State of Vermont
Agency of Human Services

Global Commitment to Health
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Annual Report
For Demonstration Year 2020
January 1, 2020 to December 31, 2020

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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.

On 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 providedto Medicaid enrollees in Institutions for Mental Disease (IMDs).

Effective January 1, 2020, the demonstration was amended to allow for otherwise covered services furnished to otherwise eligible individuals who are receiving short-term psychiatric treatment in facilities that meet the definition of an IMD.

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 fifteenth waiver year, demonstration year 2020, which ended on December 31, 2020. This report encompasses fourth quarter updates for this demonstration year (10/1/20- 12/31/20).

II. Highlights and Accomplishments

- By the end of 2020, more than 212,446 Vermonters were enrolled in Vermont Health Connect (VHC) health plans either through the marketplace or directly through an insurance carrier. This enrollment consisted of 140,641 in Medicaid for Children and Adults (MCA) and 71,805 in Qualified Health Plans (QHPs), with the latter divided between 23,686 enrolled with VHC, 7,423direct enrolled with their insurance carrier as individuals, and 40,696 enrolled with their small business employer.

- DVHA received a compliance score of 94% during this year's External Quality Review Organization (EQRO) Review of Compliance with Medicaid Managed Care Standards Audit.

- DVHA successfully completed a formal Performance Improvement Project (PIP) cycle on the topic of substance use disorder treatment initiation. A new topic was chosen during 2020, management of hypertension, and PIP activities begun.

- COVID-19 Public Health Emergency (PHE) and Response. The Vermont Chronic Care Initiative (VCCI) continued to be a resource in the state's response to the public health crisis with both licensed (10) and non-licensed (3) staff available for COVID-vaccination in roles of either vaccinator or intake/exit worker.

- The majority of Vermont's primary care practices are now Blueprint-participating Patient-Centered Medical Homes, as evidenced by 134 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 withopioid use disorder. As of September 2020, the number of clients enrolled in Regional Opioid TreatmentPrograms (OTP/Hubs) was 3,154, and the average monthly number of Medicaid beneficiaries served by Office-Based Opioid Treatment (OBOT/Spoke) programs increased to 3,777.

- On 4/1/20, Vermont Medicaid launched a medication therapy management (MTM) program for office-based clinical pharmacists operating under their scope of practice at a Federally Qualified Health Center (FQHC) or Rural Health Center (RHC).

- DAIL implemented the CBA minimum wage increase, impacting all consumer/surrogate/self-directedprograms on 12/20/2020.

- 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.

- ADAP's centralized intake and resource center, "VT Helplink: Alcohol and Drug Support Center" launched for public use in March 2020. Since launch VT Helplink has received over 1,900 calls and 22,700 website visits. Web visitors have searched for services online over 2,260 times.
- The 21st Century Cures Act required states to initiate Electronic Visit Verification (EVV) Systems for Personal Care Services (PCS). Program Integrity (PI) is supporting EVV with the implementation requirements of initiative and the required post claim PCA validation process.

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.

The table below contains Member Month Reporting for CY2020 and includes the unduplicated count of member months for SUD IMD and SMI IMD stays. CY2019 and CY2018 member months are also reported in the table below.

Table 1. Member Month Reporting – Calendar Year 2018-2020

Demonstration Population	Medicaid Eligibility Group	Total CY 2020	Total CY 2019	Total CY 2018
1, 4*, 5*	ABD - Non-Medicare - Adult	79,935	81,293	83,071
	SUD - IMD - ABD	106	149	78
	SMI - IMD - ABD	68		
1	ABD - Non-Medicare - Child	19,982	23,855	25,577
1, 4*, 5*	ABD - Dual	259,965	257,866	257,263
	SUD - IMD - ABD Dual	136	158	78
	SMI - IMD - ABD Dual	7		
2	Non ABD - Non-Medicare - Adult	111,956	104,150	143,377
	SUD - IMD - Non ABD	161	222	187
	SMI - IMD - Non ABD	24		
2	Non ABD - Non-Medicare - Child	713,975	703,957	723,120
	Medicaid Expansion			
7	Global RX	78,117	77,498	79,488
8	Global RX	41,590	44,169	46,792
6	Moderate Needs	1,991	2,208	2,319
	New Adults			
3	New Adult without Child	453,627	423,150	471,886
	SUD - IMD New Adult w/o Child	1,157	1,352	791
	SMI - IMD New Adult w/o Child	210		
3	New Adult with Child	267,315	233,294	223,882
	SUD - IMD New Adult with Child	209	259	114
	SMI - IMD New Adult with Child	43		
	Total	**2,030,574**	**1,953,580**	**2,058,023**

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, October 26, 2020. 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 September 15th, 2020. 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.

iii. *Vermont Health Connect*

Key updates:

- By the end of 2020, more than 212,446 Vermonters were enrolled in Vermont Health Connect (VHC) health plans either through the marketplace or directly through an insurance carrier. This enrollment consisted of 140,641 in Medicaid for Children and Adults (MCA) and 71,805 in Qualified Health Plans (QHPs), with the latter divided between 23,686 enrolled with VHC, 7,423direct enrolled with their insurance carrier as individuals, and 40,696 enrolled with their small business employer.
- Vermont Health Connects eighth open enrollment period launched successfully on November 1, 2020. In October 2020, 99.5% of eligible QHP renewals were handled through a single, clean automated process.
- Vermonters used the online Plan Comparison Tool more than 47,574 times between January 1, 2020 and December 31, 2020. This accounts for a 3% increase from the prior year.

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.

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Medicaid Renewals

MCA renewals were substantially impacted by the Public Health Emergency (PHE) in 2020. Renewals in progress when the PHE began – for March, April, and May - were completed where possible, or postponed if eligibility would be adverse or could not be determined with available information. Starting with renewals forJune 1, cases that could be renewed ex parte based on data sources were so renewed. Cases that required

renewal applications to determine continued eligibility were extended to future renewal dates. Those new renewal dates, and other details pertaining to restarting manual renewals, will be finalized during planning for post-PHE activities.

Overall, 58% of enrollees could be renewed without an application for the year, a substantial increase over the previous year. However, for the first eight months of the year, the percentage was 48%, which was in line with 2019. From September through December, the percentage was64%. The difference may be due to the effect of the PHE on job and income losses being reflected in the data sources by late summer, improving the likelihood of a successful renewal based on those data sources.

QHP Renewals

DVHA kicked off a series of meetings with its internal stakeholders and Maintenance and Operations vendor in early summer 2020 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 five 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 2020, this step was operated with a single, clean, automated run that took care of 99.5% of eligible cases. The 0.5% failure rate meant that only a small number of cases needed to be renewed by staff the following day, allowing all beneficiaries to have updated accounts and 2021 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 2020, this initial integration runwas 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 2021 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

Four 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 four years, increasing from 16% of VHC applications in June 2016 to 58%in December 2020. 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 the last quarter of 2020, 89% of requests were completed within tendays – slightly short of the goal.

Integration and Reconciliation

DVHA set a goal of integrating enrollment files across its insurance carrier partners' systems with no more thana 1.0% error rate and achieved this goal for 11 months of 2020. 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 2020. 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). As a caveat, Medicaid Reconciliation was able to review 100% of discrepancies in the first 3 months of 2020. Thereafter, many of the Medicaid buckets were put on hold, due to the public health emergency.

DVHA also honed its Medicaid reconciliation process in 2020. As previously mentioned, the public health emergency limited certain actions. In the first quarter of 2020, net new discrepancies were under 1,000 cases.

Customer Support Center

Callers to VHC's contracted Customer Support Center experienced prompt service throughout 2020except in the months of January, February, March, and December. During those months, the percentage of phone calls answered within 24 seconds was less than 69%. The call center, Maximus, was not adequately staffed for the incoming call volume in January and February of 2020. Additionally, there was an increase in call volumes during that time due to questions about the public health emergency. Typically, November and December have higher call volumes due to Open Enrollment. However, during the other eight months of 2020 the percentage of phone calls answered within 24 seconds was 74% or higher.

The overall inbound call volume in 2020 was higher (31%) than the corresponding months in 2019.Despite the higher call volumes in 2020, a higher percentage of calls were answered within 24 seconds in 2020 versus 2019 by 6%. Maximus has been working on retaining staff and reducing turnover, which leads to more experienced staff.

Additionally, there was an increase in the percentage of calls that Maximus needed to escalate to DVHA in 2020. In 2019, 5% of all calls were transferred to DVHA compared to 8% being transferred in 2020.

DVHA's Tier 2 call center maintained prompt service on escalated calls through 2020. In 2017 DVHA set a goal of answering 90% of calls within five minutes. 2020 they fell short of that goal by 3%. In 2019, 94% of all calls transferred to DVHA were answered within five minutes.

In-person Assisters

DVHA is currently supported by 110 Assisters (100 Certified Application Counselors, 6 Navigators, and 4 Brokers), working in 53 organizations including hospitals, clinics, and community-based organizations. Assister support is available in all of Vermont's 14 counties to help Vermonters enroll in health coverage

through Vermont's health insurance marketplace.

The program has leveraged state-based technology to significantly improve data management and online education opportunities. Coupled with an updated quality assurance program, the program's quality oversight and subsequent support has increased over the past year.

Many Vermont hospitals were able to provide ongoing in-person assistance throughout 2020 while other Hospitals and organizations alike also created new telephonic pathways for Vermonters seeking assistance.

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 couldimpact 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 2020. Vermonters used the online Plan Comparison Tool more than 15,600times between November 1st and December 15th.

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. During 2019 the pilot version went live and within Q3 2020 authentication was completed in order to allow this tool to be used by all Vermonters. Due to COVID-19, VHC has not been able to advertise this tool for use as verifications are on hold due to the Public Health Emergency.

IV. Findings

i. External Quality Review

Key updates:

- DVHA received a compliance score of 94% 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 this year, the state worked with the External Quality Review Organization (EQRO) to develop the material necessary for each of the required annual external quality review activities (i.e., performance improvement project validation, performance measure validation, and compliance review). Performance Improvement Project (PIP) validation items included the PIP validation timeline, review templates and report outline. Performance Measure Validation items included the PMV timeline, a document request letter, a rate reporting template, and HEDIS roadmap. All timelines included the following elements: start date, completion date, task, and responsible party. Review of Compliance with Standards items included a document request letter as well as desk and documentation review forms.

All letters and materials were sent to DVHA during this year. Due to the COVID-19 pandemic, the methodology of both on-site reviews (i.e., Review of compliance with standards & performance measure validation) were changed from in-person to remote. The state worked with EQRO staff to shift the content to an on-line platform and support all staff impacted by the change.

Also, during this year, the state spent time preparing subject matter experts for the 2020 EQRO compliance audit. This included an orientation to the audit standards and the audit timeline. In addition, the EQRO, HSAG, performed a fully remote version of their annual review of compliance with standards. Activities included a desk review of documents and conducting virtual interviews with key staff members. These annual audits follow a three-year cycle of standards. During this year's review, HSAG evaluated the degree to which DVHA complied with federal Medicaid managed care regulations and the associated AHS intergovernmental agreement (IGA) in eight performance categories (i.e., standards). The eight standards included requirements associated with the federal Medicaid managed care Structure and Operations standards found at CFR §438.214–438.230.

Subject matter experts and managers from several units and departments represented their programs and provided answers and documents to the reviewers. During the review, the auditors discussed some strengths and potential required corrective actions as well as some recommendations to make our programs stronger. During the exit interview, we learned that there would be required actions for this audit. Upon completion of the audit, DVHA and AHS staff discussed strategies for better document control and methods for following up on previously corrected items.

Also, during this year, the EQRO conducted the Performance Measure Validation (PMV) activities remotely. 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, virtual system demonstration, review of data output files, primary source verification, virtual observation of data processing, and review of data reports. The virtual activities are described as follows: opening session, claims and encounter data system, membership and enrollment data system and processes, provider data, data integration/reporting and primary source verification, closing summation conference and next steps.

EQRO Performance Improvement Project Validation activities are described in the Quality Improvement Section of this report.

EQRO Audit Results:

During Q4 2020, the state supported their External Quality Review Organization (EQRO), HSAG, as they prepared this year's set of reports for each of the mandatory EQR activities listed below.

Validation of the PIP

HSAG validated DVHA's PIP, *Initiation of Alcohol and Other Drug Abuse or Dependence Treatment.* HSAG reviewed DVHA's PIP to ensure that the organization designed, conducted, and reported on the project in a methodologically sound manner, allowing measurement of any real improvements in care and services, and giving confidence in the reported improvements. HSAG used CMS' PIP validation protocol[2-1] as the methodology to validate the PIP. HSAG's validation assessed Steps I through X. 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.

The validation results indicate an overall score of 100 percent across all applicable evaluation elements. DVHA continued the PIP this year and reported second remeasurement results for the study indicator. The improvement from the baseline was statistically significant, indicating real improvement in outcomes. With the second remeasurement, DVHA achieved sustained improvement in the study indicator outcomes.

DVHA's *Initiation of Alcohol and Other Drug Abuse or Dependence Treatment* PIP received a score of 100percent 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*.

Validation of Performance Measures

HSAG validated rates for a set of performance measures selected by AHS for 2020 reporting. The validation also determined the extent to which the Medicaid-specific performance measures calculated by DVHA followed the HEDIS 2020 specifications. AHS identified the measurement period for all measures as calendar year (CY) 2019. AHS required that the measures be calculated according to the National Committee for Quality Assurance's (NCQA's) *Healthcare Effectiveness Data and Information Set (HEDIS®)*[1-2] *20, Volume 2, Technical Specifications for Health Plans*. Although most measures were reported using administrative data, DVHA was required to report three measures using both administrative and medical record data, known as the hybrid methodology, to ensure that the rates more accurately reflected the services provided to beneficiaries.

The validation findings confirmed that all rates were reportable. Additionally, the measure results for HEDIS 2020 were compared to the NCQA's HEDIS Audit Means and Percentiles National Medicaid Health Maintenance Organization (HMO) Percentiles for HEDIS 2019 (the most current rates available).

[2-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 3: Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/eqr-protocol-3.pdf. Accessed on: Nov 23, 2020.

but were at or above the 25th percentile. DVHA performed at or above the 75th percentile for 16 of 46 (34.8 percent) measure rates appropriate for comparison to benchmarks, demonstrating strengths in well-child visits, adult access to routine and emergency health services, appropriate ED utilization, and engagement of AOD abuse or dependence treatment. Conversely, 17 of 46 rates (37.0 percent) fell below the 50th percentile, indicating efforts should be focused on ensuring young children and adolescents are receiving necessary well-child/well-care visits; young children and adolescents receive counseling for BMI percentage, nutrition, and physical activity; and young women are appropriately screened for chlamydia and breast cancer. Initiation of AOD abuse or dependence treatment and controlling blood pressure are additional areas of focus for DVHA.

Monitoring Compliance with Standards

AHS requires that its EQRO, HSAG, review one of the three sets of federal Medicaid managed care standards during each EQR contract year. For this EQR contract year, HSAG conducted a review of the Structure and Operations standards.

HSAG conducted the review consistent with CMS' *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, October 2019.[2-3] HSAG reviewed DVHA**'s** written operating policies and procedures, program plans, meeting minutes, numerous written reports, and other data and documentation related to DVHA**'s** performance during the review period. Reviewers also conducted staff interviews related to each of the eight standards to allow DVHA staff members to elaborate on the written information HSAG reviewed, to assess the consistency of staff responses given during the interviews against the written documentation, and to clarify any questions reviewers had following the document review.

The information included in HSAG's report of its findings related to the extent to which DVHA**'s** performance complied with the applicable federal Medicaid managed care regulations and AHS' associated IGA contract requirements for providing accessible, timely, and quality services to beneficiaries. The primary objective of HSAG's review was to identify and provide meaningful information to AHS and DVHA about DVHA's performance strengths and any areas requiring corrective actions.

HSAG reviewed DVHA's performance related to 88 elements across the eight standards. Of the 88 elements, DVHA obtained a score of *Met* for 78 of the elements, *Partially Met* for 9 of the elements, and *Not Met* for one element. As a result, DVHA obtained a total percentage of compliance score across the 88 requirements of 93.8 percent.

DVHA is required to submit CAPs to AHS that address all requirements for which HSAG scored DVHA's performance as either *Partially Met* or *Not Met*. DVHA should identify for each element that requires corrective action the specific, detailed, and actionable interventions DVHA has already in place or plans to put in place to achieve compliance with the requirement(s), the individual(s) responsible for ensuring implementation, and proposed timeline for starting and completing each planned improvement activity.

[1-2] HEDIS® is a registered trademark of the NCQA.

[2-3] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, October 2019. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: Nov 10, 2020.

Preparation of the External Quality Review Annual Technical Report

During Q4, 2020, the state supported HSAG has they compiled and analyzed all data from its 2020 EQR activities to develop the Annual Technical Report. This report summarizes findings on access to and quality of care including a description of the manner in which the data from all activities conducted in accordance with the Medicaid Managed Care regulations were aggregated and analyzed, and conclusions were drawn as to the quality and timeliness of, and access to the care furnished to its Medicaid beneficiaries.

SUD Monitoring Protocol

The SUD Monitoring Protocol describes the state's monitoring plans for their SUD demonstration. The protocol consists of two parts: a set of narrative sections and a metrics workbook. The former accommodates reporting relevant to each of the program implementation while the latter describes the data collection, reporting and analytic methodologies, and timeframes for performance measures identified by the state and CMS for inclusion, as well as identifies a baseline, a target to be achieved by the end of the demonstration and an annual goal for closing the gap between baseline and target expressed as percentage points.
The state was scheduled to begin SUD metric reporting during the early part of the year. Unfortunately, responding to data requests brought about by the COVID-19 pandemic prevented the data team from initiating SUD measure reporting with the broader 1115 waiver as planned. After a bit of a delay, the group was able to deliver ALL overdue rates later in the year. Going forward, the state expects to follow the reporting timelines outlined in Table A of Appendix A of the Monitoring Protocol Alignment Form – beginning with the broader 1115 waiver DY4 Q3 report. In addition to reviewing the technical specifications manual, the state considered which monitoring metrics may be useful to include in the formal waiver evaluation. In addition to submitting the SUD metric reports, the state also worked with their independent evaluator to review SUD Monitoring Protocol Metrics Workbook to determine which metrics could be used in the SUD Mid-Point Assessment. During Q4 2020, the state submitted DY2Q4 and DY3Q1 Metrics to CMS.

SUD Mid-Point Assessment

The assessment includes an examination of progress toward meeting each milestone and timeframe approved in the SUD Implementation Protocol, and toward closing the gap between baseline and target each year in performance measures as approved in the SUD Monitoring Protocol. The assessment also includes the methodologies used for examining progress and assessing risk, the limitations of the methodologies, its determinations, and any recommendations. In addition, the assessment includes a determination of factors that affected achievement on the milestones and performance measure gap closure percentage points to date, and a determination of selected factors likely to affect future performance in meeting milestones and targets not yet met and about the risk of possibly missing those milestones and performance targets. For each milestone or measure target at medium to high risk of not being met, the assessor will provide, for consideration by the state, recommendations for adjustments in the state's implementation plan or to pertinent factors that the state can influence that will support improvement. The state's SUD Mid-Point Assessment was submitted to CMS during Q4 2020.

SMI/SED Monitoring Protocol

The state's special terms and conditions (STCs) for its current five-year demonstration period (July 1, 2017–June 30, 2021) were amended in December 2019 to include a Serious Mental Illness (SMI) component. As per the new STCs, the state is required to submit a SMI Monitoring Protocol to CMS within 150 calendar days after approval of SMI implementation plan.

The SMI Monitoring Protocol describes the state's monitoring plans for their SMI demonstration. The protocol consists of two parts: a set of narrative sections and a metrics workbook. The former accommodates reporting relevant to each of the program implementation while the latter describes the data collection,

reporting and analytic methodologies, and timeframes for performance measures identified by the state and CMS for inclusion, as well as identifies a baseline, a target to be achieved by the end of the demonstration and an annual goal for closing the gap between baseline and target expressed as percentage points. During Q4 2020, the state submitted an updated version of the protocol – including metrics workbook. Both included edits that incorporated the CMS feedback received on June 5, 2020 to help the state further comply with its STCs as well as align with current CMS guidance. In addition to the aforementioned files – the state also submitted a document that contained specific state responses to the CMS Feedback.

As per the STCs, the Monitoring Protocol Template was submitted to CMS during this year. The state anticipates receiving CMS feedback during the next quarter.

SMI/SED Mid-Point Assessment

The state also continued to work with the evaluator on the SMI Mid-Point Assessment. During this year, a design and discussion meeting was held with DMH as well as a follow-up meeting which included DMH, DVHA and IT staff. Finally, the state worked with departments to ensure evaluation data is submitted to an independent evaluator according to the established schedule. Response to the COVID-19 public health emergency has slowed progress – but the current timeline remains applicable. The state will continue to regularly monitor the availability of data to support the evaluation report and assess its ability to maintain the current timeline.

ii. Quality Assurance and Performance Improvement Activities

Key updates from QE122020/Annual:

- DVHA successfully completed a formal PIP cycle on the topic of substance use disorder treatment initiation. A new topic was chosen during 2020, management of hypertension, and PIP activities begun.
- The Quality Team created a COVID-19 dashboard at the end of March 2020 and maintained it throughout the rest of the year to monitor the response to the pandemic: both the impact it has had on operations and the activities staff have engaged in.

The DVHA Clinical Services Team monitors, evaluates and improves the quality of care to Vermont Medicaid beneficiaries through the use of performance and utilization management frameworks. The Team 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 team is responsible for instilling the principles of quality management throughout DVHA; helping everyone in the organization to achieve excellence. The team's goal is to develop a culture of continuous quality improvement throughout DVHA.

PIHP Quality Committee

The Quality Committee remained active throughout 2020 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 our performance for the measures within *DVHA's Global Commitment to Health* Core Measure Set and based on those results recommended a new formal PIP topic focused on managing hypertension (see next item).

Additionally, the committee followed our work plan throughout the year and reviewed the annual Child and Adult CAHPS surveys, a grievance and appeals summary and confidentiality procedures, including HIPAA breach tracking.

Formal CMS Performance Improvement Project (PIP)

Submission of the PIP Summary Report during QE0620 marked the successful completion of a 3-year cycle for the substance use disorder treatment study topic. During QE0920, DVHA followed our standard operating procedure (SOP) for selection of a new formal CMS PIP topic. DVHA's Quality Committee reviewed our performance on all measures within our *Global Commitment to Health* Core Measure Set. A short list of measures for improvement resulted from that review. Senior clinical staff were consulted and managing hypertension was chosen as our recommended study topic. This recommendation was written up as a project charter proposal and submitted to DVHA's Commissioner for review. Approval to move forward with this topic was given during QE0920. The project team began work during QE1220.

Other Collaborative Quality Improvement Projects

The Quality Improvement & Clinical Integrity Unit merged with two other units (Clinical Operations

and Pharmacy) early in 2020. The new combined group is called the Clinical Services Team. Goals of this team include realizing efficiencies, aligning priorities and reducing redundancies. The Director of Quality Management lead a team of clinical and financial staff through an improvement project focused on aligning and streamlining DVHA's process for reviewing high dollar inpatient stays. An additional focus on palliative care was chosen in 2020.

As we move into 2021, the Director of Quality Management will support a palliative care review to identify potential project pathways.

Quality Measure Reporting

- CMS Medicaid Quality Core Measure Sets –
    - The Quality Unit and the Data Unit prepared and submitted the Adult and Child Quality Core Set reports by the deadline of 12/31/2020.
    - The Quality Unit staff collaborated with the Blueprint for Health who submitted a waiver request for the Health Home Core measure set.

- Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey - the DVHA Quality Unit's Director of Quality Management coordinated the 2020 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 2020. The results of the surveys were delivered to DVHA in February 2021 and will be presented by the Director of Quality Management to the PIHP Quality Committee and DVHA's Management Team in March 2021.

- HEDIS measure production – In 2020, the Quality Unit staff worked with the Business Office, Payment Reform Unit and Data Unit to re-bid the HEDIS measure production vendor contract. In addition to producing administrative (claims based) measures, the Quality Unit began preparing for the HEDIS 2021season by requested that Cotiviti perform medical record retrieval for four hybrid measures and abstraction for two of those measures. DVHA clinicians will abstract the other two 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 was performed in 2020 and indicated a need for further analysis. This work will continue into CY 2021 as we discuss with VITL the best approach to thedata comparisons we need to make.

Results Based Accountability (RBA)/Process Improvement

Results Based Accountability (RBA) scorecards are 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 to Health* Core Measure scorecard, Experience of Care, and other performance budgeting scorecards. The largest scorecard effort during 2020 was made to the 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. This scorecard includes over 100 measures, all of which were reviewed with an eye towards narrative alignment and standardization.

The Clinical Services Team also maintained their Green Belt status during 2020 by attending development courses and participating in regular Agency-level meetings. 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.

COVID-19 Dashboard

The Quality Team was tasked with creating and maintaining a COVID-19 dashboard at the end of March 2020 to monitor the response to the pandemic: both the impact it has had on operations and the activities staff have engaged in. Currently an internal evaluation tool, the dashboard is updated weekly and made available to all DVHA staff via our intranet. DVHA's Management Team highlights certain metrics within the dashboard at its regular meetings. This work was maintained throughout 2020 and continues into 2021.Additional measures are added to the dashboard as appropriate (e.g. # of VT Medicaid members having received COVID-19 vaccine.)

Vermont Next Generation Medicaid ACO

During 2020 DVHA's Director of Quality Management received, reviewed and approved the quarterly VMNG ACO quality management reports. Quality and Clinical staff from both organizations met quarterly with a focus on quality measurement and ongoing QI efforts. A representative from the VMNG ACO is a standing member on DVHA's new formal PIP, the topic of which is managing hypertension.

AHS Performance Accountability Committee

During this year, the state reviewed the meeting cadence of the AHS Performance Accountability Committee. The goal is to have regularly scheduled meetings maintain work momentum and strengthen the relationships between team members. Getting the meeting cadence right makes a huge difference in how well the team performs. The following factors were reviewed during 2020: urgency and importance of goals, tenure of participants, relevancy of topics, and interdependence. The latter factor was reviewed considering the role/responsibilities of the compliance committee. Discussions focused on how best to accomplish reciprocal strengthening of each other's functions. The state will continue to explore their interactions and how they both contribute to achieving the goals of the agency in the coming year.

Global Commitment (GC) Investment Review

AHS Departments are required to monitor and evaluate the performance of their investments 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 performance information contained in a web browser-based software application (Clear Impact Scorecard). The scorecard includes the following data elements: investment description (i.e., the goal ofthe 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). During this year, DMH, DVHA, DCF, DOC, VDH, and DAIL highlighted the performance of a subset of their investments using the scorecard in one of the quarterly reports to CMS.

Payment Models & Performance Monitoring

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 performance information contained in a web browser-based software application (Clear Impact Scorecard).

