of the CANS in 2015 with the IFS regions being early adopters. This meant the regions have had to invest time and resources in training their staff in the CANS, tracking data and embedding the CANS information in their EHR systems. These regions have begun utilizing the data to track individual's progress over time and to look at program data to assess if children are better off as a result of interventions provided by their interdisciplinary teams.

Target: IFS grantees will demonstrate a 2% increase of children who have the CANS administered per the eligibility guidelines in the IFS Procedures Manual

Partners

NCSS and CSAC.

Notes on Methodology

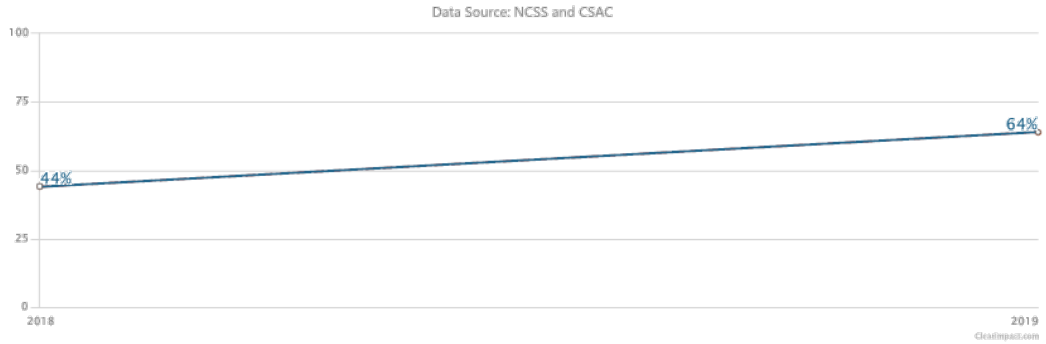
Numerator: All children with a first CANS administered

Denominator: All children eligible for a CANS receiving services

Average increase in children receiving the CANS was 8.8%

PM CMS % of clients who have a plan of care completed within 45 days of referral

2019	64%	64%	↗ 1
2018	44%	44%	→ 0



Story Behind the Curve

This measurement is a Medicaid standard which indicates access to care.

Access to care data is being focused on across all the designated agency systems and having operationalized definitions of referral date is being worked on. The definition clarity will be established for 2020. Through the process of payment reform, it became clear that across the system this was an area to work on and the engagement from both the state and DA system has been strong.

We suspect there are clients in the denominator who did not follow through with care which could explain why this percentage is so low. We will continue to monitor this data point closely. As well, with the implementation at one IFS site of a new EMR staff are getting used to a new system and paperwork which could also account for some of the decrease.

Target: IFS grantees will demonstrate a 2% increase in the percent of clients that have a plan completed within 45 days of referral during the measurement period.

Partners

NCSS and CSAC

Notes on Methodology

Numerator: All children who have a plan of care completed within 45 days

Denominator: All children eligible for a plan of care

Average of clients with a plan completed within 45 days increased by 20.3%

Actions

Name	Assigned To	Status	Due Date	Progress