The scorecard includes the following data elements: payment model description (i.e., the goal of the payment model, 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 payment model 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). During this year, scorecards for the following payment models were published in one of the quarterly reports to CMS: Dental Incentive Program, Children's Integrated Services, Vermont Medicaid Next Generation (VMNG) Accountable Care Organization (ACO), DMH, and all three Blueprint for Health payment models: Patient-Centered Medical Homes, Community Health Teams, and the Women's Health Initiative.

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

During this year, the CQS/STP was posted for public comment. The public comment period started on February 19, 2020 – and originally ran through March 20, 2020. The document was posted on the AHS website and the notice was distributed to subscribers using the Global Commitment Register (GCR). A link to the CQS/STP was also included in the body of the notice. The updated version of the strategy/plan included content that addresses the following milestones:

- completion of site-specific assessment & validation activities (VT-5.0),
- an updated chart of the number of sites falling into categories of compliance (VT-5.1),
- incorporate results of settings analysis into final version of the STP and releasing for public comment (VT-6.0),
- identification of settings that overcome the presumption and will be submitted for heightened scrutiny and notification to provider (VT-17.0),
- complete gathering information and evidence on settings requiring heightened scrutiny that it will present to CMS (VT-18.0), and
- incorporate list of settings requiring heightened scrutiny and information and evidence (VT- 19.0).

Due to the COVID-19 pandemic, the comment period was extended from 30 to 60 days. During the extended STP public comment period, the state received feedback from one stakeholder, the Vermont Developmental Disabilities Council (VTDDC). The main theme of the VTDDC feedback was concern regarding the plan's failure to address and ensure ongoing compliance with conflict of interest in the delivery of case management services in Vermont's HCBS programs. Vermont has been directed by CMS that the correct avenue for managing Conflict Free Case Management requirements is through its upcoming waiver renewal. Given this guidance, no modifications were made to the STP based on the feedback. Vermont continues to work with CMS and stakeholders, including the VTDDC, on the correct approach to these requirements for each of its home and community-based services programs outside of the Statewide Transition Plan, which is specific to CMS requirements regarding HCBS settings. A copy of Vermont's current STP was posted on the CMS HCBS STP website.

During this year, the state received feedback from CMS re: their recently submitted CQS/STP. The feedback focused on the following aspects of the plan: site-specific settings assessment, validation of the HCBS settings, remediation strategies, ongoing monitoring of settings, and heightened scrutiny. The state's response to the COVID-19 public health emergency has limited in- person, on-site visits which as caused a delay in confirming the implementation of assessment and validation generated corrective actions. The state continues to address those action items that can be resolved remotely and will reevaluate its progress during the year to come. The state expects to submit responses to the CMS feedback and an updated CQS/STP during Q1 2021.

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

During this year, the existing Global Commitment to Health demonstration evaluation contract with Pacific Health Policy Group, PHPG, was revised to add deliverables and dollars to accommodate the evaluation requirements of the recently approved Serious Mental Illness (SMI) amendment. Specifically, the document was revised to meet the requirements outlined in the demonstration's Special Terms and Conditions (STCs), include CMS SMI monitoring and evaluation tools, and align with CMS SMI evaluation design guidance. The revised draft evaluation design was completed toward the end of the year and was submitted to CMS for review/approval.

Also, during this year, the state worked with the evaluator to implement Substance Use Disorder (SUD) evaluation activities. Specifically, time was spent identifying preferred providers that would be surveyed during the second round of inquiry, finalizing the provider survey, and identifying additional data element requirements associated with performance measures used to support evaluation related research questions and hypotheses. Once the additional data elements were identified – a standardized instrument to collect the information was developed. Finally, toward the middle of the year, state staff responsible for calculating the rates associated with the measures submitted the completed tool to the evaluator.

GC Final Evaluation Design

Evaluations are crucial to understand and disseminate what is or is not working and why. The principal focus of the GC Evaluation is to obtain and analyzing data on the process (e.g., whether the demonstration is being implemented as intended), outcomes (e.g., whether the demonstration is having the intended effects on the target population), and impacts of the demonstration (e.g., whether the outcomes observed in the targeted population differ from outcomes in similar populations not affected by the demonstration). The GC Final Evaluation Design is the state's plan for how it will accomplish the evaluation of their 1115 wavier. Specifically, the design identifies the state's hypotheses, evaluation questions, associated measures, and analytic methods.

During Q4 2020, the state submitted two versions of its design to CMS. The first version was submitted on 9/14/20 and included responses to the CMS feedback received during Q3 2020. On 10/20/20, the state received feedback from CMS. Before finalizing edits to the design and resubmitting – the state wanted to make sure that the responses and proposed design changes suggested by the team addressed the outstanding issues - and put the state on the path for final approval – so it sent CMS responses and proposed edits on 10/30/20. On 11/30/20 CMS responded to the state's request indicting that the responses and proposed edits were fully responsive to the remaining issues and encouraged the state to make those indicated revisions and submit the updated version. On 12/4/20 the state submitted a final version of the GC Evaluation Design to CMS. This version incorporated the CMS feedback that was received on October 20, 2020. During a subsequent phone conversation, CMS indicated that the state's design was "for all intent and purposes" approved – but due to the administration transition – a formal approval letter would be delayed.

PHE Evaluation Design

In an effort to address the COVID-19 public health emergency, the State of Vermont applied for and was approved for a new section 1115(a) demonstration opportunity available to states under title XIX (Medicaid) of the Social Security Act. Under this demonstration opportunity, the state of Vermont requested CMS to waive the requirement, at 42 CFR 438.406(b)(4) Handling of Grievances and Appeals, that allows beneficiaries to provide evidence and testimony "in person" to appeal an adverse benefit determination during the PHE. This application was approved during Q4 2020. Consistent with the requirements in 42 CFR § 431.424(c), the state submitted an evaluation design for the COVID-19 section 1115 demonstration during Q4 2020. The design provided a background description of the policies and objectives of the state's demonstration, a general overview of the research questions the state will examine in the final report, an outline of data sources the state feels may be useful to both contextualize and respond

to these questions, and any anticipated limitations to these monitoring and evaluation plans. During a subsequent phone conversation, CMS indicated that the state's design was "for all intent and purposes" approved – but due to the administration transition – a formal approval letter would be delayed.

GC Interim Evaluation Report

The state's GC Interim Evaluation Report was submitted to CMS during Q4 2020. The report was produced by an independent evaluator using CMS tools and guidance to ensure alignment with the state's special terms and conditions and CMS expectations. Specifically, the draft interim evaluation report discusses evaluation progress and presents findings to date using hypotheses, evaluation questions, and measures identified in the CMS approved evaluation design.

Updates to Agency Approach to Medicaid Compliance

During the year, DVHA and AHS held a series of meetings to develop updates to the processes and communications channels used to manage Medicaid compliance in the agency. These updates include better lines of communication, clearer reporting and accountability requirements, updates to the Compliance Committee and better coordination of efforts across the agency. Details of this work can be found in the following section.

Compliance Committee

During this year, the state took the time to review and assess the adequacy of the committee's charter. One of the elements considered this quarter was the meeting cadence of the group. Getting the meeting cadence right makes a huge difference in how well the team performs. Other factors to be looked at include, but are not limited to the following: goals, participants, topics, and interdependence with other existing state committees. The goal is to identify improvements to the charter that allow the group to maintain work momentum and strengthen their relationships with existing structures/processes.

Later in the year, a charter and draft procedures were developed and were presented to the reconfigured Compliance Committee. The Charter outlines the following aspects of the committee: purpose, membership, scope of work, duties/responsibilities, and accountability. The procedure document outlines how the committee will conduct its day-to-day operations including the following: assessment of Operational Areas of the Medicaid Program, development of annual work plan, use of reportable events, as well as an overview of compliance monitoring processes. These documents create new lines of communications and accountability across the agency and will help us to better coordinate our Medicaid compliance activities.

During Q4 2020, the AHS Regulatory Compliance Committee continued to expand its scope to include all AHS Managed Care Compliance needs. This expansion will allow the State to more efficiently handle compliance issues with a broader focus across the Agency. The meetings will be chaired by leaders from AHS and DVHA.

Intra-Governmental Agreement (IGA) between AHS and DVHA

During this year, the AHS QIM received notice from CMS that the 2020 Agency of Human Services (AHS) and the Department of Vermont Health Access (DVHA) IGA was approved. All requested changes to the 2020 agreement are expected to be incorporated into the 2021 version and sent to CMS for review/approval during this year.

iii. Member and Provider Services

Key updates from QE122020:

- 2020 Summary
- Electronic Data Interchange (EDI)
- Non-Emergency Medical Transportation
- Interoperability and Patient Access

The Member and Provider Services (MPS) Unit ensures members have access to appropriate health care for their medical, dental, and mental health needs. The MPS 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 Title 42 Code of Federal Regulations (CFR) §455.410 and §455.450 requiring that all participating providers be screened upon initial enrollment and revalidation of enrollment.

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

2020 Summary

The Member and Provider Services (MPS) unit, like all units within DVHA, faced many challenges throughout 2020 due to the ongoing COVID-19 pandemic; however, staff and state partners rose to the occasion and effectively acted upon policy to ensure that standards were met and services properly delivered.

The year began by seeing DVHA's Provider and Member Relations Unit merging with the department's Coordination of Benefits Unit and ultimately forming the Member and Provider Services Unit. This allowed for greater uniformity, allowing staff to engage with both member and provider needs by decreasing the gap that once existed between the former units' respective work.

The end of Q1 and the beginning of Q2 also saw the initial impact of the COVID-19 pandemic. The national emergency declaration enabled CMS to grant state and territorial Medicaid agencies a wider range of flexibilities under section 1135 waivers for Provider Enrollment. The State of Vermont has implemented the following in the wake of 2019 Novel Coronavirus Disease (COVID-19):

1. Temporarily waive provider enrollment requirements to ensure a sufficient number of providers are available to serve Medicaid enrollees. Such requirements include the payment of application fees, criminal background checks, or site visits.

2. Temporarily cease the revalidation of providers who are located in-state or otherwise directly impacted by a disaster.

3. Temporarily waive requirements that physicians and other health care professionals be licensed in the state or territory in which they are providing services, so long as they have equivalent licensing in another state.

Increases in provider enrollment attributable to any of the above flexibilities allows for increased access for our members.

As a result of the State of Emergency produced by COVID-19, the Department of Vermont Health

Access (DVHA) also elected to postpone all Vermont Medicaid fee schedule updates that had originally been scheduled for July 1, 2020 until at least October 1, 2020. This postponement ensured that reimbursement rates remain stable through the Emergency period while providers and practices may have been experiencing other changes to revenue and/or expenditures as a part of their COVID- 19 response. Delaying these fee schedule updates also ensured that provider stakeholder were able to engage in discussions about any future methodological changes, allowing providers to continue to focus on COVID-19 during this critical time for Vermont's health care system.

Vermont Medicaid fee schedule updates that were be postponed until October 1, 2020 included:

- Outpatient Prospective Payment System (OPPS) fee schedule (updated November 1. 2020);
- Resource-Based Relative Value Scale (RBRVS) professional fee schedule (updated November 1, 2020);
- Home health fee schedule (updated November 1, 2020);
- Hospice fee schedule (updated November 1, 2020);
- High-Technology Nursing fee schedule; and
- Physician administered drug fee schedule (updated November 1, 2020).

DVHA remains committed to professionalized implementation and maintenance of its reimbursement systems and intends to resume normal schedules for fee schedule updates in the subsequent year.

In February 2020, Vermont received certification of the Provider Management Module released in May 2019. In response to the state's request for CMS certification, the CMS certification team reviewed the Provider Management system and relevant artifacts/materials during a certification review conducted in Waterbury, Vermont, on November 21, 2019.

CMS approved the request for certification for Vermont's Provider Management system. This was based upon CMS's comprehensive review of Vermont's Provider Management system, including all documentation provided by Vermont, discussions with Vermont and vendor staff, and observations prior to, during, and after the CMS review. Based on this review, CMS approved the state's request for certification retroactive to the date of May 1, 2019. As a result, the state is eligible to request 75 percent Federal Financial Participation (FFP) retroactive to the Provider Management system implementation date of May 1, 2019.

Q4 2020

Electronic Data Interchange (EDI)

What Information is transmitted via EDI?

EDI can involve many types of information. Currently, the State of Vermont uses EDI standards to define the format of healthcare related information (claims, payments, eligibility) when it is transferred from healthcare providers to their trade partners and to the State of Vermont.

What is the Vermont EDI Project?

The Sybase EDI Translator, a component of the current GAINWELL TECHNOLOGIES MMIS, is no longer supported and needs to be replaced. The new EDI Translator is called OXi and includes more adherence to the written EDI standards than previously but are aligned with standards used in other states and other payors. Testing in the new system continues to ensure a smooth transition. The new translator is now scheduled to begin on May 1st, 2021.

Q4 2020: Development and testing of the new EDI solution lies almost entirely within Gainwell

Technologies. Gainwell has experienced some challenges in their development work and were forced to alter the go live date from fall of 2020 to May 1st, 2021. During this time, State of Vermont created testing plans and distributed communications to the trade partner communities to prepare them for both testing and the eventual transition to the new solution.

Non-Emergency Medical Transportation

DVHA's non-emergency medical transportation (NEMT) program has adapted very well to the pressures and adjustments necessary to effectively deal with the current COVID crisis. The numbers of rides provided is still operating at a level which is less than half of what was provided during the same quarter of the previous year (166,118 scheduled/132,774 provided in 2nd quarter FY20 versus 67,223 scheduled/54,262 provided FY21). The number of rides currently being provided has only recently started to edge slightly higher, as more appointment opportunities are beginning to open up for Medicaid members. DVHA's contracted NEMT provider, the Vermont Public Transportation Association (VPTA), has handled the ride volume changes very well, adapting ride provision and capacity to reflect the current guidance and public health rules set forth by both Governor Scott and the federal government.

During the 4th quarter of 2020, DVHA staff also worked diligently to draft a new contract with VPTA, agreeing upon the terms and language late in December for a January 1st start of the new contractual period. A new version of DVHA's NEMT manual was also drafted and finalized during that time, also becoming effective the first of the year.

Interoperability and Patient Access

The CMS Interoperability and Patient Access final rule (CMS-9115-F) requires affected health plans share claims and other health information with patients. Affected health plans include any plan that is at least partially funded by CMS, including Medicare Advantage (MA), Medicaid, CHIP, and Qualified Health Plan (QHP) issuers on the Federally facilitated Exchanges (FFEs).
This rule finalizes new policies that give patients access to their health information and moves the healthcare system toward greater interoperability. As part of the CMS Final Rule, the State of Vermont Medicaid Program is required to implement the following Application Programming Interface (API) policies:

1.1. Patient Access API – Claims, Clinical, & Pharmacy Data
1.2. Provider Directory API – Provider Directory Data
1.3. Preferred Drug List (Formulary) API – Statewide listing of VT Medicaid preferred drug list
1.4. Payer-to-Payer Data Exchange API – Transfer of a Medicaid member's health data from Vermont to another payer

The Patient Access API allows patients to easily access their claims and encounter information, including cost, as well as a defined sub-set of their clinical information through third-party applications of their choice. The Provider Directory API makes provider directory information publicly available via a standards-based API. The Preferred Drug (Formulary) List API makes the Vermont Medicaid preferred drug list or formulary data available to third party developers to present the list to the Vermont Medicaid member through an app on their phone or other devices. The Payer-to-Payer Data Exchange API will allow the Vermont Medicaid member to request their data be transferred from the Vermont Medicaid program to any other state Medicaid program or transferred to a private payer.

The API workstream team is currently working on the development of a request for proposal (RFP) that will require CMS approval – target date for completion of the draft RFP is first week of March 2021.

V. Cost Containment Initiatives

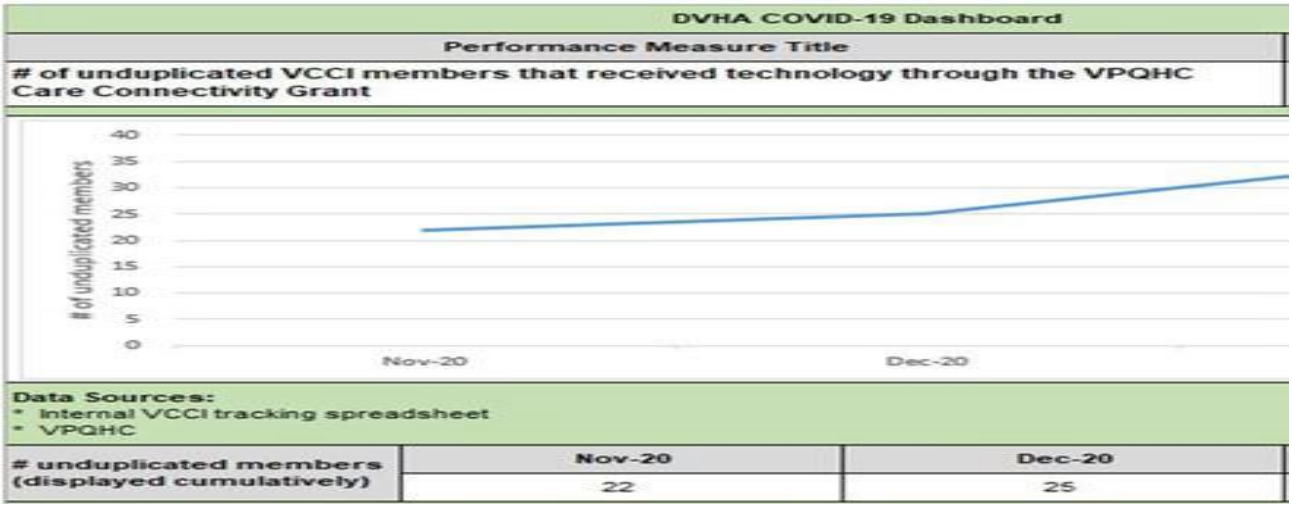
i. Vermont Chronic Care Initiative (VCCI)

Key updates from QE122020:

- COVID-19 Response
- Alignment of VCCI with state health care reform and ACO
- Working on bidirectional interface with VITL

The VCCI provides holistic, intensive case management services to Vermonters enrolled in Medicaid, including dually eligible beneficiaries. 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. Two non-licensed professional staff complement the team, with their primary role as outreach to those members new to the health plan. VCCI works with beneficiaries referred for complex case management by healthcare and human services providers, state colleagues and partners, as well as through our care management predictive modeling methodology. VCCI case managers and outreach coordinators are also welcoming members new to Medicaid (NTM), and screening members to identify and prioritize needs. Our screening tool asks members questions about access to care (including primary and dental), the presence and status of health conditions, and about other needs that would assist them in maintaining +/or improving their health such as housing, food and safety. The VCCI team works to connect members with medical homes, community-based self-management programs, local care management teams and assist member in navigating the system of health and health related care.

During QE 122020, VCCI continued to be a resource in the state's response to the public health crisis with both licensed (10) and non-licensed (3) staff available for COVID-vaccination in roles of either vaccinator or intake/exit worker. Staff schedule availability has been shared and the team are eager to help Vermont with its vaccination efforts. The pandemic has certainly highlighted telehealth services as an important tool for both patients and healthcare providers, but lack of technology access can be a barrier for some. With goal of increasing beneficiary access to telehealth services/providers, as well as to their VCCI case manager, VCCI procured technology through a federal grant. VCCI received 2 distributions of technology (November and December) and the team started to distribute both iPads and/or Wi-Fi extenders to beneficiaries with identified need and with the ability to navigate use of the technology. At end of this quarter, VCCI has been able to distribute technology to 25 unique beneficiaries and plans to continue to distribute supplies through 2021.



This quarter, VCCI continued to refine its strategy in alignment with the ACO and the formal adoption of the complex care model and supporting its expanded attribution population. The pandemic has certainly impacted the healthcare communities and their necessary prioritization of their healthcare operations, responding to acute concerns of their healthcare communities. All VCCI staff have received training in the complex care model, are trained in the ACO communication platform of Care Navigator and the VCCI care management system also identifies beneficiaries with complex health and social needs. VCCI continues to implement the model and utilizes patient engagement tools, shared care planning with care teams. VCCI has also developed or beginning to develop, depending upon the communities, workflows for management of the expanded ACO population- offering its established workstreams with those members new to Medicaid. In mid-December, VCCI was identified as a strategy of Vermont's All Payer Model reboot with an impending move to the AHS Secretary's office to further integrate the complex care model throughout the agency, as well as other partners.

In March 2020, VCCI amended its program operations in response to the public health emergency with consideration of the suspension of in- person visits with both beneficiaries and providers. Meeting with beneficiaries face-to-face; in their homes, shelters, motels, is our primary mode of intervening with members. Our field team pivoted from in-person to telephonic delivery of case management services March 16, 2020 and utilized visual platforms when appropriate. As VCCI continued to monitor the data on COVID-19, VCCI worked with DVHA leadership as well as sister departments within the Agency of Human Services, to develop guidance on resumption of in-person beneficiary visits. Our team began our gradual resumption of face-face to visits October 19, 2020 and were suspended again November 20, 2020 and remain on hold.

	SFY20						SFY21					
	Jan-21	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20
Measure	2/15/2020	3/15/2020	4/15/2020	5/15/2020	6/15/2020	7/15/2020	8/15/2020	9/15/2020	10/15/2020	11/15/2020	12/15/2020	1/15/2021
% of VCCI enrolled members with a face to face visit during the month	75.75%	72.19%	45.22%	1.28%	0.67%	0.00%	0.00%	0.00%	0.96%	6.13%	3.79%	0.31%

In March, VCCI also suspended its outreach to beneficiaries new to our state health plan. One of the goals of this outreach is the successful facilitation of primary and dental care and due to onset of pandemic, it was recognized that this may have been challenging, as dental practices were either closed or had very limited hours and primary care offices were also quickly adapting. June 2020, VCCI was able to resume its telephonic outreach to beneficiaries new to the state health plan, with goal of screening, stratification, and facilitation of access to care. The outreach helps to orient beneficiaries to the health and health related system, and concurrently helps to expand the number of members attributed to the ACO, through establishment with primary care. Establishing care with primary care continues to present with barriers, and a lack of dental providers within the system of care is challenging.

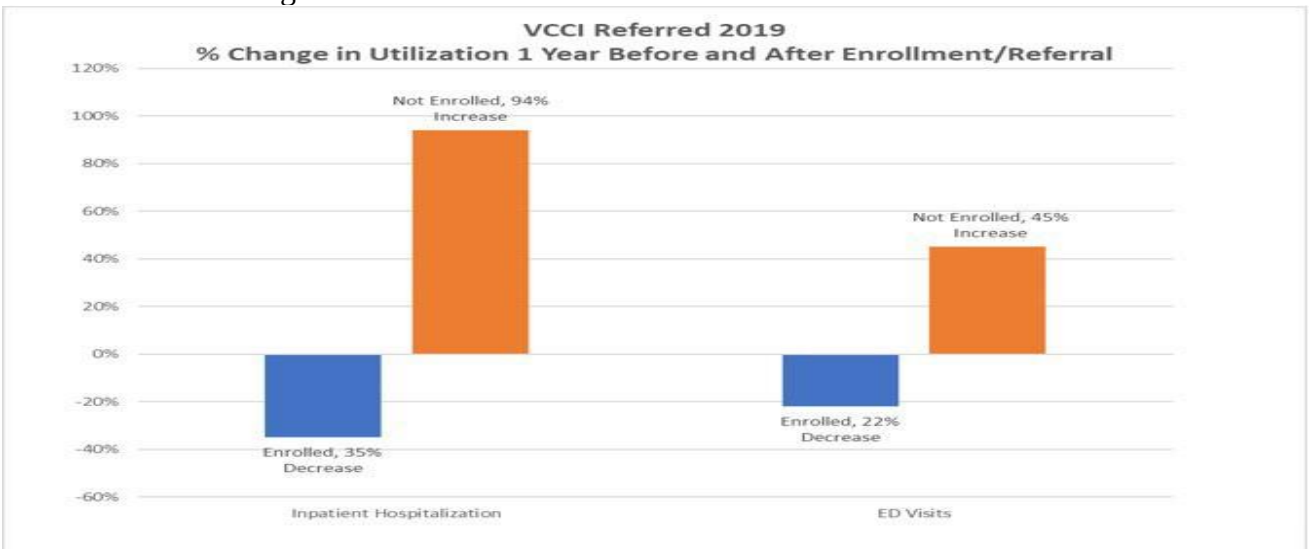
VCCI supported, and continues to support Vermont's response to the public health emergency. In addition to current request for licensed and non-licensed staff for impending role with COVID-19 vaccination clinics, from April to June, several VCCI staff were redeployed to the Vermont Department of Health for contact tracing and assisting facilities with establishing protocols for managing COVID-19 positive staff and residents. During the same timeframe, VCCI redeployed other staff to the set-up of AHS Wellness and Recovery Centers intended to house beneficiaries who were COIVD-19 (+), did not require hospital level of care and were unable to shelter in their current living environment. Good news that these sites were dismantled early on as Vermont did not end up with need for these recovery centers.

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. VCCI is working with the ACO on two main areas for alignment: formal adoption of the complex care model with utilization of common tools and expanded attribution. 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 goal setting and in the development of the shared care plan. There remains varying community implementation of this service delivery: lead care coordinator may be identified but has not yet engaged with the beneficiary; an identified care team of one provider. Information is intended to be shared within OCV communication platform of Care Navigator, but this can be challenging. The system often feels like another health record to manage; not all partners on a beneficiary care team may have access to Care Navigator; and 2021 attribution may not be loaded into Care Navigator until the Spring. All VCCI field-based staff have been trained in using Care Navigator. There remains variance with community knowledge and scope of understanding of the expanded attribution and development of community workflows to help manage this population. VCCI has assessed how we could improve our role in supporting the ACO and communities; and have coordinated with colleagues at DVHA. VCCI and Blueprint for Health have just begun to meet with managers from OCV, with the objectives of ensuring consistent communication and messaging, ensuring communities have the knowledge and tools, and review of data.

Our team continues to receive referrals, from ACO providers, on ACO attributed beneficiaries, presenting with complex health and social needs. Reasons cited for referral to VCCI versus referral to in-house care coordinator is due to the 1) members complexity requiring intensive case management 2) beneficiary is not established at the attributed practice 3) primary care office does not have the staffing resources to manage beneficiaries with complex needs 4)) Practice focus on high and very high risk members, and member being referred does not meet that criteria. VCCI works to stabilize members while building long term community care team. 5) when VCCI is in the field, VCCI ability to meet with members in-person, where member may physically be whether a motel, shelter, apartment, etc.

VCCI continues to serve beneficiaries who are at risk or high risk - discharged from an inpatient stay without an established primary care, and to a homelessness status; with a cognitive impairment trying to manage their uncontrolled diabetes; those with uncontrolled chronic conditions who utilize the ED. Our population served are often referenced to as the ‘hidden population’ or ‘those who fall through the cracks. With established workflows, utilization of evidenced based assessments with subsequent plan of care development and beneficiary centered approach, VCCI case managers provide consistent, frequent intervention to help beneficiaries meet their health and health related goals.



Another area that VCCI is working on with our partners at VITL and the Blueprint is to have the data related to social determinants of health that VCCI collects on members through our comprehensive surveys to be part of the member's record in the VHIE. This will assist the ACO with a more accurate way of predicting risk for members and being able to intervene on those members with issues earlier, so they do not become part of that very high-risk group.

The clinical documentation system that VCCI utilizes through eQ Health is CMS certified and VCCI has exercised the option to extend the contract with the Vendor for the two additional years. The system contains clinical information via an interface with Vermont's HIE vendor, VITL to enhance case managers' ability to formulate and put into motion a true patient centered, clinically focused plan of care.

VCCI is looking forward to 2021. Goals include resumption of in-person, field-based beneficiary visits; assist with standardizing the tools of the complex care model delivery statewide; the development of workstream with our colleagues at the Department of Corrections on transitions of care with beneficiaries released from/entering incarceration; and collaboration with our Agency of Human Services on procurement of safe housing for high-risk, housing unstable members. The above goals are appropriate with consideration of the VCCI role in the All Payer Model reboot and move to the AHS Secretary's Office.

ii. Behavioral Health

Key updates from QE122020:

- Inpatient psychiatric placements
- Applied Behavior Analysis

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 Agency partners to support coordination of care. The team refers members to VCCI services and helps ensure continuity of care for beneficiaries already enrolled with VCCI.

The COVID-19 pandemic resulted in an increase in length of stay for Vermont Medicaid inpatient psychiatric placements. Almost all OOS programs had a hold on admissions and the ICPC process was temporarily shut down. Residential Programs in Vermont for children and adolescents overall reduced capacity. The pandemic also impacted community and residential treatment program placements for adults. Due to the lack of placements, DVHAs authorization decisions were affected, and additional authorization was required in order to keep our members safe and stable during this time. Although many placements have reopened, the COVID-19 pandemic continues to impact the ability to place members in the appropriate programs as quickly as necessary. The testing and quarantine process has affected the speed at which members can normally be placed. Therefore, the length of stay for inpatient psychiatric placements continues to be impacted. The inpatient capacity statewide is still below what it was pre- COVID.

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 procedure for inclusion, screening tool, and a manual have been developed. The unit conducts quarterly reviews of claims data, including pharmacy and emergency department visits, to identify members who may benefit from the

support of the Team Care program. Clinicians review this data and determine enrollment of potential new members. Team Care program members 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 external 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 State 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 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 for DVHA to assist with placements when needed.

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. There has been an increase in enrollment with Vermont Medicaid of new agencies that provide ABA services. The QICI, Payment Reform, Policy, and the Business Unit have finalized reconciliation for dates of service July 1, 2019 through December 31, 2019. The team is in the process of reviewing claims data from the first half of reconciliation for dates of service January 1,2020 through December 31, 2020.

The DVHA ABA Team actively communicated with ABA providers regarding the COVID-19 pandemic, specifically regarding concerns of their abilities to continue to serve members during this time. The ABA Team reviewed the ABA CPT Codes and made recommendations to the DVHA commissioners' team regarding expanding the use of telehealth (visual and audio) specific to ABA services. Since the end of May, ABA providers have begun to slowly resume ABA services in clinics as well as in home settings.

Prior to the COVID-19 pandemic the DVHA ABA team was conducting in-person site visits/audits with Vermont Medicaid enrolled ABA providers who were providing services to Vermont Medicaid members. The purpose of these visits/audits is to assure that members are receiving quality care, that providers are accurately reimbursed for provided services, assuring that required documentation is included in members charts, and that clinical documentation aligns with ABA Policy and Clinical Practice Guideline standards. . Site visits/audits are scheduled to resume as of January 2021 and will be completed in a virtual format due to social distancing restrictions. This will entail a virtual tour of the providers Electronic Health Records system and the provider will electronically submit clinical documentation to be reviewed independently by the DVHA ABA team. The goal is to audit every provider by December 2021.

Prior to the COVID-19 pandemic, the Quality team partnered with VCCI to assist in conducting 'Initial Screening Birth to 18 Years' survey. The unit attended a training with VCCI in early 2020 and began surveying members/guardians and planned to conduct this work through 2020. This project continues to be suspended therefore no additional assistance was provided throughout 2020.

iii. Mental Health System of Care

Key updates from QE122020:

- Impact of Covid-19 on system capacity
- Integrating Family Services Activity
- Update on Mental Health Integration Council

System Overview

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 mental illnesses (SMI). Funding is provided through the Vermont Agency of Human Services (AHS) Provider Agreements (formerly termed Master Grants/Agreements) 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 mental illness;
- Adult Outpatient for adults who are experiencing emotional or behavioral distress severeenough 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 six 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.

There are several policy and programmatic updates below related to the COVID-19 pandemic. On March 24, 2020 Governor Scott issued a "Stay Home, Stay Safe" order that ordered Vermonters to restrict and minimize activities outside of the home and directed non-essential businesses and non—profits to cease in person operations. These orders have had a tremendous impact on the service delivery of mental health services throughout Vermont in all community-based settings and inpatient facilities.

Enhancements of the Mental Health System of Care:

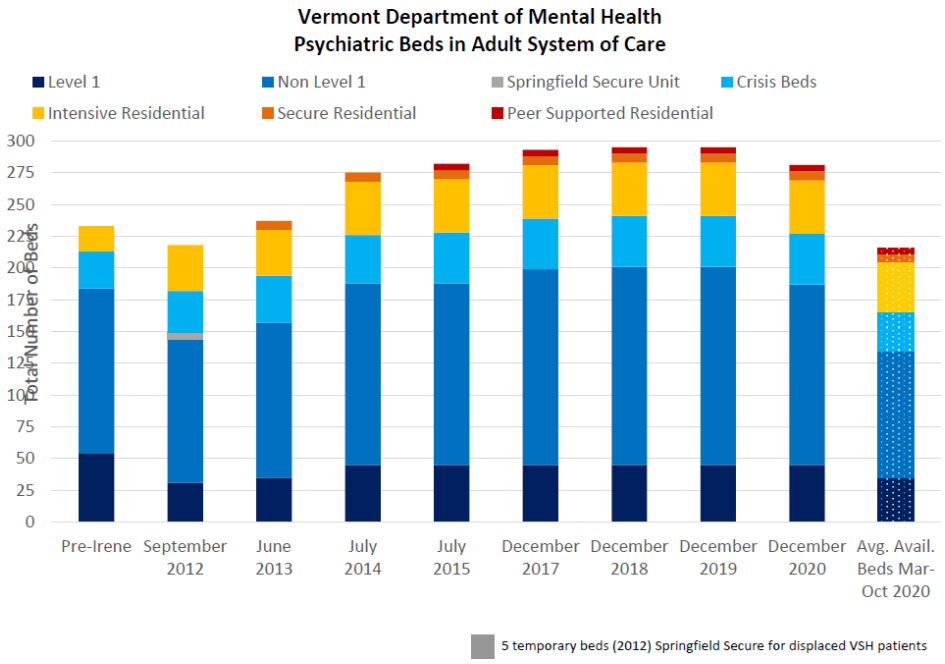
Hospital Services

There are 45 Level 1 beds and a total of 159 adult psychiatric inpatient beds across the system of care. During the Covid-19 pandemic, a number of beds closed due to low staffing, converting double occupancy rooms to single occupancy, need for quarantine spaces, and an initial decrease in individuals presenting with a need for a higher level of care. The development of 12 inpatient Level 1 beds at the Brattleboro Retreat was delayed due to the Covid-19 pandemic and are scheduled to come online in March 2021.

The above factors resulted in a temporary loss of 14 adult beds in response to public health and environmental safety guidance for both inpatients and staff until renovations are completed and effects of the Covid-19 pandemic mitigated. This temporary bed loss is identified in the chart below.

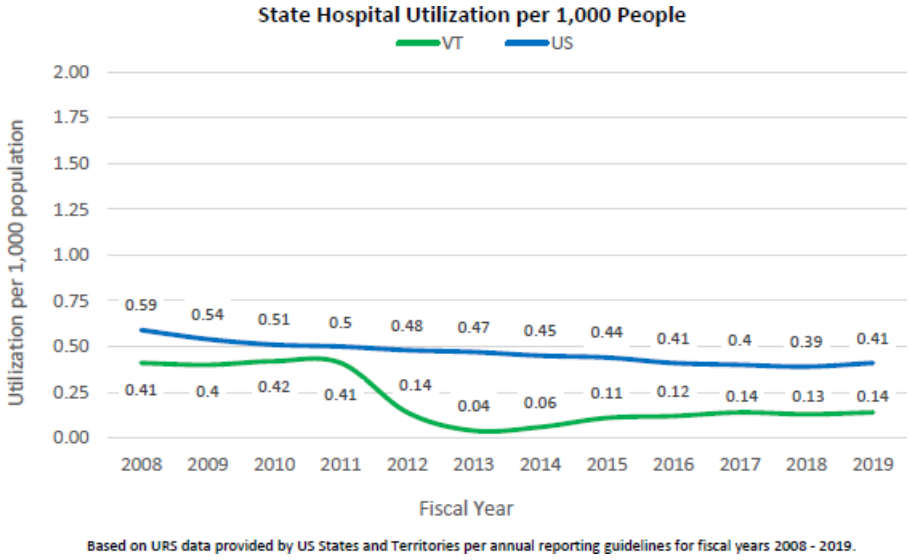
In addition to this temporary loss of adult beds, the COVID-19 pandemic had a ripple effect across the adult inpatient system of care during this same period. In the below table, a bar illustrating Average Available Beds March – October 2020 reflects a system-wide impact across inpatient and community-based crisis beds and residential programs.

Figure 3. Vermont DMH Psychiatric Beds in Adult System of Care



DMH 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 2019 is the most recent data available.

Figure 4. 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 - 2019.

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. DMH will be paying close attention to these rates as there is anticipation and evidence already that this pandemic and the social isolation that has occurred because of it will increase the needs for mental health treatment and support.

Other involuntary psychiatric hospital unit admissions, such as those at Designated Hospitals, are included in the Other Psychiatric Hospital Utilization chart. 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. Other Psychiatric Hospital Utilization per 1,000 people (in Vermont and the United States)

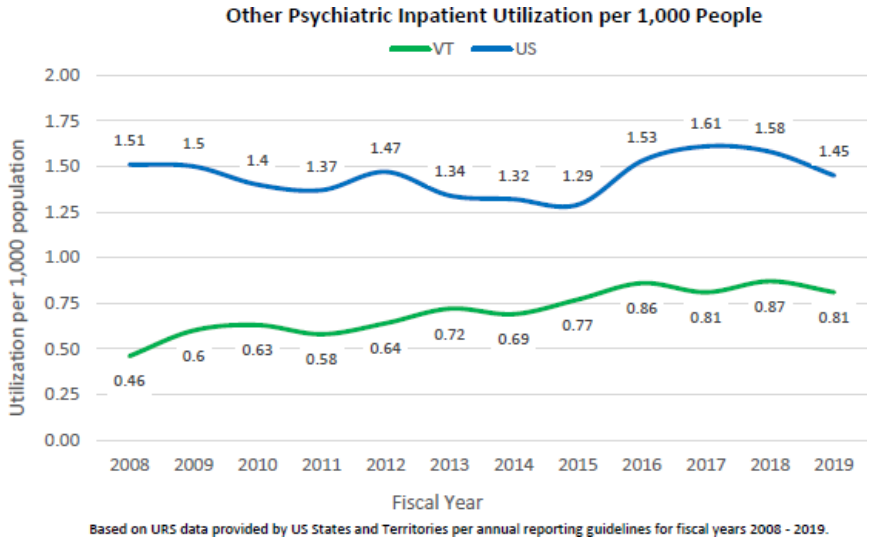
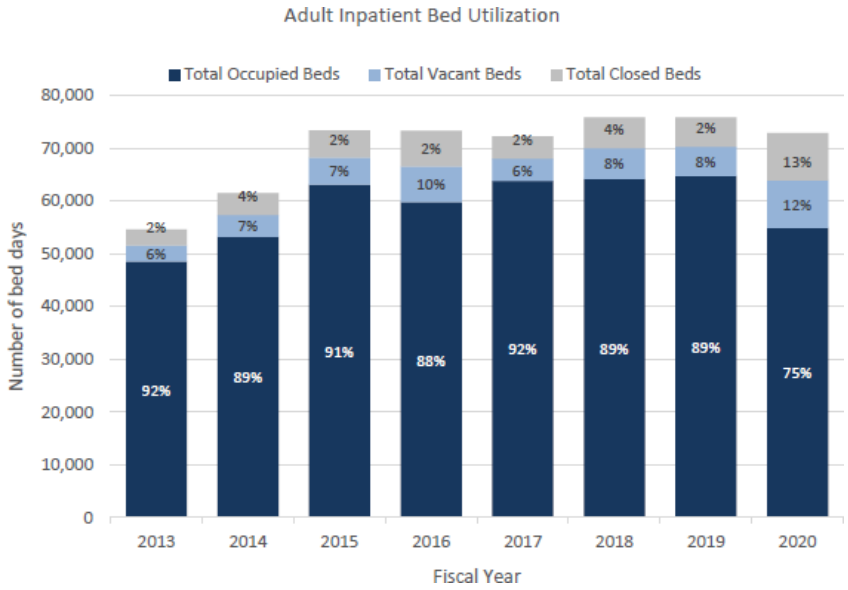


Figure 6. Adult Inpatient Utilization and Bed Closures



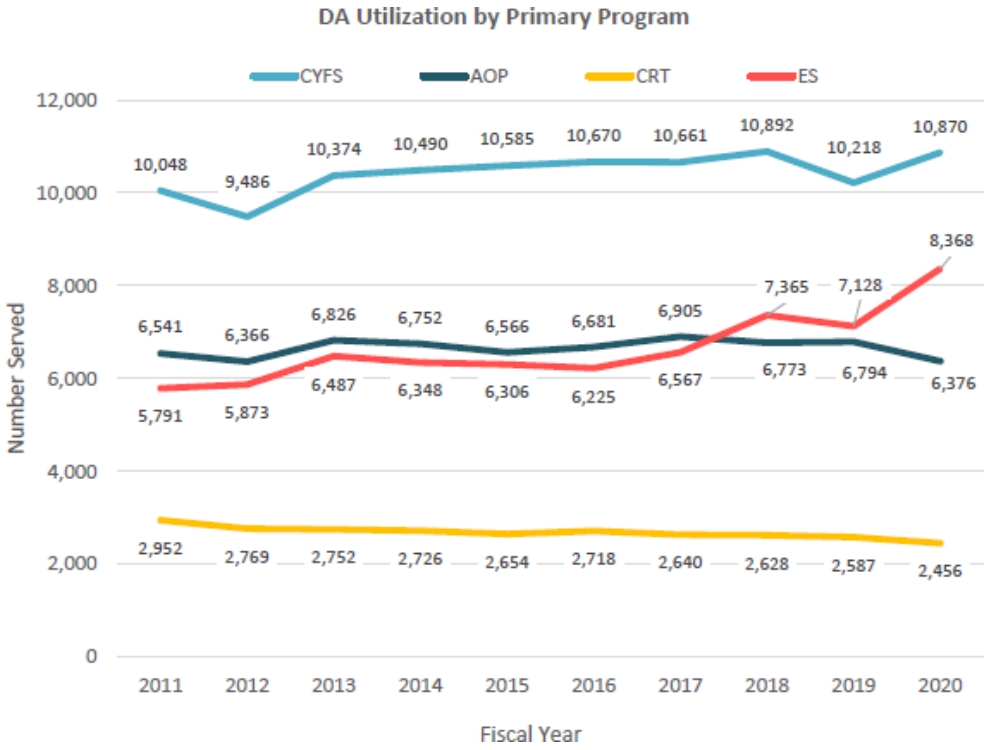
The Adult Inpatient Utilization and Bed Closures chart depicts the total bed day capacity across the Vermont Designated Hospital system through FY 2020. The total bed day availability across the system has remained relatively constant in 2018 and 2019 with bed day utilization decreasing 14% in 2020. The impact of the COVID-19 pandemic has contributed to the 4% increase in bed vacancies and the 11% increase in beds closed for much of 2020. Over this eight-year period, 2020 has seen the lowest level of adult inpatient bed utilization.

Community Services

- Establish Community Outreach Team in Washington County (Collaboration with Public Safety)
- Increased capacity within Community Rehabilitation and Treatment and peer programs toprovide 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 involuntary mental health hospitalizations
- Resources to assist individuals in finding and keeping stable housing
  Expansion of peer-supported warmline hours

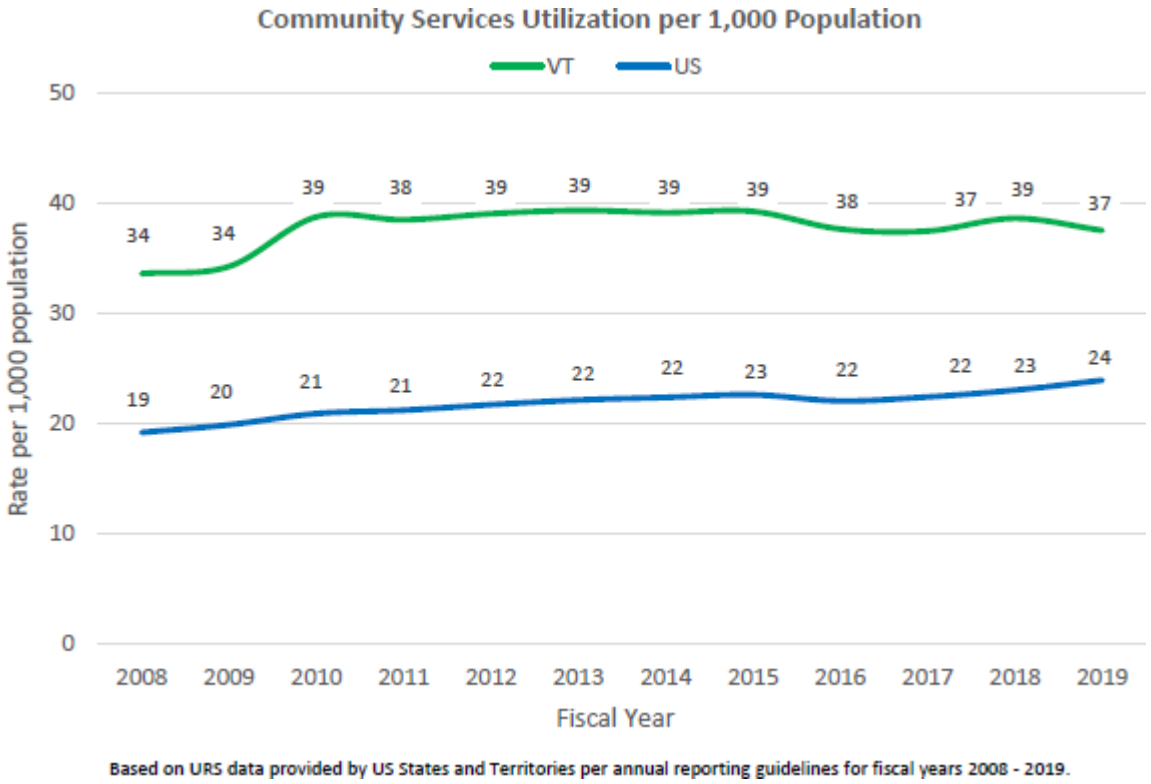
Enhanced community services funding provided by the legislature through increased appropriations to key mental health programs in the community over the last several years has helped, but staff recruitment and retention necessary to meet and expand these service capacities continues to be a struggle. 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 7. 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. The 6% decrease noted in 2019 appears to have self-corrected and closely approximates utilization in 2018. Similarly, the Emergency Services programs also had an upward trend overall in 2020 which may reflect the increased support needs associated with the impacts of Covid-19. The Adult Outpatient programs saw a 6% decline in utilization while the Community Rehabilitation and Treatment (CRT) programs saw 4% decline. Both of these adult programs have seen flat or slow trend changes over the nine-year period reflected. As FY 2020 all programs utilization essentially reflects only one quarter of potential impact from the COVID-19 pandemic, FY 2021 will be more reflective of the virus' impact to system services and capacities to meet the needs of individuals served in Calendar Year 2020.

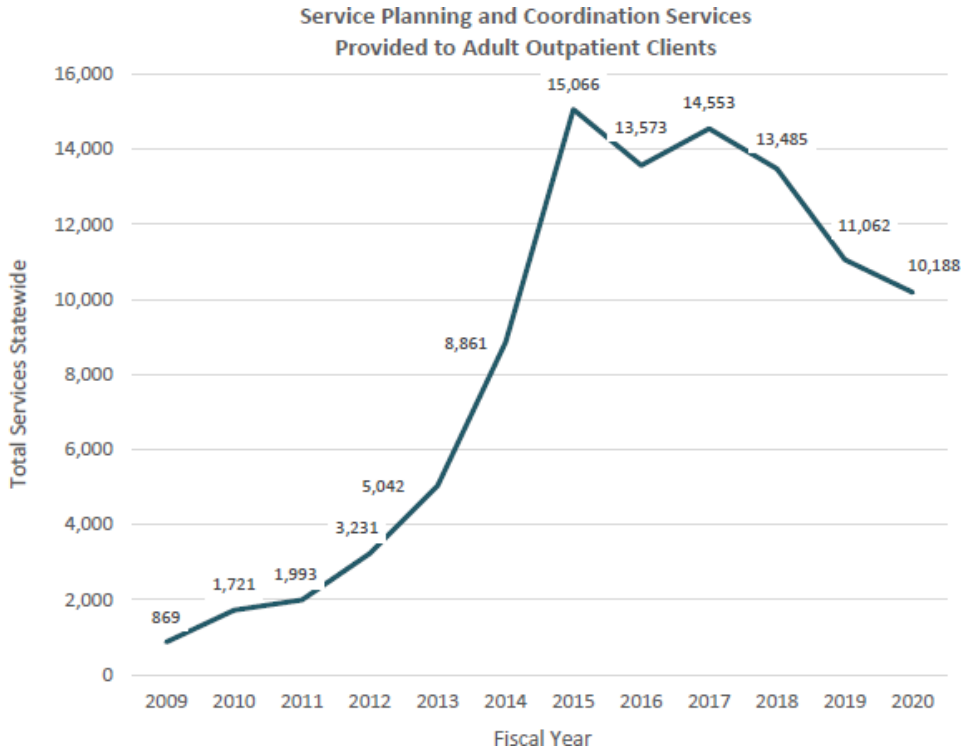
Figure 8. Community Utilization per 1,000 Populations



Based on URS data provided by US States and Territories per annual reporting guidelines for fiscal years 2008 - 2019.

The Vermont community mental health system serves nearly 40 out of every 1,000 Vermonters, which is substantially higher than the national utilization rate. 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. 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 case rate payment reforms provide the ongoing flexibility to meet the needs of the individuals and provide the necessary services.

Figure 9. Service Delivery: Planning and Coordination

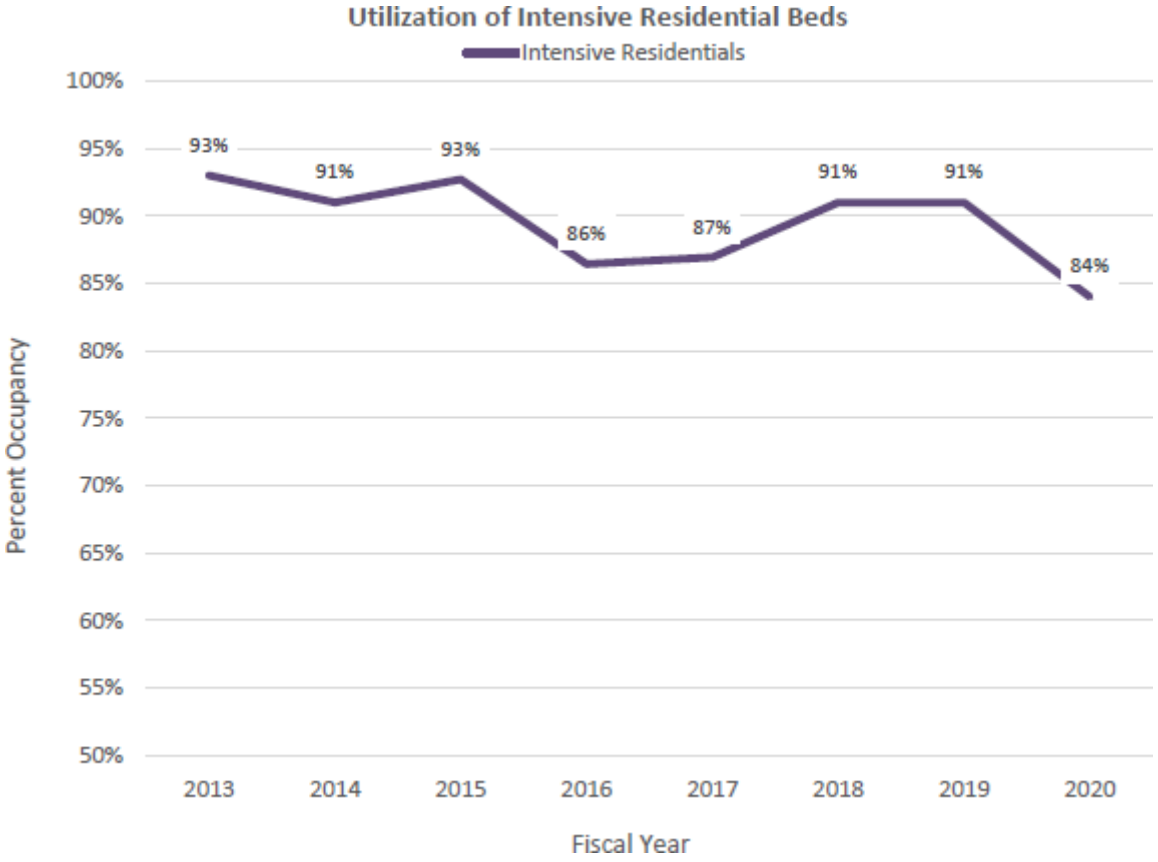


The support of non-categorical case management led to a steady increase in the number of services provided to adult outpatient clients allowing additional support to those in need but ineligible for case management through Community Rehabilitation and Treatment services through FY 2015. Levels remain 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 when needed.

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 10. Intensive Residential Bed Utilization



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.

2020 saw the greatest decrease in utilization over the eight-year period to 84%. The influence of the pandemic through much of 2020 and the changing capacities of programs to safely transfer and introduce new residents into programs likely contributed to this drop. Effects of the virus on 2020 data appears evident throughout this reporting period.

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 reportingrequirements
- 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
- DMH has several RBA scorecards containing data and performance measures related to the system of care.

Regulation and Guidance

To align with federal policy shifts brought on by the COVID-19 pandemic, DMH issued new guidance to providers this past year on:

- COVID-19 Hospital Discharge Guidance General Guidance to Designated Agencies
- Critical Incident Reporting Requirements Medical Clearance Guidance
- The use of telehealth and HIPAA requirements
- Recommended Precautions for Caregivers

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 has created a case rate for children/youth mental health services, and a case rate 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 funding stream through one AHS Provider 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.

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 funding and 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 continue to utilize 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 in the majority of situations children and youth are increasing in their strengths and decreasing needs.

During COVID, as has been true with all mental health agencies, there has been additional stress on providers and strong commitment to providing services and supports in new and creative ways. Both IFS regions, have significantly increased their offering of telehealth, treatment and

intervention in outdoor spaces and providing services to students whether they are doing online or in school learning.

Vision 2030

Through summer, fall, and early winter 2019, DMH engaged 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," was delivered to the Vermont State Legislature in January 2020.

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 the 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. The workforce must use the best technologies, evidence-based tools and practices for making 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

Following the plan submission to the legislature in January 2020, DMH was anticipating convening a Mental Health Integration Council in the fall of 2020, to begin the work of implementation. The demands of the COVID-19 pandemic on Vermont's health systems, however, has delayed that work. Work that was called for in the plan, however, has in many instances been advanced in direct response to the pandemic. Telehealth options, for example, are now available for anyone seeking mental health care, and are fully reimbursable. Much work has been undertaken to ensure children's mental health services are available even if children are not in a physical school building. DMH is creating an inventory of work that is moving ahead and continues its support in that work within the department staff capacity available. DMH has continued planning for the Council and looks forward to convening this work as soon as circumstances allow.

iv. Blueprint for Health

Key updates from QE122020:

- The majority of Vermont's primary care practices are now Blueprint-participating Patient-Centered Medical Homes, as evidenced by 134 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 September 2020, the number of clients enrolled in Regional Opioid Treatment Programs (OTP/Hubs) was 3,154, and the average monthly number of Medicaid beneficiaries served by Office-Based Opioid Treatment (OBOT/Spoke) programs increased to 3,777.
- Vermont continues to increase access to enhanced preventative health, psychosocial screening, and comprehensive family planning services, as evidenced by the commitment of 49 practices and all 12 Planned Parenthood sites to participate in the Women's Health Initiative as of June 2020

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. The 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 Teams 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

supports participating practices with a quality improvement coach, called a Quality Improvement Facilitator. Quality Improvement Facilitators use their own training and expertise in process improvement methodologies (such as Clinical Microsystems, Model for Improvement, and Lean process improvement) and data interpretation for when they review the practice's data or data provided by the Blueprint for Health. 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 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 304,685 insurer-attributed patients, of which 102,183 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 165 full- time equivalents of Community Health Team staff.

Quarterly Highlights

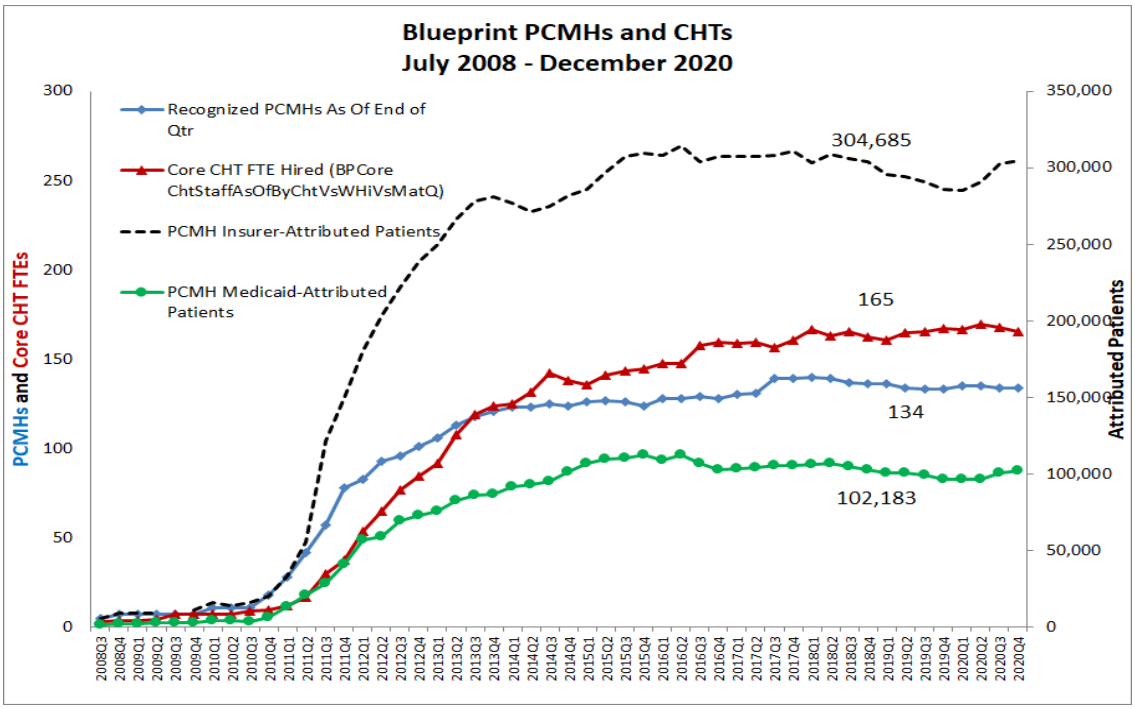
In Quarter 4 (July - December2020), 134 Vermont practices were operating as Patient-Centered Medical Homes, thanks to the commitment of providers and staff, the support of Program Managers, and the technical assistance of Quality Improvement Facilitators. The number of practices participating in the 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.

In collaboration with the Blueprint for Health, NCQA has extended the Recognition status of PCMH practices with Annual Reporting deadlines between March and December 2020. The adjusted deadlines now reflect an Annual Reporting date of December 1, 2020, and a Recognition End date of December 31, 2020.

Since Governor Phil Scott has declared a state of emergency in Vermont, which continued through the 3rd quarter, Patient-Centered Medical Homes, specialty practices, and Spokes have acted quickly to provide continuity of care. Most of the network used their electronic health records to run various reports based on a few factors of risk: age greater than 60 with chronic conditions, John Hopkins ACG scale, potential for fragmented care, mental health and substance use diagnosis, and high healthcare resource usage. They also cross-referenced patients who missed appointments and who needed follow up as soon as possible. The Community Health Teams reached out to the patients who met these criteria. On these calls, they would also inquire about other social determinants of health, such as access to food and medicine. While in-person

visits have increased, telehealth continues to be an option for primary care appointments and screenings. The network continues to work diligently to ensure excellent patient care and care coordination for the best health outcomes.

Figure 2. Patient-Centered Medical Homes and Community Health Teams



Practice Health Profiles and Community Health Profiles

In the past, the Blueprint for Health has supported data-driven population health improvement by producing profiles that describe the health status, health care utilization, expenditures, and outcomes of populations in each health service area and patients in each Patient-Centered Medical Home. Unfortunately, due to budget constraints, these profiles were not produced this year. Previous publications covered the following data time periods:

01/2013 – 12/2013
07/2013 - 06/2014
01/2014 - 12/2014
07/2014 - 06/2015
01/2015 – 12/2015
07/2015 – 06/2016
01/2016 – 12/2016
07/2016 – 06/2017
01/2017 – 12/2017
01/2018 – 12/2018

Profiles are posted at http://blueprintforhealth.vermont.gov/community-health-profiles. Most recently, the Blueprint for Health published its 2020 Annual Report. This report reviews more in

depth how the Program Managers, Quality Improvement Facilitators, Patient-Centered Medical Homes, Community Health Teams interact to provide services, coordinate care across communities, and work with the state's accountable care organization. The report is available at: https://blueprintforhealth.vermont.gov/sites/bfh/files/doc_library/BlueprintforHealthAnnualReportCY2020.pdf.

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 2020, capacity for receiving medication-assisted treatment in Spoke settings continued to increase, as evidenced by 3777 Vermonters with Medicaid insurance receiving medication-assisted treatment for opioid use disorder from 265 prescribers and 74.23 full-time equivalent Spoke staff, working as teams,

across more than 90[1] different Spoke settings (as of December 2020).

Quarterly Highlights

Vermont continues to demonstrate substantial access to medication-assisted treatment for Vermonters with opioid use disorder. As of December 2020, a monthly average of 3777 Medicaid beneficiaries were served by Office-Based Opioid Treatment (OBOT/Spoke) programs. As of 2020-Q3 3,154 Vermont residents aged 18-64 received treatment in a Hub (source: ADAP Hub and Spoke Quarterly Report for 2020-Q3).

Medication-assisted treatment for opioid use disorder is being offered across the State of Vermont by more than 90 different Spoke settings and by 265 medical doctors, nurse practitioners and physician assistants who work with 74.23 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 2020).

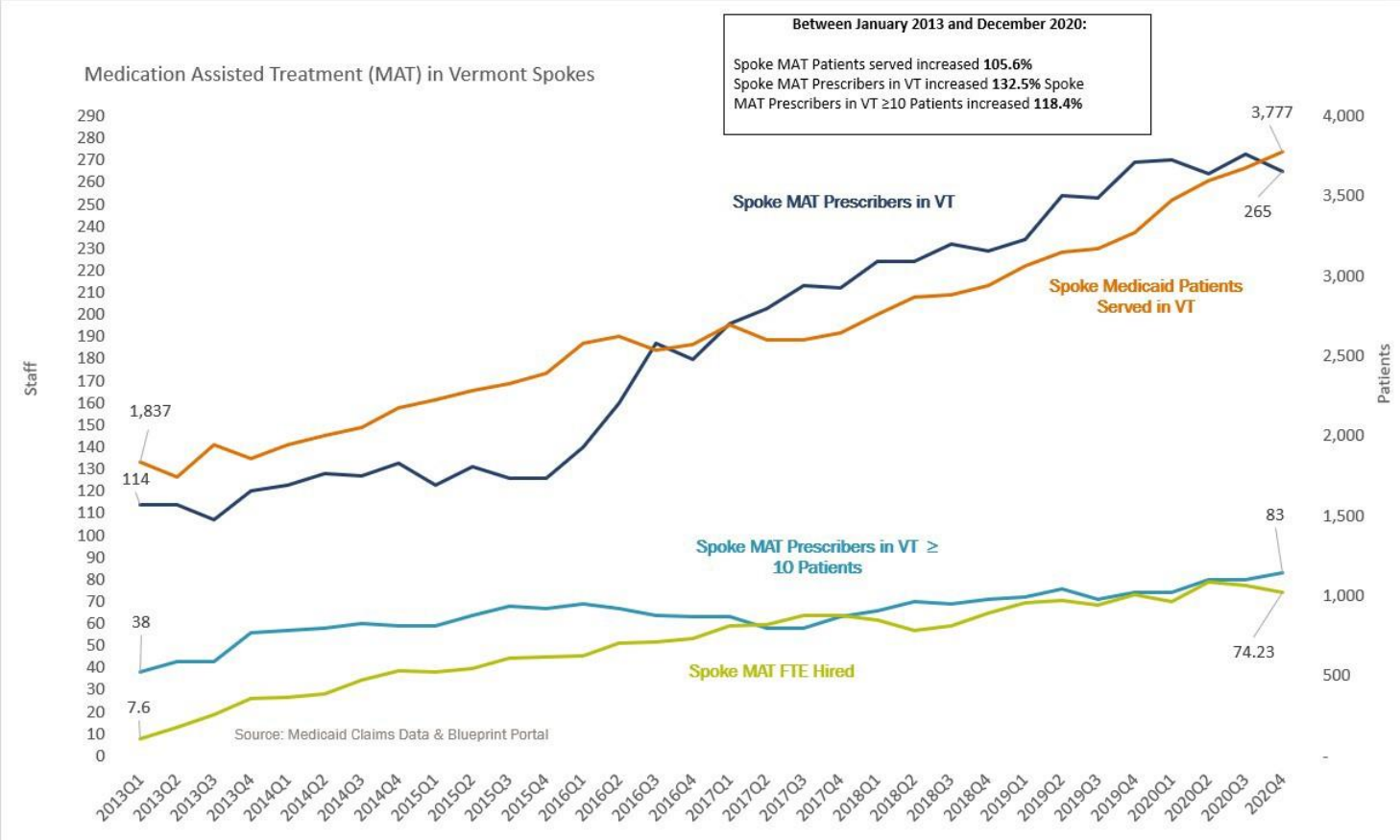
Toward the end of Q1 2020, all Spoke sites began transitioning to remote and telehealth services in response to Vermont's "Stay Home, Stay Safe" emergency order that went into effect on March 13, 2020. At the end of Q4 2020, many Spoke nurses were providing care in both telehealth and in-person visits, and the Spoke counselors were continuing to deliver care remotely. Dependent on COVID-19 case rates throughout the state, in Q4 of 2020 Spoke nurses fluctuated their frequency of in-person care. For example, in areas of the state where case rates increased, Spoke nurses reduced the amount of in-person visits they had based on patient risk stratification as evaluated by the provider and care team. Patients who were determined to be stable were more likely to have telehealth-only visits from both the Spoke nurse and the Spoke counselor at the end of 2020.

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 included a series of five webinars, six training sessions, and one statewide conference. In response to the COVID-19 pandemic and Vermont's "Stay Home, Stay Safe" emergency declaration, Dartmouth College restructured the remainder of the Learning Collaborative to accommodate entirely virtual sessions as of June 2020. For the 4th quarter of 2020, the 2019-2020 Learning Collaborative event orchestrated by Dartmouth College, in conjunction with Blueprint for Health and Vermont Department of Health's Division of Alcohol and Drug Abuse Programs, consisted of a two-day statewide virtual conference. The 2019-2020 Learning Collaborative cycle concluded in October 2020.

As of November 1, 2020, the Blueprint extended their contract with Dartmouth College through June 2021, in alignment with the end of the Sate fiscal year. The remainder of Q4 in 2020 consisted of curriculum planning for six virtual learning sessions hosted monthly from January – June 2021. The key themes for this set of learning sessions will involve the intersection of Alcohol Use Disorder (AUD) with MAT, long-term MAT care, and the intersection of mental illness with MAT.

[1] Number of Spoke settings is defined as the number of unique practices where Spoke providers are located.

Figure 2. MAT-SPOKE Implementation Jan 2013 – December 2020



Women's Health Initiative

The Women's Health Initiative (WHI) began as a state initiative to support pregnancy intention. The WHI program continues to evolve and strives to support Vermont women in their efforts to experience healthy pregnancies, avoid unintended pregnancies, and build thriving families. The Blueprint partners with women's specialty health providers and primary care practices, providing additional resources to support of the women they serve. These resources include payments for participating in the WHI and Community Health Team staff. In return, practices attest that they provide enhanced screenings, brief interventions and referrals to treatment, initiate referral agreements with key community-based organizations in their HSA, conduct comprehensive family planning counseling, and provide patients with access to same day long-acting reversible contraception (LARC).

At a minimum, WHI providers engage with patients at new patient and annual visits to screen for social determinants of health needs including food and housing insecurity and interpersonal violence, as well as depression, anxiety, harm to self or others, and substance use disorders. They also discuss pregnancy intention for the coming year using the One Key Question®12, which asks if, when, and under what circumstances a woman would like to become pregnant. Women with a desire to become pregnant receive services to support a healthy pregnancy. If the woman would like to prevent pregnancy, contraception methods are discussed and timely access to

LARC is offered on site for the same day, if clinically indicated.

Like the core CHT and Spoke programs, the WHI provides increased mental health and social service staffing at specialty practices and utilizes the CHT at Blueprint PCMH practices. If a patient identifies as at-risk, they have immediate access to a WHI social worker for brief interventions, counseling, and navigation to community-based services and treatment as needed. WHI clinicians work closely with community partners and develop mutual referral agreements and establish meaningful relationships with those partners to support patients.

Quarterly Highlights

- Vermont continues to increase access to enhanced preventative health, psychosocial screening, and comprehensive family planning services, as evidenced by the commitment of 49 practices (25women's health and 24 primary care) to participate in the Women's Health Initiative as of December 2020.
- This quarter we have collected new attestation forms from each WHI practice. Practices are working hard to engage community partners in referral agreements. These agreements enhance relationships and pathways to care.
- We have presented a WHI data dashboard to the field in our monthly call. We received feedback on what would be useful data for the field from claims and will continue to support the field with this information.
- Dr. Lauren MacAfee from the UVM network supported our field with a hour long lunch and learn on tips to support a busy practice supporting same day LARC.
- The Community Quality Improvement Facilitator and Assistant Director meet with each Health Service Area practice leads and quality improvement facilitators to engage in continuous quality improvement projects related to the attestation elements. Program Managers reported that these were helpful to continue keeping a focus on this program.
- The Middlebury Health Service was the hiring entity for PPNNE staff and when their staff member left, they decided to transition their position to the PPNNE team as the hiring entity.

The WHI is approaching statewide coverage. We have engaged the Newport HSA in discussions on joining the WHI program in the next quarter. We also hope to engage the last HSA in discussion about WHI in the upcoming months.

Figure 3. Women's Health Initiative: Practices, Patients, and Community Health Team (CHT) Staffing

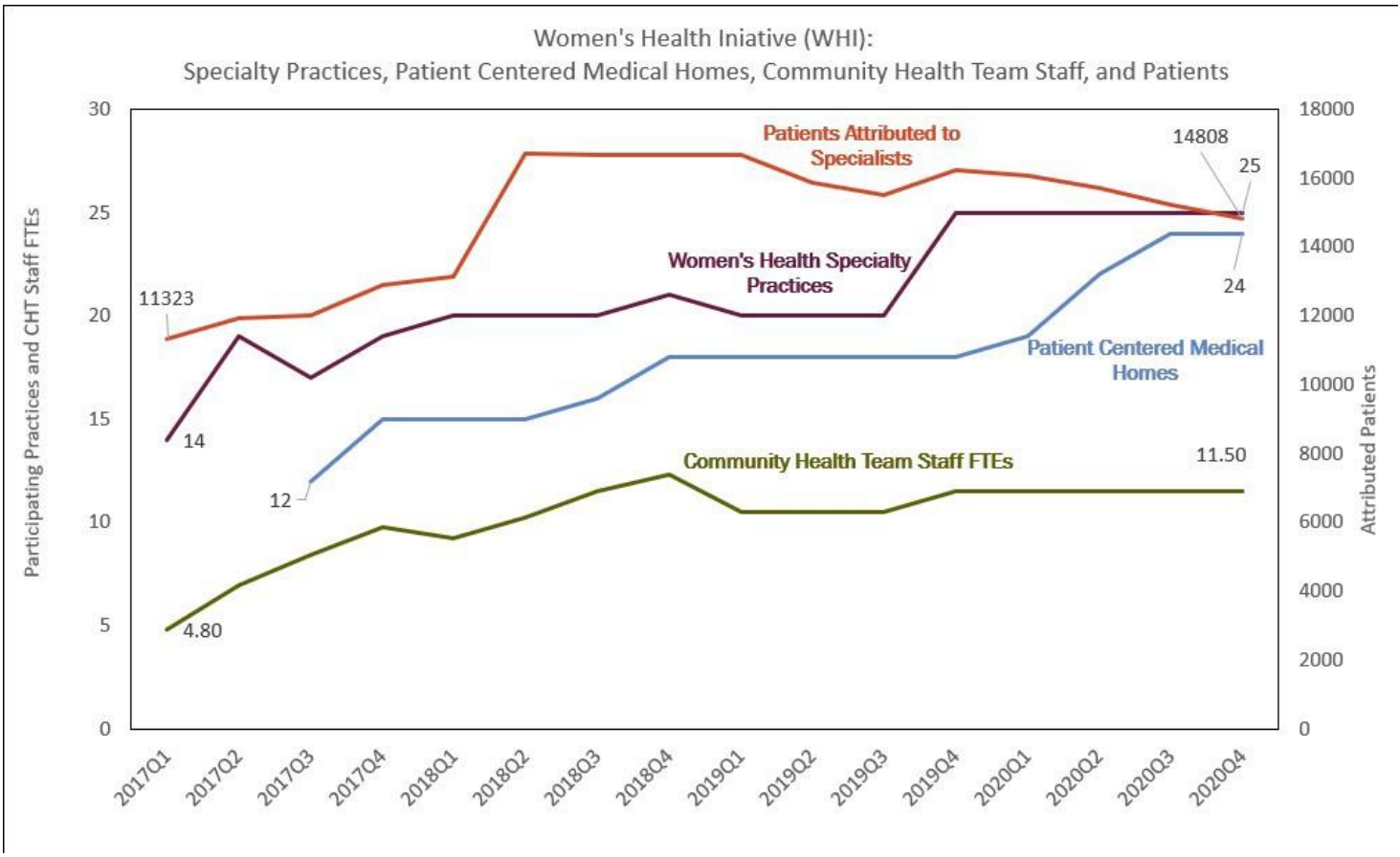


Table 4. Women's Health Implementation by Region

Health Service Area / Team	WHI Specialist Practices as of December 2020	WHI PCMH Practices as of December2020	WHI CHT Staff FTE Hired as of December 2020	WHI Specialist Quarterly Attributed** Medicaid Beneficiaries as of December 2020	WHI PCMH Quarterly Attributed** Medicaid Beneficiaries as of December 2020
Barre	1	1	1.00	710	417
Bennington	1	2	0.50	947	267
Brattleboro	1	0	1.00	864	0
Burlington	3	8	3.00	25428	4571
Middlebury	2	0	0.75	711	0
Morrisville	1	4	0.50	446	1363
Newport	0	0	0.00	0	0
Randolph	2	0	0.50	500	0
Rutland	2	1	1.50	1702	155
Springfield	1	5	1.00	0	1728
St. Albans	1	0	0.00	1026	0
St. Johnsbury	1	2	0.75	861	768
Windsor*	0	0	0.00	0	0
Planned Parenthood (Statewide)	12	0	1	4613	0
Total	25	24	11.5	14808	9269

*The Windsor Health Service Area does not have women's health specialty practices.
**Quarterly attributed patient counts at the HSA level have a small amount of overlap due to patients moving across HSAs in different months. The statewide quarterly total is deduplicated.
***PPNNE practices in Rutland and Middlebury are included in both the WHI Specialist field for those HSA's and in the PPNNE statewide field. Patients are allocated to the Rutland and Middlebury HSA's. Total WHI Specialist practice count is deduplicated.

v. Pharmacy Program

Key updates from CY2020

- Operational Activities
    - Prior Authorization (PA) Data
    - Paid Claims and Drug Spend
    - Provider Communications
    - COVID Changes/Accommodations
- Clinical Activities
    - Pharmacist enrollment
    - Drug Utilization Review Board (DURB)/Preferred Drug List
    - Medication Therapy Management (MTM) Program
    - Pharmacy Cost Management (PCM) Program
- Legislative Changes: Federal/State
    - SUPPORT Act Medication Assisted Treatment (MAT) Rebate Issue
    - Pharmacist Prescribing Authority

Pharmacy Benefit Management Program

The DVHA's Pharmacy Unit manages the pharmacy benefits for all of Vermont's publicly funded pharmacy benefit programs. The Pharmacy Unit's goal is to provide the highest quality prescription drug benefits in the most cost-effective manner possible. This is accomplished by providing broad coverage of prescription and over-the-counter pharmaceuticals, while controlling pharmacy expenditures through both utilization and cost management strategies. The DVHA utilizes the pharmacy benefit management company, Change Healthcare (CHC), to provide a full complement of operational, clinical, and programmatic supports in addition to managing a call center in South Burlington for pharmacies and prescribers. The Pharmacy Unit is also responsible for overseeing the contract with CHC. The Pharmacy Unit manages approximately $200 million in gross drug spend, and routinely analyzes national and DVHA drug trends, reviews drug utilization, and seeks innovative solutions to delivering high-quality customer service, assuring optimal drug therapy for DVHA members while managing drug utilization and cost.

Pharmacy Operations

- Pharmacy claims processing – Assuring that members have access to medically-necessary medications within the coverage rules for DVHA's various pharmacy benefits.
- Pharmacy provider assistance – Assisting pharmacies and prescribers with various issues related to claims processing, prior authorizations, and other operational and clinical issues.
- Pharmacy Interface to Coordination of Benefits Unit/Part D Plan Team/Eligibility/Member Call Center to coordinate benefits and resolve member issues.
- Liaison to Vermont Department of Health (VDH) in multiple clinical areas-Vaccines including COVID vaccines, Alcohol & Drug Abuse Programs (ADAP), Asthma, Smoking Cessation, and Department of Mental Health (DMH) related to management of psychotherapeutic drug use in children. The Pharmacy Team also works with Vermont Medication Assistance Program (VMAP) and Children with Special Health Needs (CSHN) to assist in the drug and rebate management of the programs.
- Clinical Activities include managing drug utilization and cost.
    - Federal, State, Supplemental rebate programs
    - Preferred Drug list management

- Prior authorization and utilization management programs
- Drug Utilization Review Board activities-therapeutic class reviews, new drug reviews, prior authorization criteria review and step-therapy protocols.
- Specialty pharmacy management
- Physician-administered drug management

- Manages exception requests, EPSDT requests, appeals and fair hearings with Policy Unit.
- Works with Program Integrity Unit on drug utilization issues related to fraud, waste, and abuse.

Operational Activity Reports

Prior Authorization Data (PA)-This report outlines quarterly claims prior authorization activity.

Period	Claims Paid w/o PA	Claims Paid w/Automated PA	Paid with Automated PDL Edit	Claims Paid w/Online Override	Claims Paid with Clinical PA	Claims Paid w/Emergency PA	Claims Paid due to Grandfathering	Total Claim Count
Quarter 1	415,869	101	64,187	402	21,433	104	10,488	512,584
	93%	<1%	13%	<1%	5%	<1%	2%	100%
Quarter 2	388,953	86	47,418	442	19,713	83	8,517	465,212
	93%	<1%	10%	<1%	5%	<1%	2%	100%
Quarter 3	409,658	92	49,891	363	20,551	58	7,896	488,509
	93%	<1%	10%	<1%	5%	<1%	2%	100%
Quarter 4	421,635	109	49,115	306	20,073	58	7,426	498,722
	94%	<1%	10%	<1%	4%	<1%	2%	100%
Total	**1,636,115**	**388**	**210,611**	**1,513**	**81,770**	**303**	**34,327**	**1,965,027**
	93%	**0%**	**11%**	**0%**	**5%**	**0%**	**2%**	**100%**

- Total claim count does not include compounded drugs.

Paid Claims and Drug Spend

MEDICAID

Period	# Claims	# of Members	State Paid Amounts
1Q2020	436,797	73,487	$ 50,723,614.13
2Q2020	394,361	65,718	$ 48,964,147.32
3Q2020	419,827	70,295	$ 52,077,908.51
4Q2020	433,196	71,964	$ 54,188,780.71
Total CY 2020	**1,684,181**		**$ 205,954,450.67**

VPHARM

Period	# Claims	# of Members	State Paid Amounts
1Q2020	76,517	8,058	$1,912,757.49
2Q2020	71,582	7,586	$1,318,243.36
3Q2020	69,417	7,454	$1,179,358.87
4Q2020	66,342	7,266	$1,016,523.51
Total CY 2020	**283,858**		**$5,426,883.23**

COVID-19 Communications

COVID-19 Retail Pharmacy Home Delivery Services	A list of pharmacies that home deliver was sent to providers to instruct members to utilize this service if preferred.
Important Pharmacy Information in Response to COVID-19	Effective 3/18/2020, the days' supply limit for Suboxone Film was extended up to 30-days. The non-preferred buprenorphine formulations days' supply limit has also been extended up to 30-days. This remains in effect.
COVID-19 Updates	Effective 3/18/20 the mandatory 90-supply requirement for select medications was suspended to allow pharmacies to better manage their inventory and help avoid drug shortages and may now override this reject code without calling the Pharmacy Help Desk; All Albuterol HFA formulations are available without prior authorization; These provisions were discontinued on 1/1/2021.
Reminder to DME Providers and Prescribers: Continuous Glucose Monitors (CGM) PA Waived	Prior authorization requirements have been waived for DME & supplies, including Continuous Glucose Monitors for ease of access to members. This provision remains in effect.
Extension of Prior Authorizations - Response to the COVID-19 Emergency	An extension of all prior authorizations was made for medications dispensed at point of sale (pharmacy) and for physician administered drugs, this includes all drugs except those that are not clinically appropriate to extend (for example, acute antibiotics, Hepatitis C antivirals, loading doses, or medications used during pregnancy). Extensions were discontinued on 1/1/2021.
COVID-19 Specimen Collection by Pharmacists	The Department of Vermont Health Access (DVHA) is implementing changes to support reimbursement of specimen collection by pharmacists for COVID- 19 testing. In addition, since pharmacists are authorized to order and administer COVID-19 tests in accordance with their scope of practice and state and federal law, pharmacists performing specimen collection must enroll with Vermont Medicaid as ordering providers.
Pharmacist Enrollment Required for Reimbursement of COVID-19 Vaccine Administration	Guidance for pharmacies and pharmacist who plan to administer or supervise administration of a COVID-19 vaccine. They must be enrolled with Vermont Medicaid to be eligible for reimbursement of vaccination administration.
Billing Information for COVID-19 Vaccines	Communication on COVID-19 billing guidance and requirements for pharmacies.

Provider Communications Issued

Changes to Refill Tolerance for Controlled Substances	Effective 1/9/20 a new edit will begin to cumulatively count early refills and a maximum accumulation of seven extra days of medication will be allowed at any given time. This is important step in reducing the availability of unused medication and preventing medication misuse.

IMPORTANT: Discount Card Reminder	A reminder/informational communication was sent to providers about using discount cards to bill for medications dispensed. In some instances, pharmacies are using discount cards as primary "insurance", Medicaid is then billed as a secondary payor and is paying most of the cost of the drug.
Attention Pharmacies - Important Information about the DVHA Team Care Program	A reminder was sent to providers about DVHA's Team Care Program, which is designed to decrease over-utilization, misuse and/or abuse of covered health services/benefits; to improve coordination and quality of care by minimizing duplicate and inappropriate drug utilization. The Team Care Program is used to identify members who may need support in getting the best healthcare available to meet their needs, to establish a method of monitoring members who have utilized non-emergency health care services frequently and identify excessive prescribing habits.
Important Update on Early Refill Overrides with Submission Clarification Code (SCC)=13	Effective on July 24, 2020. DVHA no longer allows the use of SCC=13 (overrides refill too soon) for controlled substances. Pharmacies must call the Help Desk for an override.
Changes to Buprenorphine/Naloxone Tablets PDL Status	Effective 8/1/20 generic buprenorphine/naloxone combination tablets will be moving to preferred status and will be co-preferred with Suboxone® Film. To align with the Suboxone® Film criteria, a prior authorization will not be required for the combination tablets unless the daily dose exceeds 16mg.
Influenza (Flu) 2020/2021 Season Provider Notification	This notice provided an update on the 2020-2021 flu season preferred vaccines
Smoking Cessation	Reminder to pharmacists about resources available to help your patients to quit tobacco.
Pharmacies and Pharmacists - Administration of Vaccines to Children 3-18 Years of Age	Communication on the Vermont Child Vaccine Program (VCVP) participation is mandatory for providers who wish to provide vaccinations to children insured by Vermont Medicaid, how to order pediatric vaccines, Board of Pharmacy guidance and how a pharmacist can enroll.
Changes to Preferred Albuterol Inhalers	Effective 1/1/21 ProAir® HFA, ProAir RespiClick®, and Ventolin®HFA albuterol inhalers have preferred status on the DVHA Preferred Drug List (PDL).
Preferred Drug List (PDL) January 1, 2021 Changes	Changes to the Preferred Drug List (PDL) for 2021.
Changes to Coverage for Taltz	Effective 1/1/21 Taltz® is moving to preferred status on the Preferred Drug List (PDL)

Clinical Activities

Pharmacist Enrollment

Effective September 1, 2020, under the guidance of the federal PREP Act and Vermont Board of Pharmacy Emergency Guidance pharmacists, pharmacy technicians, and pharmacy interns under the supervision of a licensed pharmacist were able to enroll in the Vermont Medicaid program as licensed providers to provide Medicaid services in accordance with their scope of practice, and state and federal law allowing them to administer COVID-19 Vaccines to Vermont Medicaid members.

This includes ordering and administering COVID-19 diagnostic tests and COVID-19 vaccines during the public health emergency. Pharmacists who plan on administering or supervising administration of a COVID-19 vaccine must be enrolled with Vermont Medicaid for the pharmacy to be eligible for reimbursement for such vaccinations. COVID-19 vaccines for pediatric patients are not expected to be reviewed or approved under an EUA until additional clinical trials are conducted. DVHA will issue guidance on COVID-19 vaccines for children when more information becomes available.

Medication Therapy Management (MTM) Program

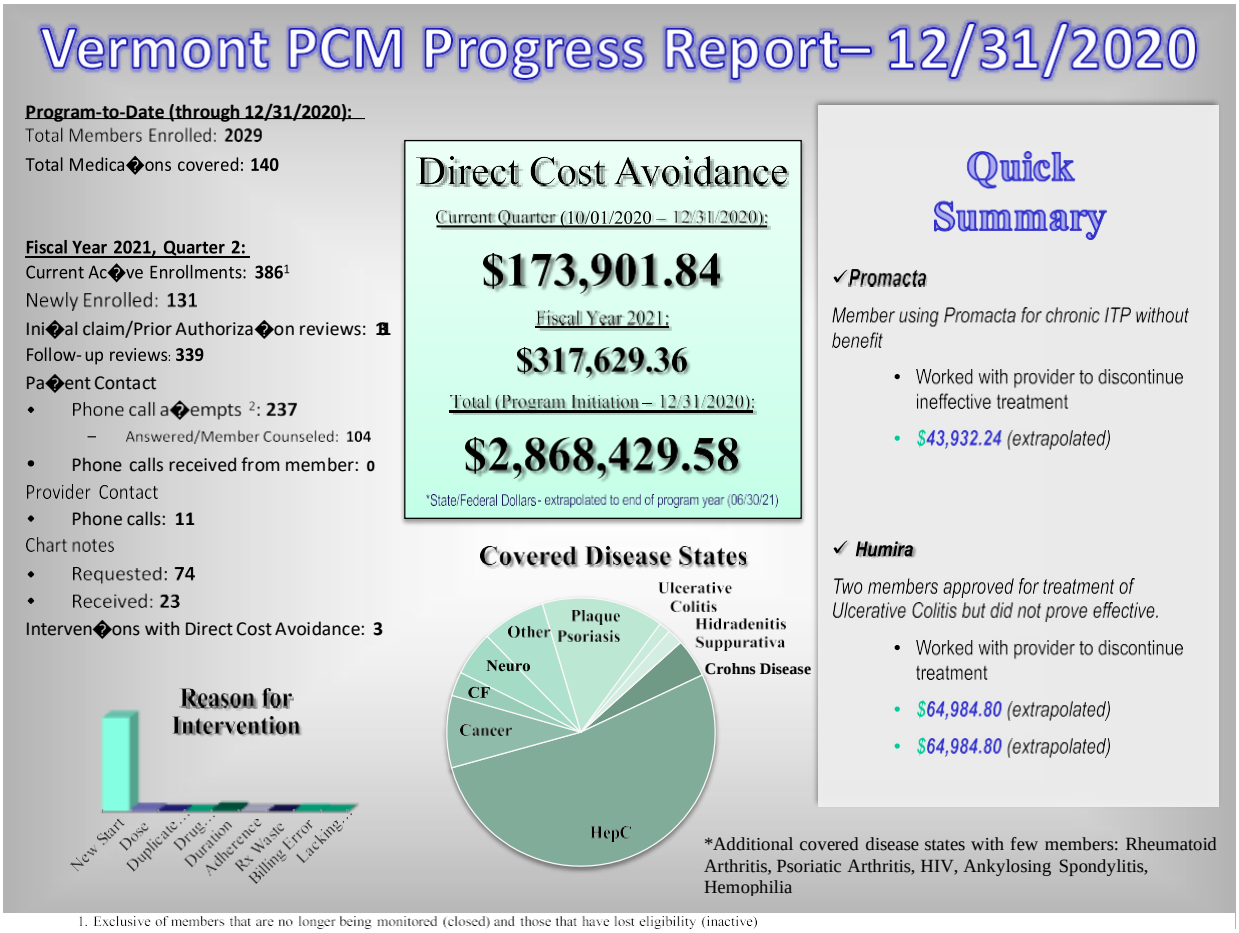
Policy Summary: On 4/1/20, Vermont Medicaid launched a medication therapy management (MTM) program for office-based clinical pharmacists operating under their scope of practice at a Federally Qualified Health Center (FQHC) or Rural Health Center (RHC). Coverage is limited to Medicaid members with alcohol/substance use disorder or a mental health diagnosis. MTM provided by a clinical pharmacist is a valuable addition to a health care team and can contribute medication expertise to improve patient compliance and adherence, reduce medication-related adverse events, and improve health outcomes. Pharmacists providing this service must have a nationally recognized MTM certification and bill the appropriate CPT codes for MTM.

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.

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 (PCM) program continued throughout calendar year 2020. The entire second quarter took place during the COVID-19 pandemic and social distancing protocols, and the PCM program adapted to these changes. The clinical pharmacist continued outreach to members and providers although making a connection has been more challenging during the Public Health Emergency. We are now seeing a gradual transition from telehealth appointments back to in-person laboratory and provider visits, although not to pre-pandemic levels. The PCM program continues to operate normally while allowing for longer response times from providers.



Change Healthcare (January 1, 2020 through December 31, 2020). Change Healthcare Pharmacy Management Reporting Suite by a collection of reports recording the process and progress of PCM.

In the fourth quarter of 2020, the PCM program enrolled an additional 131 members for a total of 2,029 members on 140 unique medications. The program is actively monitoring 386 enrollees. A total of 237 outgoing telephone calls were placed to members, 104 of which resulted in member counseling. During this quarter of the Vermont PCM program, three interventions led to direct and measurable cost avoidance. Furthermore, interventions that do not bring about direct cost avoidance are in place to encourage adherence and thus improve member outcomes and avoid unnecessary medical costs. Through interventions in the PCM program, unnecessary drug spend of nearly $578,000 was avoided in state fiscal year 2020, and $317,630 so far in SFY2021. More than $2.8 million in unnecessary drug spend was avoided over the duration of the program.

Legislative Changes: Federal/State

Medication Assisted Treatment (MAT) Rebate Issue - SUPPORT ACT

The "Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act" or the "SUPPORT ACT" passed in 2018 contains language requiring states to cover all Medication-Assisted Treatments (MAT) for Opioid Use Disorder (OUD) under a "mandatory benefit". Due to the placement of this language in Title 19 and outside of Section 1927 of the SSA where the Medicaid federal rebate language exists, states were notified in June 2020 that all MAT drug treatments would no longer be eligible for federal or supplemental rebates effective October 1st, 2020. This would have had a huge impact on DVHA's drug spend since we collect nearly $16 million on this entire class of drugs. To remedy this impact, a change to federal law was required. The National Association of Medicaid Directors and our Congressional delegation was made acutely aware, and the DVHA Pharmacy Unit prepared a mitigation plan which included negotiating State only rebate agreements, and rapidly adjusting preferred products on the

Preferred Drug List (PDL). A final mitigation plan and fiscal impact was presented to Senior Leadership in July.

Based on information collected during rebate negotiations, it was determined that the generic buprenorphine/naloxone tablets are a cost-effective choice compared to the brand Suboxone Film which has been a preferred product on DVHAs PDL for several years. On August 21st, DVHA moved the generic buprenorphine/naloxone tablets to preferred status, to be co-preferred with Suboxone Film.

We expected that Congress would fix the MAT rebate issue in the continuing resolution to fund the federal government that was a top legislative priority in September. The MAT rebate fix is a federal cost saver, and had bipartisan and bicameral support, and corrects a statutory interpretation that Congress did not initially intend, therefore we did not expect any barriers to passage. DVHA confirmed with NAMD and our congressional delegation in August that corrective language was drafted retroactive to October 1st, 2020 and confirmed that legislation was signed on that date, therefore rebates will continue to be in place for MAT without interruption.

In summary, DVHA was faced with a potentially large impact to net drug spend, largely mitigated that potential impact through negotiating new rebate agreements and making changes to its PDL, while working with the congressional delegation on a successful federal law change. We will continue to monitor the net cost of MAT drugs and determine if any further changes in the PDL are warranted.

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Pharmacist Prescribing Authority

Act 178 was signed into law on October 12th, 2020. Section 11 allows clinical pharmacy prescribing with specific restrictions on permitted prescriptions and in six defined contexts: 1) by collaborative practice agreement; 2) pursuant to State protocol; 3) for accessory devices; 4) to substitute drugs in the same therapeutic class; 5) over-the-counter drugs; and 6) for one-time, short-term extensions. State Protocols are to be approved by the Commissioner of Health and for the Board of Pharmacy is to adopt rules to administer this new authority. Under state protocol a pharmacist may prescribe or administer:

(i) opioid antagonists.
(ii) epinephrine auto-injectors.
(iii) tobacco cessation products.
(iv) tuberculin purified protein derivative products.
(v) self-administered hormonal contraceptives.
(vi) dietary fluoride supplements.
(vii) influenza vaccines.
(viii) in the event of a significant public health risk, an appropriate vaccine to mitigate the effects on public health after finding that existing. channels for vaccine administration are insufficient to meet the public health need.
(ix) emergency prescribing of albuterol or glucagon while contemporaneously contacting emergency services; and
(x) tests for SARS-CoV for asymptomatic individuals or related serology for individuals by entities holding a Certificate of Waiver pursuant to the Clinical Laboratory Amendments of 1988 (42 U.S.C. § 263a).

DVHA requires enrollment of any pharmacist engaging in prescribing under Act 178 and the pharmacist NPI must be submitted on the claim as the prescriber. The same drug coverage rules apply regardless of the prescriber.

vi. Choices for Care and Traumatic Brain Injury Programs

Key updates from QE122020:

- DAIL implemented the CBA minimum wage increase, impacting all consumer/surrogate/self-directed programs on 12/20/2020.
- DAIL has received an extension to funding of the Money Follows the Person (MFP) demonstration grant through calendar year CY2023

DAIL continues to respond to the COVID-19 pandemic by supporting increased flexibility in the established Waiver. These flexibilities will be continued through the state of emergency. DAIL COVID-19 resources can be found online here: https://dail.vermont.gov/novel- coronavirus-information.

Choices for Care Regulations

DAIL continued to engage with stakeholders to develop an acuity-based screening tool for use when a waitlist is required for the Moderate Need Program. Piloting of the screening tool was initiated for 11/2020, with further implementation planned for Q1 2021.

Adult Day Services

Adult Day Centers were required to close on March 17, 2020 as a result of the State of Vermont declaration of emergency and Stay Home/Stay Safe order. DAIL continues to support providers and participants whose services have been disrupted and to explore to opportunities mitigate the effect of social isolation of those impacted by Adult Day closure. DAIL is working closely with Adult Day providers on their plans to safely reopen at reduced capacity. Several Adult Day Centers targeted 11/2020 for reopening but were unable to open due to continued impact of COVID -19. Stakeholder engagement has continued to explore options for alternative adult day service models to support individuals through telehealth/telephonic methods.

New Minimum Wage

December 20,2020 DAIL implemented new minimum wage requirements according to the State's Collective Bargaining Agreement for Independent Support Workers. The minimum wage increased from $11.55/hour to $12/hour for all employees of self-managed hourly services and from $176.48 per day to $192.00 per day for daily respite. Using minimum wage as a starting point, employers are allowed to set their own wages for their employees within their state approved individualized budget.

Money Follows the Person (MFP)

In December, CMS approved reauthorization for at least 3 more years.
Vermont transitioned 10 participants on the MFP program during this quarter. The program has been vetting possible initiatives for the $5M supplemental budget application through both internal and external stakeholder feedback.

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 712 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 in the process of revising the wait list procedures from chronological to acuity-based in order to serve applicants with the greatest needs first. There is currently no wait list for the TBI program.

Annual Summary:

We provided flexibilities in Choices for Care, Moderate Needs, and the Brain Injury Program to allow for assessments and services to be delivered remotely, for more funds to be used for assistive devices and home modifications, for many different types of caregivers to be paid, and for care plans to be modified and funding to be shifted to different services

and providers. We continue to support these flexibilities and began planning for any policy and practice flexibilities provided during the COVID-19 emergency that could be continued in the future that have been successful in meeting people's needs.

In April 2020, our new Choices for Care regulations were approved by the Vermont legislature. A pilot study was initiated in 11/20 using a risk acuity assessment to establish a waitlist based on highest need vs chronological order. Stakeholder feedback on process improvement was gathered. A small workgroup will continue the work in 2021.

We engaged with stakeholders and surveyed participants regarding federal conflict-free case management rules for Choices for Care and the TBI programs.

In 2020, the Traumatic Brain Injury Program:

- Had 39 individuals are enrolled in TBI Long Term Program
- Had 40 individuals are enrolled in TBI Rehab Program
- Implemented of Year Three of the federal TBI State Partnership grant.
- Began work to rename the program Brain Injury Program to more accurately reflect the scope of individuals served.

In 2020, the Money Follows the Person Grant:

- Transitioned 29 participants
- Received notice of extended funding to the Money Follows the Person (MFP) demonstration grant through calendar year CY2023.

For CY2021, Vermont has been awarded enough funds to support approximately fifty-three (53) Choices for Care (CFC) participants transitioning from a skilled nursing facility. Anyone that meets the MFP eligibility requirements outlined below will be eligible for this CFC program.

CMS has notified Vermont that we are eligible for an MFP supplemental grant of up to $5M dollars. Under this supplemental funding opportunity, MFP grant funds are being made available to state MFP demonstrations that are currently operating MFP funded transition programs, for planning and capacity building activities to accelerate LTSS system transformation design and implementation and to expand HCBS capacity. This funding is expected to strengthen focus and attention on LTSS rebalancing among states participating in the MFP demonstration and to support MFP grantees with making meaningful progress with LTSS rebalancing. The program has been vetting possible initiatives for the $5M supplemental budget application through both internal and external stakeholder feedback.

vii. Developmental Disabilities Services Division

Key updates from QE122020:

- Coronavirus 19 Response
- Payment Reform Activities
- HCBS Rules Implementation

Coronavirus 19 Response

The quarter ending 12/2020 continued to be dominated by responses to the coronavirus pandemic. The Developmental Disabilities Services Division (DDSD) took continuing steps to protect the health and safety of developmental services recipients. New guidance in QE122020 included:

- Tools for provider agencies to gauge allowable levels of in-person service delivery based on rates of incidence of coronavirus cases in the county.
- A return to the temporary coronavirus 19 DDSD HCBS case rate payment model that was in place during

QE062020 through part of QE092020 due to exhaustion of coronavirus relief funds and an uptick in cases.

- Additional grants made through the final allotment coronavirus relief funds to support Difficulty of Care stipends for unpaid family caregivers.

Actions taken throughout CY2020 include:

- Creation of tools to support the resumption of some community activities and employment supports after meeting with the person and their team to conduct a person-centered assessment of risk.
- Changes to service delivery requirements supporting health and safety, including but not limited to; personal protective equipment requirements, allowances for telehealth services,transportation guidelines, home-visiting requirements, signature requirements, and redeployment of support staff.
- Weekly provider video calls and monthly advocacy and stakeholder video town-halls.
- Difficulty of Care stipends for unpaid family caregivers who were providing care in lieu of typically available supports.
- Difficult of Care stipends for shared living providers who were providing additional care in lieu of typically available supports.

Payment and Delivery System Reform

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). This project was put on hold during the quarter ending 06/2020 due to the coronavirus pandemic.

The DD HCBS 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 previously engaged a Medicaid reimbursement consultant firm to assist the State in completing a provider rate study. The rate study collected detailed information from providers regarding actual costs to deliver the defined categories of service under HCBS. The rate study was completed and new rates for services were proposed. The information gathered will be utilized initially in developing the future 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 has examined alternative assessment tools, resource allocation methods and options for more efficiently capturing encounter data for these services. A new methodology was established for providers to report encounter data regarding services being delivered to participants. Provider agencies are still 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 has resumed work on preparing providers to report encounter date in the first quarter of CY2021. The State developed an RFP for a contractor to conduct needs assessments using a standardized assessment tool, the Supports Intensity Scale. However, this RFP was interrupted due to the pandemic. The RFP was reposted in September and the State has selected a vendor and is in the process of finalizing a contract to begin in the first quarter of CY2021. Design of the new payment model will be continuing as the tempo of state response to the pandemic abates. Ongoing work will be required, including seeking any needed CMS approval.

HCBS Rules Implementation

HCBS Settings Requirements - Work on HCBS rules implementation was paused in CY2020 due to additional workload and pressures of the coronavirus pandemic. DDSD plans to resume work on implementing the HCBS rules to ensure compliance with all requirements by 2022.

Summary of work to date- the Division completed site visits to validate survey information submitted by providers in September 2019. 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. This information was included in the Vermont's State Transition Plan in February 2020. In addition, DDSD has been 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. With the completion of the site visits and information incorporated in the Vermont STP, the DDSD Quality Management Unit is preparing and sending reports to each provider agency requiring a plan of correction to address the areas of non-compliance by the 2022 deadline.

Conflict of Interest in Case Management- In QE 122020, the State continued to work with its technical assistance (TA) vendor made available through CMS. DDSD contributed information for a presentation of the current array of programs and case management to be provided to CMS and participated in conversations with DVHA and other AHS departments about ways to improve safeguards and mitigation strategies that would reduce potential conflict.
Previously, in CY2020, Vermont engaged with its TA contractor to confirm its understanding of prior communications with CMS in QE 032020, describing that the current system appears to comport with the home and community-based services conflict of interest regulation as long as Vermont also meets the safeguard requirements found on page 180-181 of the Technical Guide. With this confirmation, the Division resumed design activities focused on mitigation strategies and continued to engage with its TA contractor. A key component of Vermont's mitigation strategies includes reissuing the RFP for an independent developmental service needs assessor, also described in the section above regarding payment reform. As of the QE 122020 the Division was in contract negotiations with the apparently successful bidder. The Division continues to work with the Department of Vermont Health Access and other AHS Departments on a plan for inclusion in the next Global Commitment to Health waiver renewal 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 thereare 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 6/30/20, there were 243 people who requested HCBS services but were denied because they did not meet a funding priority. 7 people were waiting for FMR and 5 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 listis also reviewed when additional funds become available for other programs.

viii. All Payer Model: Vermont Medicaid Next Generation Program

Key updates from QE122020:

- Executed a contract extension with OneCare for a 2021 performance year of the program.
- 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 2021 performance year in Q4. Programmatic changes to the model were minor, the most notable being a slight adjustment to how quality is tied to payment in OneCare's Value Based Incentive Program. A minimal number of changes ensures program stability and continued alignment across payer programs as part of the Vermont All Payer ACO Model.

The VMNG program saw provider participation stabilize for the 2021 performance year, which indicates that the program may have reached scale in the state. The number of risk-bearing hospital communities remained constant at fourteen for the 2021 performance year. The number of attributed lives for the 2021 performance year decreased slightly from approximately 114,335 lives (85,937 lives through the traditional methodology and an additional 28,398 lives through the expanded attribution methodology) to 111,532 (83,685 through the traditional methodology and 27,847 lives through the expanded attribution methodology.

DVHA and OneCare modified several financial and quality components of the VMNG program to hold providers harmless for negative impacts related to the COVID-19 pandemic and State of Emergency. DVHA implemented a contract amendment with these modifications in Q4 to align with the Medicare Next Generation ACO program changes due to COVID-19 for Performance Year 2020.

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 (SUD Demonstration Monitoring Report)

1. Title Page for Vermont's SUD Components of the Global Commitment to Health Demonstration

State	Vermont
Demonstration Name	Global Commitment to Health 1115 Demonstration
Approval Date	July 1, 2018
Approval Period	July 1, 2018 – December 31, 2021
SUD (or if broader demonstration, then SUD Related) Demonstration Goals and Objectives	*Enter summary of the SUD (or if broader demonstration, then SUD related) demonstration goals and objectives as summarized in the STCs and/or demonstration fact sheet.*

Key updates for QE122020:

- Reporting on metrics began with the second quarter report of 2020 (QE0620).
- Recovery Coaches in the Emergency Room Program services are now virtual.
- ADAP has been collecting stakeholder feedback in anticipation of a Request for Information related to the overall SUD treatment system.

2. Executive Summary

The State of Vermont continued to have all ASAM levels of care available and no ongoing waitlist to access to Medication Assisted Treatment. Treatment providers shifted to telemedicine, where appropriate, while others adjusted daily census and implemented social distancing and other strategies to continue serving patients requiring in person services during the COVID-19 pandemic. One Vermont residential provider experienced a COVID-19 outbreak among staff but were able to contain the outbreak to a small number of staff and resumed admissions.

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

ADAP suspended plans to develop the value-based payment model for residential programs, to align with its All-Payer Model Agreement with CMS, due to the COVID-19 pandemic. ADAP met with the residential providers to review data since the payment adjustment and solicited feedback from the providers on additional options for improving the methodology to accurately reflect the needs of the clients. ADAP has been collecting stakeholder feedback in anticipation of a Request for Information (RFI) related to the overall SUD treatment system. The value-based payment component of the residential payment model is in consideration for inclusion in the larger system reform.

ADAP's centralized intake and resource center, "VT Helplink: Alcohol and Drug Support Center" launched for public use in March 2020. Since launch VT Helplink has received over 1,900 calls and 22,700 website visits. Web visitors have searched for services online over 2,260 times. 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. ADAP continues work to onboard SUD treatment providers into the provider portal and expand the database of SUD resources available to consumers.

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. The SMPC has met ten times between October 2019 to October 2020. The SMPC has three goals of the SMPC are the following:

1. Increase protective factors and build resilience and feelings of connectedness in Vermont communities, across all ages, cultures, and socioeconomic conditions.
2. Decrease risk factors for substance use in Vermont for individuals of all ages, cultures, and socioeconomic conditions.
3. Increase efficiency and collaboration on prevention efforts across all state, public, and private entities, through a consolidated and holistic approach to prevention that is sustainable, scalable, and equitable.

Information on the SMPC can be found here: www.healthvermont.gov/SMPC

The SMPC submitted their 2021 Annual Report and the Inventory of Prevention Services report to the Vermont General Assembly. The SMPC will be focusing their efforts in three subcommittees for calendar year 2021:

- Prevention Services
- Policy
- Equity and Health Disparities

Vermont launched the Recovery Coaches in the Emergency Department Program on July 1, 2018. 12 hospitals are participating in the program. Virtual recovery services were implemented.

Assessment of Need and Qualification for SUD Services

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.	DY2 Q2	3 Medicaid Beneficiaries with SUD Diagnosis (monthly) 4 Medicaid Beneficiaries with SUD Diagnosis (annually) 5 Medicaid Beneficiaries Treated in an IMD for SUD	Vermont experienced a decrease in the number of Medicaid beneficiaries identified with SUD diagnoses leading to decreases in people receiving SUD services other than medication assisted treatment for opioid use disorder. These changes in provision of treatment coincide with the COVID-19 pandemic which first peaked in Vermont in April and then again in November/December2020. People were not seeking care across the healthcare system during the pandemic, which would account for the decrease. ADAP has worked with VT Helplink and SUD treatment providers to

			market and educate Vermonters that treatment services are available, and it is safe to seek treatment.
[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.	DY2 Q2	6 Any SUD Treatment	In 2020, Vermont experienced a decrease in people receiving SUD treatment in April, when COVID-19 was prevalent and there was a stay-at-home order in place. This rebounded quickly for the July and October periods. These changes in provision of treatment coincide with the COVID-19 pandemic which first peaked in Vermont in April and then again in November/December 2020. People were not seeking care across the healthcare system during the pandemic, which would account for the April decrease. ADAP has worked with VT Helplink and SUD treatment providers to market and educate Vermonters that treatment services are available, and it is safe to seek treatment.
		7 Early Intervention	Services coded as early intervention have been consistently low (averaging one beneficiary per month) as most intervention services in Vermont are provided through other funding mechanisms.
		8 Outpatient Services	Outpatient services decreased in April due to COVID-19 and increased in both July and October although they remain below prior year. Providers ramped up capacity to provide services through telemedicine while the stay-at-home order was in place and are currently able to provide services through telemedicine and in person, giving more options for those seeking services which we expect will make treatment more accessible.
		9 Intensive Outpatient and Partial Hospitalization Services	IOP services remain low due to the difficulty of providing group-based services during the pandemic. Some services are being provided via telemedicine.
		10 Residential and Inpatient Services	One residential treatment provider experienced a COVID-19 outbreak among staff and were required to hold admissions while the provider and Health Department

			staff worked to contain the outbreak. The provider was successful in containing the outbreak to a small number of staff and admissions were able to resume. Residential providers have continued to experience a reduction in available capacity due to COVID-19 safety precautions to reduce the potential for outbreaks in their facilities. Additionally, challenges with ensuring all clients are tested for COVID-19 immediately prior to admission has impacted pacing of admissions.
		11 Withdrawal Management	This has been trending downward with some month-to-month variation
		12 Medication Assisted Treatment	The number of beneficiaries receiving MAT has continued to increase quarter by quarter.
		36 Average Length of Stay in IMDs	2020 data not yet available
[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 32 substance use disorder treatment provider locations. The Substance Use Disorder Treatment Standards and corresponding compliance assessment tool were effective January 1, 2020. Due to the COVID pandemic, provider site reviews were put on hold. ADAP has completed one remote site visit utilizing the tool this quarter. **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 suspended plans to develop a value-based payment model for residential programs to align with its All-Payer Model Agreement with CMS due to the impact of the COVID-19 pandemic. The rates for the episodic payments were adjusted effective January 1, 2020. ADAP has solicited feedback from the providers on the rate adjustment and opportunities for continued improvement of the model. ADAP has been collecting stakeholder feedback in anticipation of a Request for Information (RFI) related to the overall SUD treatment system. The value-based payment component of the residential payment model is in consideration for inclusion in the larger system reform.

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 32 substance use disorder treatment provider locations. The Substance Use Disorder Treatment Standards and corresponding compliance assessment tool were effective January 1, 2020. Due to the COVID pandemic, provider site reviews were put on hold. ADAP has completed one remote site visit utilizing the tool this quarter.			
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.			
xThe 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		13 SUD Provider Availability 14 SUD Provider Availability – MAT	The number of providers who were enrolled in Medicaid and qualified to deliver SUD services, including those who meet the standards to provide buprenorphine/methadone as part of MAT, has increased.

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 suspended plans to develop a value-based payment model for residential programs to align with its All Payer Model Agreement with CMS due to the COVID-19 pandemic. The episodic payments were adjusted effective January 1, 2020. Vermont solicited feedback from providers on the rate adjustment and opportunities to continue to refine the model to reflect the needs of the population served. Vermont anticipates resuming work on the model in spring/summer 2021. ADAP's centralized intake and resource center "VT Helplink: Alcohol and Drug Support Center" launched for public use March 2020. Since launch VT Helplink has received over 1,900 calls and 22,700 website visits. 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. ADAP continues work onboard SUD treatment providers into the provider portal and expand the database of SUD resources available to consumers.			
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		15 Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment 18 Use of Opioids at High Dosage in Persons Without Cancer 21 Concurrent Use of Opioids and Benzodiazepines 22 Continuity of Pharmacotherapy for Opioid Use Disorder	The percentage of adults in continuous pharmacotherapy for OUD has decreased which may be an unintended consequence of Vermont's robust access to MAT. Individuals who may be ambivalent about treatment may be less concerned about leaving treatment since they know there will be no wait to get back in; also, there are a number of cash only and other Spoke options available which may lead to more movement in and out of treatment. Additionally, Vermont had a period where Medicaid renewal was assumed and then a significant push to revalidate eligibility which may have led to more instability in people's Medicaid coverage, leading to treatment lapses.

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.		17 Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence	Recovery Coaches are dispatched to 12 emergency departments to support individuals who present with a SUD at the ED including providing linkages to follow-up visits upon discharge.

[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. 12 hospitals are participating in the program. Virtual recovery services have been implemented.			
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.		Q1 PDMP Users/Checks Q2 PDMP Linkages Q3 HIT/HIE Plan	
[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. However, deployment of VPMS staff for COVID-19 response has delayed the start of this initiative.
- 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. However, deployment of VPMS staff for COVID-19 response has delayed the start of this initiative.
- 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.
- Vermont continues to offer prescriber reports on a quarterly basis.
- Vermont has enabled permissions for the Veteran's Association to integrate with VPMS as required by the Mission Act. This project went live in November 2020. VPMS data is available for VA providers nationwide who are providing services to Vermonters.

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 (+		23 Emergency Department Utilization for SUD per 1,000 Medicaid Beneficiaries 24 Inpatient	Overdose deaths are variable. Vermont has seen a significant increase in fentanyl involvement in opioid overdose fatalities. Fentanyl is 50-100 times stronger than heroin and the amount in the drug supply often isn't known to users until it is used. Fentanyl is currently the most

or -) greater than two percent should be		Stays for SUD per 1,000 Medicaid	prevalent substance involved in opioid-related deaths. In 2020, it was found in 89% (through November 2020)

described.		Beneficiaries 25 Readmissions Among Beneficiaries with SUD 26 Overdose Deaths (count) 27 Overdose Deaths (rate) 32 Access to Preventive/ Ambulatory Health Services for Adult Medicaid Beneficiaries with SUD	of opioid-related fatalities and has increased each year since 2011 (9%). Of note, deaths involving fentanyl can include prescription and/or illicit fentanyl and fentanyl analogues. Vermont has been working to decrease drug overdoses and in 2020, published a social autopsy showing places where individuals who died of a drug overdose interacted with a variety of Vermont programs. Fatal overdoses have increased in 2020 after a decrease in 2019. This is likely due to the stress, social isolation, and disruptions in services and drug supply associated with COVID-19. Community support systems such as recovery groups were moved to a remote format, a method not accessible or accepted by everyone accessing these services. COVID-related social isolation may have resulted in more people using alone and anecdotal information suggests that the stimulant payments allowed for larger drug purchases. Medication assisted treatment provision increased in 2020 but residential and intensive outpatient care were less available due to the group nature of these services, and outpatient care was provided remotely. Provision of harm reduction services, which includes information about safer use and referrals to treatment as well as distribution of naloxone and clean syringes were less able to be provided in-person. There was a 40% reduction in people visiting sites where naloxone is distributed and a 24% decrease in naloxone kits distributed in the first six month of 2020 compared to first six months of 2019.

[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.			As a result of COVID-19, the Vermont Department of Health Division of Alcohol and Drug Abuse (ADAP) is taking the following actions to address the increase in drug overdoses.
			• Naloxone – The Department continues to provide naloxone and training through collaborations with community-based organizations, including getting naloxone to the motels where the state is housing people experiencing homelessness.
			• VT Helplink is a free and confidential referral service available to connect people to resources and treatment (802-565-LINK or VTHelplink.org)
			• Recovery Centers are doing more outreach to reduce relapse and prevent overdoses (e.g. Harm Reduction Pack distribution, peer support specialists, Recovery Coaching referrals, etc.)
			• Providers are increasing outreach to patients and are continually re-evaluating patients' stability to triage for in-person supports, decreased take-homes, etc.
			• ADAP has weekly calls with Preferred Providers.
			  ○ The clinical team at ADAP receives critical incidents for overdoses from the preferred providers for people currently in treatment.
			  ○ Overdoses were reported by providers to include people in longer-term recovery and people who had left treatment prior to COVID.
			• The Department is working with partners to continue to disseminate key harm reduction messaging on the increased risks associated with overdose and using alone.
			• ADAP is collaborating with communities to implement Rapid Access to Medication Assisted

			Treatment (RAM). The statewide expansion includes 11 hospital emergency departments starting individuals with OUD on medication with a warm handoff to a designated outpatient treatment provider.
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 Section V. *Financial/Budget Neutrality Development/Issues* 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 Sections VIII. *Quality Improvement* and IX. *Demonstration Evaluation* 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 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?			Updates on the Monitoring Protocol work, deliverables, and timeline can be found in Section X. *Compliance* 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.			
[Add rows as needed]			
☒ The state has no notable achievements or innovations to report for this reporting topic.			

x. Global Commitment Register

Key updates from 2020:

- 71 policies were posted to the GCR in 2020.
- Since the Global Commitment Register (GCR) launched in November 2015, 240 final GCR policies have been publicly posted.

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 AHS 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 365 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 Committee.

A public health emergency (PHE) was declared in March 2020 due to the COVID-19 pandemic. The PHE has significantly impacted the state budget and Medicaid operations, which is reflected in the number and type of policies being posted to the GCR. There were 31 proposed policies posted in 2020, including 15 in the 4th quarter of the year. A total of 26 final policies were posted in 2020, including one final policy in Q4. Fourteen policy clarifications, including 1 in Q4, were posted to the GCR in 2020, all of which were related to the COVID-19 response. Changes included updates to rates and/or rate methodologies, clinical coverage changes, and administrative rulemaking notices. Policy changes stemming from the public health emergency and the COVID-19 pandemic included changes to vaccine coverage, provider enrollment, prior authorization, copayments, and service authorizations.

The GCR can be found here: https://humanservices.vermont.gov/about-us/medicaid-administration/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 Drug Utilization Review Board (DURB) was authorized by Congress under Section 4401, 1927(g) of the Omnibus Reconciliation Act of 1990. This act mandated that AHS develop a drug use review program for covered outpatient drugs, effective January 1, 1993. The Act required the establishment of a DUR program to:

1) Review and approve drug use criteria and standards for both retrospective and prospective drug use reviews.
2) Apply these criteria and standards in the application of DURB activities.
3) Review and report the results of DUR programs; and
4) Recommend and evaluate educational intervention programs.

Additionally, per State statute (Act 127 passed in 2002) the DVHA Commissioner was required to establish a pharmacy best practice and cost control program. This program is designed to reduce the cost of providing prescription drugs, while maintaining high quality in prescription drug therapies. This legislation allowed DVHA to create a Preferred Drug List (PDL) defined as a " list of covered prescription drugs that identifies preferred choices within therapeutic classes for particular diseases and conditions, including generic alternatives."

The DURB was designated as the entity to provide clinical guidance on the development of a Preferred Drug List for Medicaid beneficiaries. The DURB typically includes 10-12 members, who are appointed to three-year terms with the option to extend an additional three years. At least one-third, but not more than half, of the Board's members are licensed and actively practicing physicians and at least one-third of its members are licensed and actively practicing pharmacists, in addition to one member at large who is currently a nurse practitioner. Board members are recommended by the DVHA Commissioner and approved by the Governor.

The chart below lists some of the state fiscal year 2020 activities of the Drug Utilization Review Board.

Review Topic	**SFY 2020 Total**
Therapeutic Drug Classes: Periodic Review	56
Full New Drug Reviews	42
FDA Safety Alerts	9
New/Updated Clinical Guidelines	20
RetroDUR/ProDUR reviews	6
New Managed Therapeutic Drug Classes	4
BioSimilar Drug Reviews	2

Drug Utilization Review Board (DURB) Meetings

Drug Utilization Review Board meetings occur seven times per year and always have a robust agenda. Information on the DURB and its activities in 2020 is available at this link: https://dvha.vermont.gov/advisory-boards/drug- utilization-review-board

The sample agenda typically follows this format.

.DUR Board Meeting Agenda

- **Executive Session** **6:00 - 6:30**
- **Introductions and Approval of DUR Board Minutes** **6:30 - 6:35**
  (Public Comment Prior to Board Action**)**
- **DVHA Pharmacy Administration Updates** **6:40 - 6:45**
- **Medical Director Update** **6:45 - 6:50**
- **Follow-up Items from Previous Meetings** **6:50 - 6:50**
- **RetroDUR/ProDUR** **6:50- 7:10**
  - Introduce:
  - Data presentation:
- **Clinical Update: Drug Reviews** **7:10-7:45**
  (Public comment prior to Board action)
  Biosimilar Drug Reviews
- **Full New Drug Reviews**
  (Any new drug reviews that also fall within the Therapeutic Class Review (TCR) will be discussed during the Therapeutic Class Review)
- **New Managed Therapeutic Drug Classes** **7:45 -7:45**
  (Public comment prior to Board action)
- **Therapeutic Drug Classes – Periodic Review** **7:45 - 8:30**
  (Public comment prior to Board action)
- **Review of Newly Developed/Revised Criteria** **8:30 - 8:30**
  (Public comment prior to Board action)
- **General Announcements** **8:30 – 8:30**
- **Adjourn** **8:30**

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:

- The 21st Century Cures Act required states to initiate Electronic Visit Verification (EVV) Systems for Personal Care Services (PCS). Program Integrity (PI) is supporting EVV with the implementation requirements of initiative and the required post claim PCA validation process.

- PI has focused on conducting more proactive provider audits. By auditing more providers, PI can assess the accuracy and completeness of documentation in support of claims billed, which will allow for recovery of overpayments if needed, and prevent future inaccurate claim submissions.

Program Integrity Unit

The Program Integrity Unit (PI is responsible for ensuring provider and beneficiary compliance with federal and state Medicaid regulations and has the responsibility to prevent, detect, and investigate fraud, waste, and abuse within the program.

The PI 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 provider enrollment information, which allows review and scrutiny of the Medicaid eligibility, enrollment, and claims data.

PI staff examine beneficiary eligibility, provider enrollment and claims data to verify appropriate determinations when conducting post-payment reviews. Staff utilize data mining techniques and have developed a variety of algorithms to detect aberrant utilization. Medicaid policies, guidelines, current trends 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.

PI 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.

PI also has the responsibility to investigate, detect and prevent beneficiary healthcare eligibility and enrollment fraud in the Vermont Medicaid Program. PI works with the Health Access Enrollment & Eligibility Unit (HAEEU), as well as other state and federal partners to ensure Vermonters enrolled in the program are eligible and are current residents of Vermont. PI reviews the federal PARIS (Public Assistance Reporting Information System) Report that identifies if a recipient is receiving duplicate benefits in more

than one state at the same time. PI reviews the individuals identified in this report and initiates removal of recipients that are not eligible for Vermont Medicaid.

All other non-healthcare programs (3SquaresVT/Supplemental Nutrition Assistance Program (SNAP), Fuel Assistance, etc.) remain the responsibility of the Department for Children and Families (DCF), and PI will work with DCF to evaluate and investigate allegations received with and joint nexus.

Outcomes

Vermont PI is regularly regarded by CMS, as well as other federal and state partners, as a leading and strong unit. PI takes pride in ensuring the appropriate use and spending of Medicaid federal and state dollars, which diverts dollars that could otherwise be spent to safeguard the health and welfare of Medicaid recipients, and allows more funds available for the recipients that really need it.

In 2020, the PI reviewed approximately 106 cases related to potential provider fraud, waste, and abuse allegations. Related to provider cases the PI successfully settled, and cost-avoided a collective$3,338,125. In addition, PI cost-avoided and estimated $1,060,092by reviewing the PARIS Report and removing recipients from Vermont Medicaid that are active in Vermont and another state's Medicaid program simultaneously, and do not reside in Vermont.

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 2020 the O&M unit continued its work in coordinating DVHA participation in State, Federal, and independent audits and examinations, seeking to ensure that information shared is consistent, accurate, and timely. In general, the public health emergency resulted in somewhat reduced external audit activity this year. During 2020 O&M:

- Facilitated seven state and federal audits of DVHA programs
- Provided ongoing tracking and monitoring and follow-up of Corrective Action Plans.
- Supported AHS and DVHA staff with documentation standards for better Standard Operating Procedures and policies. Twenty new SOPs were created and approved in 2020.

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)

The Payment Error Rate Measurement (PERM) audit, required by CMS to review for improper payments in Medicaid or CHIP programs, runs on a three-year cycle and looks at the full scope of a paid claim including beneficiary eligibility determinations, healthcare provider enrollment, and medical records to substantiate the claim. Vermont was very near the end of the PERM audit cycle when the Public Health Emergency (PHE) went into effect in March and the audit was suspended.

CMS resumed the PERM audit effective in August, but with modifications. Because the reviews were suspended early, there has been no reporting of state level errors for the cycle. Instead, CMS has provided a template of PERM audit error trends seen nationally and requires states to respond with corrective action plans where applicable.
OMU has worked with DVHA units and others to review the templates and determine the state's compliance status regarding the national error trends.

Outcomes

The national trend CMS 2020 PERM Corrective Action Plans for Medicaid and CHIP were submitted to CMS on February 16, 2021. Once approved by CMS, periodic check-in meetings will be established to ensure timely completion.

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),. 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.
- For FY 2020, 947 cases have been reviewed.
- To date for FY 2021, 358 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
- On 3/18/2020, due to the national health emergency, the MEQC audit was halted and modifications were made to the sample size.
- Streamlined the Difference Resolution process to mirror the CMS DR process.
- On 8/17/2020 CMS issued an MEQC COVID-19 Supplemental guidance outlining the relaxed policy regarding auditing activities. Seen below are these relaxed policies specific to Cycle 2 states:
    - Sample size reduction from 800 to 200
    - Streamlined reporting (summary reports): in lieu of submitting comprehensive case level reports, states will submit summary reports that list the percentage of errors and technical deficiencies found in the cases that were reviewed and describe the corrective action plans developed for the top 10 most frequent errors broken out by active and negative case actions.
    - Suspension of Payment Reviews and adjustments: States will not be required to conduct payment reviews for active cases with erroneous eligibility determinations and not be requiredto make payment adjustments for identified overpayments using the CMS-64 and 21 reports.
    - Deadline extensions for Summary reports: The CAP summary report due date has been extended to 11/1/2021from 8/1/2021.

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.
- In response to the COVID-19 emergency and to reduce the burden on medical practices, audit notification and documentation requests were suspended in March of 2020. Audit work using documentation submitted with applications, data within our MMIS, as well as work related to

thenext version of the Audit Plan continued during this time.

- Audit notification and documentation requests resumed in July of 2020.
- Version 8.0 of the Audit Plan was approved by CMS in August of 2020.
- Approximately ten percent of individual providers and fifty percent of hospitals are selected for audit each program year.
- This year, thirty-three individual and one hospital audit have been completed. One incentive payment was returned to the state as a resultof a failed audit.

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 (Gainwell) 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 2018-20 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 10/1/2017 and 9/30/2020, 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 2018-20.

Table 5. Inpatient Utilization by Fiscal Year and Age Group

Total Inpatient:								
	Sum LOS Days			**Discharges**		**Average LOS Days**		
Age	**2018**	**2019**	**2020**	**20182019**	**2020**	**2018**	**2019**	**2020**
<1	10,658	11,119	9,984	2,7942,667	2,565	3.8	4.2	3.9
1-9	2,606	2,834	2,740	461544	439	5.7	5.2	6.2
10-19	8,979	8,718	7,378	1,1941,069	930	7.5	8.2	7.9
20-44	31,704	29,487	27,376	6,1845,889	5,344	5.1	5.0	5.1
45-64	23,809	25,801	27,534	3,9343,764	3,593	6.1	6.9	7.7
65+	590	1,067	1,027	8566	73	6.9	16.2	14.1
Overall	**78,346**	**79,026**	**76,039**	**14,65213,999**	**12,944**	**5.3**	**5.7**	**5.9**

[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.

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

	Sum LOS Days			Discharges			Average LOS Days		
Age	**2018**	**2019**	**2020**	**20182019**		**2020**	**2018**	**2019**	**2020**
<1	10,549	10,783	9,734	2,7742,640		2,530	3.8	4.1	3.8
1-9	2,216	2,493	2,506	384464		375	5.8	5.4	6.7
10-19	8,020	8,133	6,857	1,01(921		819	7.9	8.8	8.4
20-44	25,398	23,089	22,043	4,9194,672		4,199	5.2	4.9	5.2
45-64	17,315	19,294	21,265	2,8822,782		2,715	6	6.9	7.8
65+	526	958	855	7458		59	7.1	16.5	14.5
Overall	**64,024**	**64,750**	**63,260**	**12,04311,537**		**10,697**	**5.3**	**5.6**	**5.9**

A1) Alcohol/Substance Inpatient Medical:

	Sum LOS Days			Discharges			Average LOS Days		
Age	**2018**	**2019**	**2020**	**20182019**		**2020**	**2018**	**2019**	**2020**
<1	-	-	-	-	-	-	-	-	-
1-9	-	-	-	-	-	-	-	-	-
10-19	63	47	49	1312		5	4.8	3.9	9.8
20-44	1,558	1,774	1,583	401399		356	3.9	4.5	4.4
45-64	1,955	1,613	1,411	367325		322	5.3	5	4.4
65+	4	-	25	1	-	1	4	-	25.0
Overall	**3,580**	**3,434**	**3,068**	**782736**		**684**	**4.6**	**4.7**	**4.5**

A2) Mental Health Inpatient Medical:

	Sum LOS Days			Discharges			Average LOS Days		
Age	**2018**	**2019**	**2020**	**20182019**		**2020**	**2018**	**2019**	**2020**
<1	-	27	25	-	3	1	-	9	25.0
1-9	1,239	1,323	991	7483		54	16.7	15.9	18.4
10-19	6,261	6,388	5,277	572519		401	10.9	12.3	13.2
20-44	13,200	10,909	10,330	1,2611,174		911	10.5	9.3	11.3
45-64	4,965	6,718	9,212	429402		331	11.6	16.7	27.8
65+	149	274	120	6	6	4	24.8	45.7	30.0
Overall	**25,814**	**25,639**	**25,955**	**2,3422,187**		**1,702**	**11**	**11.7**	**15.2**

A3) Other Inpatient Medical:

	Sum LOS Days			Discharges			Average LOS Days		
Age	**2018**	**2019**	**2020**	**20182019**		**2020**	**2018**	**2019**	**2020**
<1	10,549	10,756	9,709	2,7742,637		2,529	3.8	4.1	3.8
1-9	977	1170	1,515	310381		321	3.2	3.1	4.7
10-19	1,696	1698	1,531	425390		413	4	4.4	3.7
20-44	10,640	10,406	10,130	3,2573,099		2,932	3.3	3.4	3.5
45-64	10,395	10,963	10,642	2,0862,055		2,062	5	5.3	5.2
65+	373	684	710	6752		54	5.6	13.2	13.1
Overall	**34,630**	**35,677**	**34,237**	**8,9198,614**		**8,311**	**3.9**	**4.1**	4.1

B) Inpatient Surgery:									
Sum LOS Days				**Discharges**			**Average LOS Days**		
Age	**2018**	**2019**	**2020**	**2018**	**2019**	**2020**	**2018**	**2019**	**2020**
<1	109	336	250	20	27	35	5.5	12.4	7.1
1-9	390	341	234	77	80	64	5.1	4.3	3.7
10-19	959	574	521	184	146	111	5.2	3.9	4.7
20-44	6,306	6,355	5,333	1,265	1,205	1,145	5	5.3	4.7
45-64	6,494	6,507	6,269	1,052	982	878	6.2	6.6	7.1
65+	64	109	172	11	8	14	5.8	13.6	12.3
Overall	**14,322**	**14,222**	**12,779**	**2,609**	**2,448**	**2,247**	**5.5**	**5.8**	5.7

The following table (Table 6) presents visit counts by age for outpatient services provided in FFY2020-20, 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

FFY18	**Age**	**Emergency Department**		**Other Outpatient**		**Total**
		N	%Total	N	%Total	N
	<1	2,473	46%	2,958	54%	5,431
	1-9	13,764	41%	19,581	59%	33,345
	10-19	15,181	32%	32,037	68%	47,218
	20-44	36,322	26%	104,607	74%	140,929
	45-64	15,572	15%	88,145	85%	103,717
	65+	162	11%	1,303	89%	1,465
	Overall	**83,474**	**25%**	**248,631**	**75%**	**332,105**
FFY19	**Age**	**Emergency Department**		**Other Outpatient**		**Total**
		N	%Total	N	%Total	N
	<1	2,505	47%	2,816	53%	5,321
	1-9	13,358	41%	19,618	59%	32,976
	10-19	14,687	31%	32,290	69%	46,977
	20-44	34,750	25%	102,742	75%	137,492
	45-64	14,958	15%	84,431	85%	99,389
	65+	154	12%	1,165	88%	1,319
	Overall	**80,412**	**25%**	**243,062**	**75%**	**323,474**
FFY20	**Age**	**Emergency Department**		**Other Outpatient**		**Total**
		N	%Total	N	%Total	N
	<1	1,784	39%	2,753	61%	4,537
	1-9	9,550	35%	17,408	65%	26,958
	10-19	11,704	29%	28,480	71%	40,184
	20-44	29,294	25%	89,798	75%	119,092
	45-64	13,094	15%	74,401	85%	87,495
	65+	146	14%	915	86%	1,061
	Overall	**65,572**	**23%**	**213,755**	**77%**	**279,327**

Discussion

In FFY2020, Global Commitment, Medicaid, paid for 12,944 inpatient stays and 279,327 outpatient visits for

Vermonters. The total number of inpatient stays decreased 8% during FFY19 to FFY20. Outpatient visits decreased by 14% during the same period.

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 13% of the total inpatient stays and 34% of inpatient days. Average length of stay alcohol/substance abuse was about the same duration with an average of 4.5 days in FFY20 and inpatient psychiatric medical average length of stay has increased to 15 days. The longest stays for inpatient psychiatric were in the 45-64 age group.

Among outpatient visits, emergency department visits constituted roughly 25% of the outpatient visits during FFY19 and emergency department was 23% of outpatient visits during FFY20.

VII. Policy and Administrative Difficulties

Fiscal & Operational Management:

For all CY2020, 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 served as the proxy by which to draw down federal funds for Global Commitment. For each quarter in CY2020, 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.

CY 2020 – Annual Expenditures: Budget Neutrality Test

For CY2020, total "With Waiver" expenditures resulted in a surplus of $231,373,171 (15.7%), when compared to the total "Without Waiver" amount (caseloads multiplied by the Budget Neutrality PMPMs). This is a moderate change from CY19, when "With Waiver" expenditures resulted in a surplus of $143,723,507 (10.1%).

Calendar Year	Surplus/(Deficit)	Surplus/(Deficit) Percent
2017	$ 148,077,153	10.7%
2018	$ 120,939,335	8.6%
2019	$ 143,723,507	10.1%
2020	$ 231,373,171	15.7%

Calendar Year 2020 Global Commitment Expenditures	Quarter 1 QE 0320	Quarter 2 QE 0620	Quarter 3 QE 0920	Quarter 4 QE1220	Q3 - Q4 Change	All Quarters JAN - DEC
Total Expenditures Without Waiver	$ 358,271,218	$ 367,697,724	$ 373,110,341	$ 377,356,949	1.1%	$ 1,476,436,233
Total Expenditures With Waiver	$ 349,958,877	$ 310,290,568	$ 267,889,714	$ 315,681,124	17.8%	$ 1,243,820,283
Surplus / (Deficit)	$ 8,312,341	$ 57,407,156	$ 105,220,626	$ 61,675,825		$ 232,615,949
Surplus / (Deficit) - Percent	2.3%	15.6%	28.2%	16.3%		15.8%
Deficits from Supplemental Tests						
Supplemental Test for SUD	$ 109,396.19	$ (57,002.22)	$ (29,278.90)	$ (57,066.93)		$ (33,952)
Supplemental Test for SMI			$ (782,957.00)	$ (425,869.00)		$ (1,208,826)
Total With Waiver Savings After Supplemental Tests	$ 8,421,737	$ 57,350,154	$ 104,408,391	$ 61,192,889		$ 231,373,171
Suplus (Deficit) - Percent	2.4%	15.6%	28.0%	16.2%		*15.7%*

In order of the above exhibit, CY 2020 GC Waiver Expenditures:

Total Expenditures Without Waiver reflects enrollment as it is calculated by multiplying actual enrollment by the Budget Neutrality PMPMs. The 1.1% increase from QE0920 to QE1220 indicatesthat enrollment has remained relatively unchanged from the last quarter.

Total Expenditures With Waiver: There was a 17.8% increase in total "With Waiver" expenditures in from QE0920 to QE1220. This indicates increased utilization after two quarters of decreased utilization (QE0620 and QE0920) attributed to the COVID public health emergency.

Surplus (Deficit): Throughout CY2020, the State has maintained a surplus. However, the Surplus has been higher during the COVID Public Health Emergency due to decreased utilization. QE 1220 showed a modest recovery in utilization of services.

Supplemental Budget Neutrality Tests:

New Adult: The New Adult Budget Neutrality for each quarter began with a deficit in the first quarter, butultimately resulted in annual surplus of $52,035,084.

Supplemental Test: New Adult (Gross)	Quarter 1 QE 0320	Quarter 2 QE 0620	Quarter 3 QE 0920	Quarter 4 QE1220	Q3-Q4 DIFF	All Quarters JAN- DEC
Limit New Adult - Without Waiver	$ 95,219,271	$ 103,565,821	$ 109,071,553	$ 114,860,488	5.3%	$ 422,717,132
Without Waiver SUD - IMD New Adult Expenditures	$ 1,732,804	$ 616,914	$ 837,673	$ 943,516	12.6%	$ 4,130,907
Without Waiver SMI - IMD New Adult Expenditures	$ -	$ -	$ 2,625,525	$ 326,732	-87.6%	$ 2,952,257
Total Without Waiver	**$ 96,952,074**	**$ 104,182,735**	**$ 112,534,751**	**$ 116,130,736**		**$ 429,800,296**
New Adult- With Waiver Expenditures	$ 102,902,443	$ 85,446,457	$ 87,527,691	$ 92,289,937	5.4%	$ 368,166,528
With Waiver SUD - IMD New Adult Expenditures	$ 1,396,448	$ 721,575	$ 917,599	$ 1,214,588	32.4%	$ 4,250,210
With Waiver SMI - IMD New Adult Expenditures	$ -	$ -	$ 4,256,200	$ 1,092,274	-74.3%	$ 5,348,474
Total With Waiver	**$ 104,298,891**	**$ 86,168,032**	**$ 92,701,490**	**$ 94,596,799**		**$ 377,765,212**
Surplus (Deficit)	***$ (7,346,817)***	***$ 18,014,703***	***$ 19,833,261***	***$ 21,533,937***	**8.6%**	***$ 52,035,084***

This chart illustrates:

New Adult "With Waiver" Limit show increased enrollment throughout the year while New Adult "Without Waiver" expenditures decreased significantly in the second quarter and have been increasing slowing since then.
From QE 0920 to QE1230, New Adult "Without Waiver" Limit increased 5.3%. This is consistent with overall enrollment and utilization patterns attributed to the public health emergency. During the public health emergency, enrollment has increased due to higher unemployment and that the State is not reviewing members for continued eligibility.

The New Adult SUD "Without Waiver" and "With Waiver" expenditures decreased significantly in QE 0620, at the beginning of the Public Health Emergency. See SUD IMD description below, as it describes changes observed in the non-New Adult SUD IMD population.
While the New Adult SMI Medicaid Eligibility Group was established by waiver in January 2020, claims began to be processed in the MMIS in QE 0920. Claims for the first two quarters of 2020 had been paid out of Investment funds and were reprocessed to the new Medicaid Eligibility Group in the QE0920. Therefore, QE0920 appears so significantly higher than QE 1220.

SUD IMD: Claims reporting showed a significant decrease in enrollment in the IMD SUD eligibility groups after the first quarter, QE 0320 (see enrollment section of this report), but as enrollment for IMD SUD is derived from claims data, this enrollment decline could be due to claims lag and late billing at the IMDs.

As shown below, there is an SUD IMD deficit for the calendar year 2020 of $33,952. That deficit is applied to the overall budget neutrality test. There is ample room in the overall budget neutrality test to accommodate this overage. The overall Budget Neutrality is in a favorable position.

CY 2020 GC WAIVER EXPENDITURES	Quarter 1 QE 0320	Quarter 2 QE 0620	Quarter 3 QE 0920	Quarter 4 QE1220	Q3-Q4 %Change	All Quarters JAN - DEC
Supplemental Test: IMD SUD (Gross)						
SUD - IMD ABD - Non-Medicare - Adult	$ 172,680	$ 66,133	$ 62,459	$ 88,177	41.2%	$ 389,449
SUD - IMD ABD - Dual	$ 182,389	$ 56,997	$ 65,546	$ 82,645	26.1%	$ 387,577
SUD - IMD Non ABD - Non-Medicare - Adult	$ 219,632	$ 65,604	$ 88,423	$ 85,571	-3.2%	$ 459,230
Limit SUD IMD Without Waiver	**$ 574,701**	**$ 188,734**	**$ 216,428**	**$ 256,393**	**18.5%**	**$ 1,236,256**
SUD - IMD ABD Non Medicare Adult	$ 169,698	$ 65,385	$ 54,600	$ 121,568	122.7%	$ 411,251
SUD - IMD ABD - Dual	$ 106,654	$ 65,468	$ 80,377	$ 111,190	38.3%	$ 363,689
SUD - IMD Non ABD - Non-Medicare - Adult	$ 188,953	$ 114,883	$ 110,730	$ 80,702	-27.1%	$ 495,268
Limit SUD IMD With Waiver	***$ 465,305***	***$ 245,736***	***$ 245,707***	***$ 313,460***	**27.6%**	***$ 1,270,208***
Surplus (Deficit)	*$ 109,396*	*$ (57,002)*	*$ (29,279)*	*$ (57,067)*	94.9%	*$ (33,952)*

SMI IMD: As shown below, there is an SMI IMD deficit for the calendar year 2020 of $1,208,826 that will be applied to the overall budget neutrality test. There is ample room in the overall budget neutrality test to accommodate this deficit. The overall Budget Neutrality is in a favorable position.

While the SMI Medicaid Eligibility Group was established by waiver in January 2020, claims began to be processed in the MMIS in QE 0920. Claims for the first two quarters of 2020 had been paid out of Investment funds and were reprocessed to the new Medicaid Eligibility Group in the QE0920. Therefore, QE0920 appears so significantly higher than QE 1220.

CY 2020 GC WAIVER EXPENDITURES	Quarter 1 QE 0320	Quarter 2 QE 0620	Quarter 3 QE 0920	Quarter 4 QE1220	All Quarters JAN - DEC
Supplemental Test: IMD SMI (Gross)					
SMI - IMD ABD - Non-Medicare - Adult	$ -		$ 826,111	$ 233,805	$ 1,059,916
SMI - IMD ABD - Dual	$ -		$ 18,896	$ 113,376	$ 132,272
SMI - IMD Non ABD - Non-Medicare - Adult	$ -		$ 261,456	$ (20,112)	$ 241,344
Limit SMI IMD Without Waiver	**$ -**		**$ 1,106,463**	**$ 327,069**	**$ 1,433,532**
SMI - IMD ABD Non Medicare Adult	$ -	$ -	$ 965,399	$ 761,285	$ 1,726,684
SMI - IMD ABD - Dual	$ -	$ -	$ 244,918	$ (77,687)	$ 167,231
SMI - IMD Non ABD - Non-Medicare - Adult	$ -	$ -	$ 679,103	$ 69,340	$ 748,443
Limit SMI IMD With Waiver	**$ -**	**$ -**	**$ 1,889,420**	**$ 752,938**	**$ 2,642,358**
Surplus (Deficit)	*$ -*	*$ -*	*$ (782,957)*	*$ (425,869)*	*$ (1,208,826)*

Supplemental Test: New Adult: In QE 1220, there was a surplus of $21,533,937, with a total annual Surplus of $52,035,084. As you can see from the below exhibit, the first quarter of CY 2020 had a deficit of $7.3M, and the following quarters had surpluses. This exhibit illustrates shows increased

enrollment with decreased utilization during the public health emergency.

Supplemental Test: New Adult (Gross)	**Quarter 1**	**Quarter 2**	**Quarter 3**	**Quarter 4**	**Q3-Q4**	**All Quarters**
	QE 0320	**QE 0620**	**QE 0920**	**QE1220**	**DIFF**	**JAN - DEC**
Limit New Adult - Without Waiver	$ 95,219,271	$ 103,565,821	$ 109,071,553	$ 114,860,488	5.3%	$ 422,717,132
Without Waiver SUD - IMD New Adult Expenditures	$ 1,732,804	$ 616,914	$ 837,673	$ 943,516	12.6%	$ 4,130,907
Without Waiver SMI - IMD New Adult Expenditures	$ -	$ -	$ 2,625,525	$ 326,732	-87.6%	$ 2,952,257
Total Without Waiver	**$ 96,952,074**	**$ 104,182,735**	**$ 112,534,751**	**$ 116,130,736**		**$ 429,800,296**
New Adult- With Waiver Expenditures	$ 102,902,443	$ 85,446,457	$ 87,527,691	$ 92,289,937	5.4%	$ 368,166,528
With Waiver SUD - IMD New Adult Expenditures	$ 1,396,448	$ 721,575	$ 917,599	$ 1,214,588	32.4%	$ 4,250,210
With Waiver SMI - IMD New Adult Expenditures	$ -	$ -	$ 4,256,200	$ 1,092,274	-74.3%	$ 5,348,474
Total With Waiver	**$ 104,298,891**	**$ 86,168,032**	**$ 92,701,490**	**$ 94,596,799**		**$ 377,765,212**
Surplus (Deficit)	***$ (7,346,817)***	***$ 18,014,703***	***$ 19,833,261***	***$ 21,533,937***	**8.6%**	***$ 52,035,084***

Investments

AHS continues to actively monitor Investment spending. The total CY2020 Budget Neutrality Investment Limit was $136,500,000. The State's CY2020 annual investment expenditures of $114,857,151 complies with the STC#84 annual limit.

State-Funded Marketplace Subsidies

Per STC#41, the State stayed below the CY2020 funding limit of $8,678,971 for state-funded marketplace subsidies with a cumulative total of $5,862,966.

VIII. Capitated Revenue Spending

The PMPM rates as set for 1/1/20-12/31/20 are listed below. AHS submitted the calendar year 2021 PMPM Medicaid rates to CMS in December 2020.

Table 14. PMPM Capitated Rates (Includes SUD and SMI MEGs)

PMPM Rates	
Medicaid Eligibility Group	**1/1/2020 - 12/30/20**
ABD Adult	$ 2,479.52
ABD Child	$ 3,061.99
ABD Dual	$ 2,091.25
Global Rx	$ 107.09
Moderate Needs	$ 682.34
New Adult	$ 503.41
Non-ABD Adult	$ 667.59
Non-ABD Child	$ 531.85

Attachments

Attachment 1 – Budget Neutrality Report

State of Vermont Global Commitment to Health
Budget Neutrality PMPM Projection vs 64 Actuals Summary
February 5, 2021

ELIGIBILITY GROUP	DY 12 JAN - DEC 2017	DY 13 JAN - DEC 2018	DY 14 JAN - DEC 2019	DY 15 JAN - DEC 2020	DY 16 JAN - DEC 2021	Total
Without Waiver (Caseload x pmpms)						
ABD - Non-Medicare - Adult	$ 142,860,455	$ 130,050,973	$ 131,976,747	$ 134,573,770	$ -	$ 539,461,945
ABD - Non-Medicare - Child	$ 85,359,001	$ 78,434,428	$ 75,860,331	$ 65,895,041	$ -	$ 305,548,801
ABD - Dual	$ 664,153,383	$ 693,539,886	$ 720,885,032	$ 753,643,734	$ -	$ 2,832,222,035
Non ABD - Non-Medicare - Adult	$ 101,757,250	$ 96,887,008	$ 73,827,769	$ 83,250,482	$ -	$ 355,722,508
Non ABD - Non-Medicare - Child	$ 392,665,288	$ 406,444,058	$ 413,877,439	$ 439,073,206	$ -	$ 1,652,059,992
Total Expenditures Without Waiver	**$ 1,386,795,376**	**$ 1,405,356,354**	**$ 1,416,427,318**	**$ 1,476,436,233**	**$ -**	**$ 5,685,015,281**
With Waiver						
ABD Non Medicare Adult	$ 162,602,154	$ 162,728,372	$ 168,382,861	$ 177,858,506	$ -	$ 671,571,892
ABD - Non-Medicare - Child	$ 66,593,208	$ 60,077,015	$ 58,176,676	$ 55,369,700	$ -	$ 240,216,598
ABD - Dual	$ 445,847,909	$ 461,739,496	$ 484,543,363	$ 476,164,427	$ -	$ 1,868,295,194
Non ABD - Non-Medicare - Adult	$ 84,040,228	$ 84,275,155	$ 67,221,781	$ 69,967,054	$ -	$ 305,504,217
Non ABD - Non-Medicare - Child	$ 305,543,574	$ 335,706,591	$ 350,804,595	$ 334,351,461	$ -	$ 1,326,406,222
Premium Offsets	$ (655,991)	$ (772,935)	$ (774,152)	$ (413,790)	$ -	$ (2,616,867)
Moderate Needs Group	$ 1,488,408	$ 1,378,915	$ 1,429,868	$ 703,701	$ -	$ 5,000,892
Marketplace Subsidy	$ 6,355,286	$ 6,242,717	$ 5,915,336	$ 5,862,966	$ -	$ 24,376,306
VT Global Rx	$ 13,824,166	$ 15,300,919	$ 10,692,124	$ 3,494,233	$ -	$ 43,311,442
VT Global Expansion VHAP	$ 414,824	$ (0)	$ 0	$ -	$ -	$ 414,824
CRT DSHP	$ 10,331,787	$ 9,240,772	$ 6,787,058	$ 5,604,875	$ -	$ 31,964,492
Investments	$ 142,332,671	$ 148,500,000	$ 119,133,231	$ 114,857,150	$ -	$ 524,823,052
Total Expenditures With Waiver	**$ 1,238,718,223**	**$ 1,284,417,019**	**$ 1,272,312,740**	**$ 1,243,820,283**	**$ -**	**$ 5,039,268,265**
Supplemental Test: New Adult (Gross)						
Limit New Adult	$ 370,689,611	$ 375,735,593	$ 369,387,603	$ 422,717,132	$ -	$ 1,538,529,940
Without Waiver SUD - IMD New Adult Expenditures		$ 2,704,249	$ 4,842,747	$ 4,130,907	$ -	$ 11,677,902
Without Waiver SMI - IMD New Adult Expenditures				$ 2,952,257	$ -	$ 2,952,257
With Waiver New Adult Expenditures	$ 295,620,340	$ 312,104,578	$ 315,241,704	$ 368,166,528	$ -	$ 1,291,133,149
With Waiver SUD - IMD New Adult Expenditures		$ 2,826,119	$ 5,869,169	$ 4,250,210	$ -	$ 12,945,498
With Waiver SMI - IMD New Adult Expenditures				$ 5,348,474	$ -	$ 5,348,474
Surplus (Deficit)	*$ 75,069,271*	*$ 63,509,145*	*$ 53,119,477*	*$ 52,035,084*	$ -	$ 243,732,978
Supplemental Test: IMD SUD (Gross)						
SUD - IMD ABD - Non-Medicare - Adult		$ 268,039	$ 529,433	$ 389,449	$ -	$ 1,186,921
SUD - IMD ABD - Dual		$ 214,495	$ 442,312	$ 387,577	$ -	$ 1,044,384
SUD - IMD Non ABD - Non-Medicare - Adult		$ 533,391	$ 633,224	$ 459,230	$ -	$ 1,625,845
Limit SUD IMD Without Waiver		**$ 1,015,926**	**$ 1,604,968**	**$ 1,236,256**	**$ -**	**$ 3,857,150**
SUD - IMD ABD Non Medicare Adult		$ 249,820	$ 646,440	$ 411,251	$ -	$ 1,307,512
SUD - IMD ABD - Dual		$ 199,224	$ 545,837	$ 363,689	$ -	$ 1,108,750
SUD - IMD Non ABD - Non-Medicare - Adult		$ 540,841	$ 803,762	$ 495,268	$ -	$ 1,839,872
Limit SUD IMD With Waiver		**$ 989,886**	**$ 1,996,039**	**$ 1,270,208**	**$ -**	**$ 4,256,133**
Surplus (Deficit)		*$ 26,040*	*$ (391,071)*	*$ (33,952)*	$ -	$ (398,983)
Supplemental Test: IMD SMI (Gross)						
SMI - IMD ABD - Non-Medicare - Adult				$ 1,059,916	$ -	$ 1,059,916
SMI - IMD ABD - Dual				$ 132,272	$ -	$ 132,272
SMI - IMD Non ABD - Non-Medicare - Adult				$ 241,344	$ -	$ 241,344
Limit SMI IMD Without Waiver		**$ -**	**$ -**	**$ 1,433,532**	**$ -**	**$ 1,433,532**
SMI - IMD ABD Non Medicare Adult				$ 1,726,684	$ -	$ 1,726,684
SMI - IMD ABD - Dual				$ 167,231	$ -	$ 167,231

SMI - IMD Non ABD - Non-Medicare - Adult				$ 748,443	$ -	$ 748,443
Limit SMI IMD With Waiver		**$ -**	**$ -**	**$ 2,642,358**	**$ -**	**$ 2,642,358**
Surplus (Deficit)		*$ -*	*$ -*	*$ (1,208,826)*	*$ -*	$ (1,208,826)
Waiver Savings Summary						
Annual Savings	$ 148,077,153	$ 120,939,335	$ 143,723,507	$ 231,373,171	$ -	$ 644,113,167
Shared Savings Percentage	30%	25%	25%	25%	25%	
Shared Annual Savings	$ 44,423,146	$ 30,234,834	$ 35,930,877	$ 57,843,293	$ -	$ 168,432,149
Total Savings	$ 44,423,146	$ 30,234,834	$ 35,930,877	$ 57,843,293	$ -	$ 168,432,149
Cumulative Savings	***$ 44,423,146***	***$ 74,657,980***	***$ 110,588,857***	***$ 168,432,149***	***$ 168,432,149***	***$ 168,432,149***

11% 9% 10% 16%

New Adult Waiver Savings Not Included in Waiver Savings Summary See Budget Neutrality New Adult tab (STC#64)

See CY2020 Investments tab

See EG MM CY 2020 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

Attachment 2 - Enrollment and Expenditures Report

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: Michael K. Smith, Secretary
Agency of Human Services

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

Report Date: September 1, 2020
(Revised October 1, 2020)

VERMONT

AGENCY OF HUMAN SERVICES
DEPARTMENT OF VERMONT HEALTH ACCESS

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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 Medicaid program enrollment and expenditure reports have traditionally reported caseload representative of a year-to-date average monthly member enrollment. The Per Member Per Month (PMPM) is calculated using the average monthly enrollment and expenses/budget for each Medicaid Eligibility Group. Due to the impact of the public health emergency produced by the novel coronavirus, SARS-CoV-2, this report is being revised to include an additional column that indicates point-in-time enrollment, as of the last month of the quarter, into the Medicaid program. The "Ending Enrollment" column was included to communicate the observed increases in enrollment during the public health emergency.

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

	SFY'20 BAA2			SFY'20 Actuals Thru June 30, 2020				
Medicaid Eligibility Group	Caseload	Budget	PMPM	Caseload	Expenses	PMPM	% of Expenses toBudget Line Item	Ending Enrollment asof June 2020
ABD Adult	6,475	$ 180,315,261	$ 2,320.66	6,298	$ 144,689,782	$ 1,914.4		6,244
ABD Dual	17,828	$ 299,575,358	$ 1,400.30	17,521	$ 226,244,970	$ 1,076.0	80.24%	17,434
General Adult	9,657	$ 71,277,457	$ 615.08	8,287	$ 64,603,420	$ 649.64	75.52%	8,996
New Adult Childless	35,559	$ 228,537,967	$ 535.58	35,009	$ 226,756,641	$ 539.76	90.64%	37,185
New Adult w/Child	19,550	$ 105,905,193	$ 451.43	20,178	$ 111,464,776	$ 460.34	99.22%	22,053
							105.25%	
BD Child	2,138	$ 77,718,086	$ 3,029.24	1,758	$ 55,631,340	$ 2,636.68		1,642
General Child	58,256	$ 426,194,781	$ 609.66	57,692	$ 340,328,506	$ 491.59	71.58%	58,451
Underinsured Child	540	$ 1,802,962	$ 278.23	561	$ 1,155,169	$ 171.57	79.85%	524
CHIP	4,399	$ 10,914,620	$ 206.76	4,535	$ 13,602,322	$ 249.96	64.07%	4,231
							124.62%	
Vermont Premium Assistance	16,988	$ 5,986,200	$ 29.36	16,237	$ 5,732,382	$ 29.42		16,039
Vermont Cost Sharing	3,879	$ 1,355,401	$ 29.12	3,518	$ 1,170,612	$ 27.73	95.76%	3,252
Pharmacy Only	10,050	$ 5,038,270	$ 41.78	9,988	$ 3,451,390	$ 28.80	86.37%	10,158
Choices for Care - Traditional	4,135	$ 223,970,679	$ 4,513.72	4,515	$ 223,809,460	$ 4,130.62	68.50%	4,500
Choices for Care - Acute	4,135	$ 36,280,841	$ 731.17	4,515	$ 41,837,929	$ 772.16	99.93%	4,500
Total Medicaid	185,575	$ 1,674,873,074	$ 752.11	182,579	$ 1,460,478,699	$ 666.60	115.32%	187,45

The Department of Vermont Health Access

Caseload and Expenditure Report

All AHS YTD SFY'20

Medicaid Eligibility Group	SFY'20 BAA2 Caseload	SFY'20 BAA2 Budget	SFY'20 BAA2 PMPM	SFY'20 Actuals Thru June 30, 2020 Caseload	SFY'20 Actuals Thru June 30, 2020 Expenses	SFY'20 Actuals Thru June 30, 2020 PMPM	% of Expenses toBudget Line Item	Ending Enrollment asof June 2020
ABD Adult	6,475	$ 187,939,49 8	$ 2,418.78	6,298	$ 143,539,978	$ 1,899.25	76.38%	6,244
				17,521	$ 226,109,248	$ 1,075.40	67.00%	17,434
ABD Dual	17,828	$ 337,463,95 1	$ 1,577.41	8,287	$ 64,401,879	$ 647.61	71.98%	8,996
				35,009	$ 226,660,912	$ 539.54	106.83%	37,185
General Adult	9,657	$ 89,474,13 9	$ 772.10	20,178	$ 111,461,688	$ 460.33	135.75%	22,053
				1,758	$ 43,634,364	$ 2,068.08		1,642
New Adult Childless	35,559	$ 212,160,33 4	$ 497.20	57,692	$ 306,451,522	$ 442.66	67.49%	58,451
				561	$ 911,542	$ 135.38	83.37%	524
New Adult w/Child	19,550	$ 82,110,57 1	$ 350.00	4,535	$ 12,073,760	$ 221.87	63.96%	4,231
				16,237	$ 5,732,382	$ 29.42	78.95%	16,039
BD Child	2,138	$ 64,653,23 7	$ 2,520.00	3,518	$ 1,170,612	$ 27.73	95.76%	3,252
				9,988	$ 3,451,390	$ 28.80	86.37%	10,158
General Child	58,256	$ 367,602,05	$ 525.84	4,515	$ 223,809,460	$ 4,130.62	68.50%	4,500
				4,515	$ 41,809,018	$ 771.63	99.93%	4,500
				182,579	$ 1,411,217,757	$ 644.11	141.05%	187,45

The Department of Vermont Health Access

Caseload and Expenditure Report

DVHA

Only YTDSFY'20

Medicaid Eligibility Group	SFY'20 BAA2 Caseload	SFY'20 BAA2 Budget	SFY'20 BAA2 PMPM	SFY'20 Actuals Thru June 30, 2020 Caseload	SFY'20 Actuals Thru June 30, 2020 Expenses	SFY'20 Actuals Thru June 30, 2020 PMPM	% of Expenses to Budget	Ending Enrollment as of June 2020 Item
ABD Adult	6,475	$ 58,151,996	$ 748.42	6,298	$ 57,489,532	$ 7[illegible].0 67	98.86%	6,244
ABD Dual	17,828	$ 55,019,826	$ 257.18	17,521	$ 53,812,435	$ 255.94	97.81%	17,434
General Adult	9,657	$ 48,717,821	$ 420.40	8,287	$ 51,559,566	$ 51[illegible].47	105.83%	8,996
New Adult Childless	35,559	$ 180,640,323	$ 423.33	35,009	$ 192,985,152	$ 459.37	106.83%	37,185
New Adult w/Child	19,550	$ 88,271,162	$ 376.26	20,178	$ 98,886,805	$ 408.40	112.03%	22,053
BD Child	2,138	$ 21,308,947	$ 830.56	1,758	$ 22,103,589	$ 1,047.61	103.73%	1,642
General Child	58,256	$ 156,319,23	$ 223.61	57,692	$ 161,637,12	$ 233.48	103.40%	58,451
							108.94%	524
							100.59%	4,231
							95.76%	16,039
							86.37%	3,252
							68.50%	10,158
							0.00%	4,500
							126.33%	4,500

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
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http://dvha.vermont.gov

Questions, Complaints and Concerns Received by Health Access Member Services October 1, 2020 – December 31, 2020

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. Member and Provider Services, 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 2020:

Caller is leaving negative feedback about the lack of dental providers and the VT Medicaid portal not being up to date. She used VT medicaid.com to do a provider search for list of orthodontists. She said she called 8 providers, either not accepting new patients and 4 that do not accept Vermont Medicaid at all... one specifically told her they have not accepted Medicaid for years and "they tried to get off the list and the state won't take them off". She also added that she is frustrated to access her full benefits due to the lack of orthodontists in her area that participate in Medicaid. She said she wanted to let the state know to please update the provider list. CSR apologized for her frustration, tried to assist her in finding a dentist in her area and offered feedback.

November 2020

Caller wanted to submit negative feedback. She wanted us to know that the process of having to get a referral to a specialist (out of network) is not efficient as she cannot find out the status without bothering her PCP. CSR apologized for the frustration, explained the policy and offered to document her feedback.

December 2020

Caller wanted to submit feedback regarding the type of compression socks that we approve to cover. Caller states this is concerning compression socks/garments for circulation. She feels that if Medicaid should switch vendors, that the State please take into consideration dyes in the material. New vendor has no white option. Must use dyed option. If caller's wound re-opens, dye could cause problems. I.E. - 4 more months with a surgeon, which will cost a lot more to Medicaid. CSR apologized for her frustration and offered to document her feedback.

Caller wished to record their dissatisfaction for having to wait until February for an appointment. Caller does not understand why there are not more specialist in Vermont. He needed to see a specific cardiologist for a specific procedure, but he cannot get an appointment with the doctor he was referred to until February and is upset about that. He asked member

services to look up a cardiologist that does a specific procedure but was unhappy when advised member services can only look for cardiologist, not the specific procedures they may perform. He feels member services should have better access to this type of information to assist customers. CSR & CSR supervisor apologized for his frustrations, offered to help him find a specialist, when that didn't satisfy him we offered to document his feedback.

Caller wanted to submit negative feedback regarding the online provider list. She feels the provider list is not up to date, she has called multiple places that are not taking new patients. She thinks we should have more transparency in our lists and would like if we could update if doctors are still taking our coverage or reminding them to update. CSR apologized for her frustration and offered to assist with finding a doctor. Also, offered to document her feedback. The provider portal is updated daily and relies on providers relaying availability and other important information to VT Medicaid when changes may be necessary.

Agency of Human Services

Grievance and Appeal Quarterly Report Medicaid Managed CareModel All Departments Combined Data October 1, 2020 – December 31, 2020

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 ManagedCare 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 from the centralized database that were filed from October 1, 2020 through December 31, 2020.

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 6 grievances filed; one was addressed. 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, 100% were filed by the beneficiary. DMH had 100% of the grievances filed. There were no grievances filed for DCF, DAIL, DVHA or VDH during this quarter.

Grievances were filed for service categories case management, program/policy concerns, psychiatric, and mental health services.

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

During this quarter, there were 15 appeals filed. Of these 15 appeals, 15 were resolved (100%).

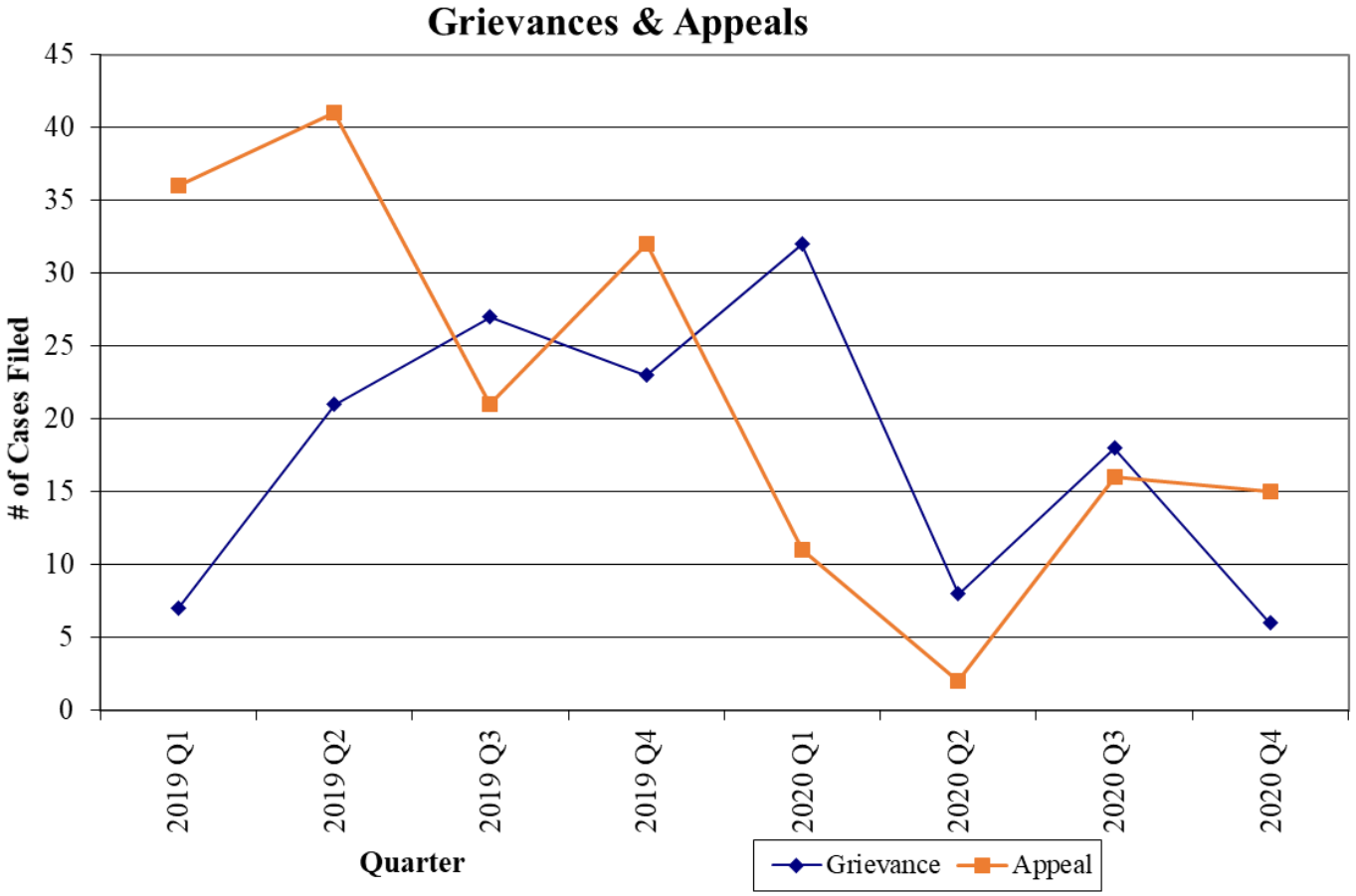
Of the 15 appeals that were resolved this quarter, 100% were resolved within the statutory time frame of 30 days. The average number of days it took to resolve these cases was 15 days. Acknowledgement letters of the receipt of an appeal must be sent within five days; the average was two days.

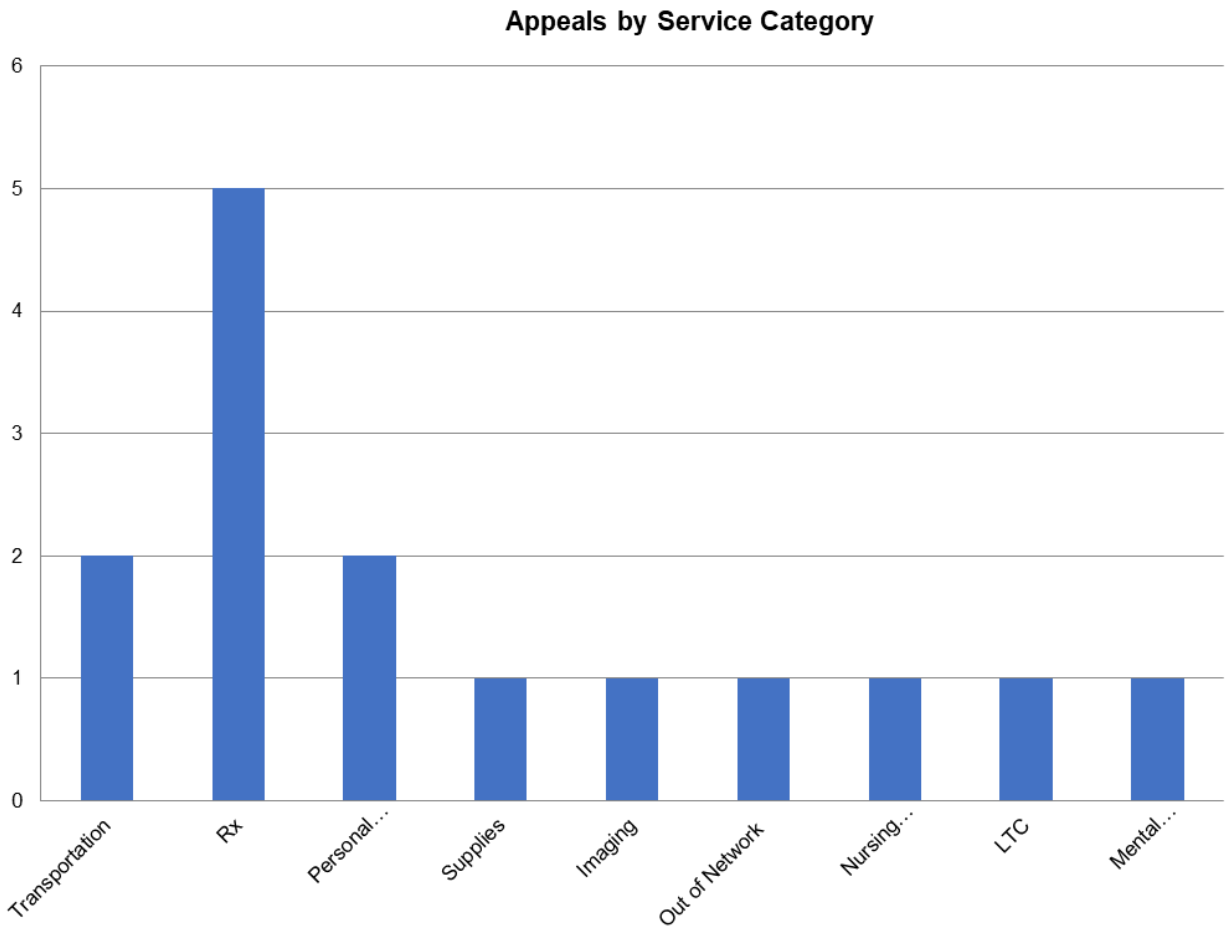
Of the 15 appeals filed, DVHA had 10 appeals filed (67%), DAIL had 2 (13%), VDH has 2 (13%) and DMH had 1 (7%).

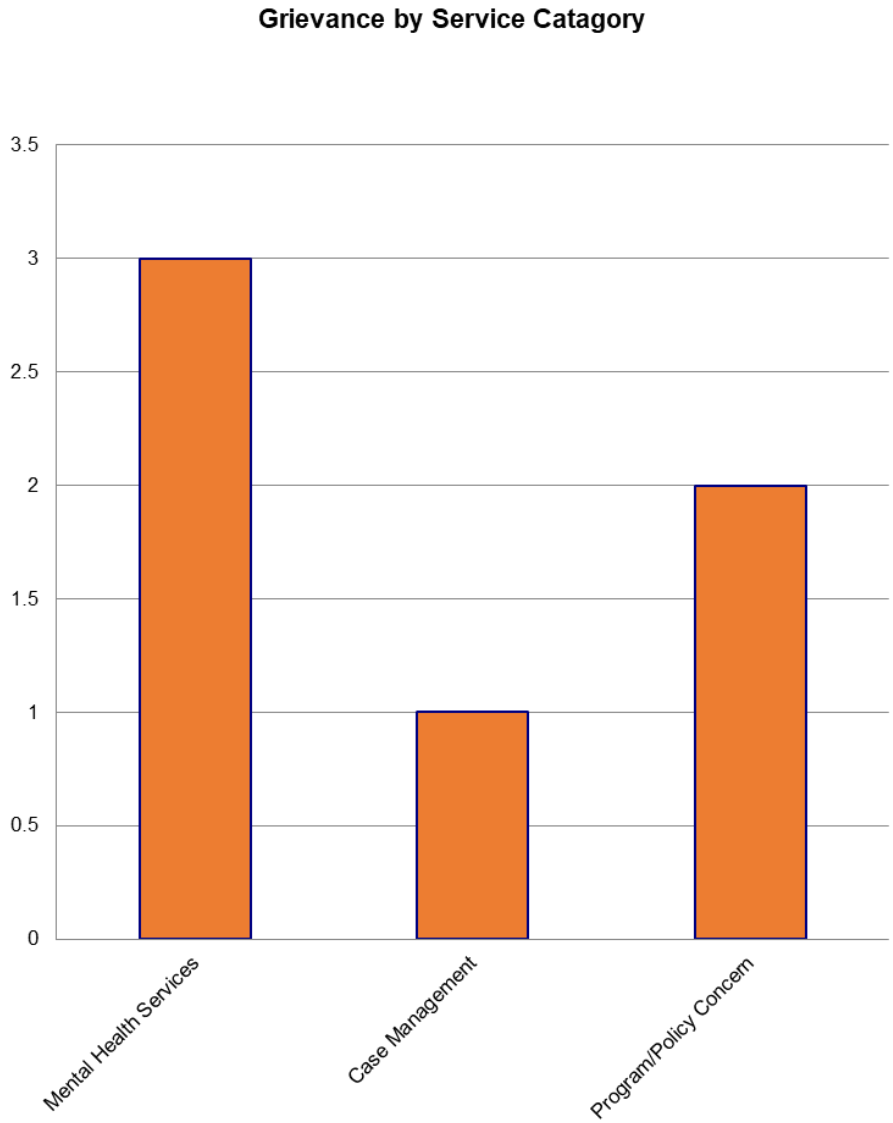
The appeals filed were for service categories, transportation, dental, imaging, prescriptions, and mental health services.

Beneficiaries must exhaust the internal appeal process before they can file a fair hearing if their appeal is not decided in their favor. There was no fair hearing filed this quarter.

Enrollees may participate in appeals, by written testimony, telephonically, and by video or virtual communication.


Grievances & Appeals
45
40
35
30
25
20
15
10
5
0
# of Cases Filed
2019 Q1
2019 Q2
2019 Q3
2019 Q4
2020 Q1
2020 Q2
2020 Q3
2020 Q4
Quarter
Grievance
Appeal


Appeals by Service Category
6
5
4
3
2
1
0
Transportation
Rx
Personal…
Supplies
Imaging
Out of Network
Nursing…
LTC
Mental…


Grievance by Service Catagory
3.5
3
2.5
2
1.5
1
0.5
0
Mental Health Services
Case Management
Program/Policy Concern

Vermont Legal Aid

Office of the Health Care Advocate

Quarterly Report

October 1, 2020 - December 31, 2020

to the

Agency of Administration

submitted by

Michael Fisher, Chief Health Care Advocate Office of the Health Care Advocate

January 20, 2021

Summary and Update

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.

Since Governor Scott's "stay at home" order on March 24, 2020, the HCA has been operating remotely and it anticipates operating remotely through the spring of 2021, at least. The HCA helpline now has eight advocates working to resolve issues during this crisis During this quarter, both Vermont Health Connect and Medicare Part D had their open enrollment periods. The advocates focused on consumer education and advising Vermonters about their eligibility for 2021. We talked to 117 households about Medicaid eligibility and 92 about eligibility for Premium Tax Credit. We provided consumer education about Medicare for 82 households. On our website, our page on Medicaid eligibility had over 2,000 pageviews. Our Medicare pages also saw a large amount of web traffic. The Medicare Savings Programs, State Pharmacy Assistance programs, and Dual-eligibility pages had almost 900 page views in total. We also had 109 online help requests from our website.

The HCA also held an hour-long virtual Town Hall event on VHC Open Enrollment and plan design. Viewers were given the opportunity to ask the presenters questions. This presentation had 170 views from November 1 - December 15, 2020. All of the HCA's virtual town halls are available for further viewings. The HCA continued to do regular, periodic outreach on social media and post ads on Front Porch Forum to reach more consumers.

The HCA helpline had 810 calls this quarter. During the COVID-19 crisis, the State of Vermont has not been conducting Medicaid reviews or closing state health care programs. Medicaid eligibility istypically a top issue for the HCA, so it is not surprising to see a decrease in some of those calls. As the state of Vermont starts processing some changes in 2021, we expect to see an increase in calls.

The HCA helpline continues collaborating with other parts of Vermont Legal Aid to make sure the community understands the impact on health care programs of both new unemployment programs, hazard pay, and the stimulus checks created by the CARES ACT and second stimulus package. We are continually working on updating our website so consumers can access the latest information on how these programs will impact their Medicaid and other public benefits. The HCA is participating with the Disability Law Project at Vermont Legal Aid on a workgroup to make sure that Vermonters on

Vivian's Story:

Vivian called the HCA because she was having trouble signing up for a planon Vermont Health Connect.(VHC). Vivian had lost her job and her employer-basedinsurance. That meant she had a special enrollment period to get a health plan on VHC. When she applied online, however, it said she was not eligible because shehad Medicare. Vivian was only in her thirties and had never been on Medicare.
The HCA contacted VHC andalerted it to this glitch. The HCA advocates had noticed multiple consumers having the same issue as Vivian.
VHC discovered a software issue was causing it. They were able to resolve it, so Vivian was able to completethe application. She was found eligible for Advance Premium Tax Credit to help reduce her

Medicaid for the Working Disabled who have temporarily lost their jobs due to COVID-19 will not lose their Medicaid coverage.

The HCA policy team also participates on the Vaccine Implementation Advisory Committee convened by the Vermont Department of Health. We have advocated for a balance between directing this scarce resource to people most likely to have severe illness or death, and Vermont populations in correctional facilities and in our BIPOC communities.

As the COVID-19 pandemic stretches on and Vermonters confront its ongoing economic and health impacts, we will continue to advocate for accessible and affordable coverage for all.

Ramona's Story

Ramona was having trouble with her Medicare costs. She was paying over $50 per month for her Part D plan, which covered her prescriptions. Unfortunately, Ramona called after the end of the annual open enrollment period for Part D. During the open enrollment, you can sign up for a different Part D plan. When the HCA advocate investigated the situation, she discovered that Ramona was eligible for VPharm, the state pharmacy assistance program. If she applied for VPharm,she would get help with her monthly Part D premium costs, and her prescription co-payments wouldbe $1 to $2. Being enrolled in VPharm also makes you eligible for a special enrollment period for a Part D plan. With the SEP, Ramona would be able to switch to a Part D plan that had a lower premium. The HCA advocate helped Ramona apply for VPharm—and she was approved for the program.

Overview

The HCA provides assistance to consumers through our statewide helpline (**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 810 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:

24.08% about **Access to Care**
11.12% about **Billing/Coverage**
5.13% about **Buying Insurance**
12.71% about **Complaints**
11.61% about **Consumer Education**
22.37% about **Eligibility** for state and federal programs
12.10% were categorized as **Other**, which includes Medicare Part D, communication problemswith 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 multiple issues. For example, although 183 of our cases had eligibility for state and federal healthcare programs listed as the primary issue, an additional 453 cases had eligibility listed as a secondary concern.

In each section of this narrative, we indicate whether we are referring to data based on primary issues only, 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 2020, includes:

This narrative

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

Seven data reports, including three based on the caller's insurance status:

All Calls/All Coverages: 810

Department of Vermont Health Access (DVHA) beneficiaries: 275

Commercial Plan Beneficiaries: 170

Uninsured Vermonters: 57

Vermont Health Connect (VHC): 179

Reportable Activities (Summary & Detail): 22 activities and 1 document

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 810 (vs. 738 last quarter)

MAGI Medicaid Eligibility 117 (vs. 100 last quarter)
Information/applying for DVHA programs 95 (67)
Premium Tax Credit Eligibility 92 (42)
Complaints about Providers 88 (123)
Medicare Consumer Education 82 (42)
Medicaid eligibility (non-MAGI) 73 (65)
Access to Prescription Drugs/Pharmacy 63 (50)
Buy-in programs/Medicare Savings Programs 60 (44)
Eligibility for Special Enrollment Periods 59 (50)
Buying QHPs through VHC 55 (14)
Nonfinancial Eligibility Requirements 48 (34)
Complaints about Hospitals 42 (35)
Not health related 40 (43)
Information about HCA 39 (35)
ACA Tax issues 38 (9)
Termination of Insurance 38 (35)

Vermont Health Connect Calls 179 (137)

Premium Tax Credit eligibility 87 (40)
MAGI Medicaid Eligibility 76 (67)
Buying QHPs through VHC 54 (13)
Information about DVHA 42 (29)
ACA Tax issues 38 (9)
Eligibility for Special Enrollment Periods 38 (38)
Information about ACA 33 (21)
IRS Reconciliation Education 32 (23)
Termination of Insurance 27 (25)
Complaints about VHC Eligibility Error 22 (4)

DVHA Beneficiary Calls 275 (vs. 230 last quarter)

MAGI Medicaid Eligibility 53 (34)
Information about DVHA 43 (22)
Medicaid Eligibility (non-MAGI) 40 (37)
Access to Prescription Drugs/Pharmacy 33 (22)
Complaints about Providers 25 (31)
Medicare Consumer Education 25 (7)
Access to Dental Care 17 (8)
Not Health Related 17 (13)
Access to Transportation 14 (13)
Nonfinancial Eligibility Requirements 14 (8)

Commercial Plan Beneficiary Calls 170 (vs. 116 last quarter)

Premium Tax Credit Eligibility 49 (18)
MAGI Medicaid eligibility 32 (23)
Buying QHPs through VHC 27 (6)
Special Enrollment Period Eligibility 26 (19)
Medicare Consumer Education 24 (10)
IRS Reconciliation Education 20 (13)
ACA Tax issues 19 (4)
Termination of Insurance 18 (20)
Information about ACA 16 (13)
Information about DVHA 16 (14)

The HCA received 810 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% (275 calls)
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): 28%% (226 calls)
Commercial plan beneficiaries (employer-sponsored insurance, small group plans, or individualplans 21% (170 calls)
Uninsured: 7% (57 calls)

Dispositions of Closed Cases

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

All Calls: We closed 832 cases this quarter. Overall, 362 were resolved by brief analysis and advice. Another 233 were resolved by brief analysis and referral. There were 97 complex interventions involving complex analysis, and more than two hours of an advocate's time and 45 cases that involved at least one direct intervention on behalf of a consumer. The HCA provided consumer education to more than half of all the cases (456). We also estimated eligibility for insurance coverage and got people onto coverage in 100 cases. We saved consumers $20,111.72 this quarter.

Consumer Protection Activities

Rate Review

The HCA reviews and analyzes all commercial insurance carrier requests to the Green Mountain Care Board (Board) to change premium prices.

The Board decided one premium price change request during the quarter from October 1, 2020 through December 31, 2020. Additionally, there is one COVID-19 consumer premium rebate request pending as of the end of this quarter.

MVP Health Plan, Inc. (MVP) submitted the only premium price change request decided by the Board this quarter: the MVP 2021 Large Group HMO Filing. This premium price change request affected approximately 2,100 Vermonters. MVP proposed changing premiums by, on average, -1.2% for this book of business. Under the proposed change request, effected large employers would experience between a -6.91% to 6.07% change in their premium. The HCA appeared on behalf of Vermonters and submitted a memorandum in lieu of hearing in this matter. The Board ordered MVP to reduce the average premium charged by -4.3%, a 3.1% reduction below the -1.2% change MVP proposed.

There is one COVID-19 consumer rebate request pending at the end of this quarter: Cigna Health and Life Insurance Company COVID-19 Medical Premium Credit. Cigna Health and Life Insurance Company proposes to give a premium rebate to its guaranteed cost large group policyholders with effective dates from May 2019 to April 2020 considering decreased medical utilization due to COVID-19 and various related public health restrictions. The HCA will appear on behalf of Vermonters in this matter. Further, we intend to file all appropriate memoranda and other documents to represent the interests of Vermonters in this matter.

You can find this year's HCA Qualified Health Plan post hearing memos here:

BCBS *https://ratereview.vermont.gov/sites/dfr/files/PDF/GMCB%20005-20rr_HCA_PostHearingMemorandum.pdf*

MVP *https://ratereview.vermont.gov/sites/dfr/files/PDF/GMCB-006-20rr_HCA_PostHearingMemorandum.pdf*

Hospital Budget Review

The HCA participates in the Board's annual hospital budget review process, which ends in September. Following this year's budget review, Chief Mike Fisher spoke at the Green Mountain Care Board's public Hospital Budget Debrief session. Chief Fisher thanked the hospitals for their hard work during the Covid-19 epidemic, but stressed the need for Vermonters to be able to access affordable health care.

Oversight of Accountable Care Organizations

The HCA participates in the Board's annual ACO budget review process. This quarter, the HCA reviewed OneCare Vermont's annual budget submission, including its responses to Board and HCA questions. We also participated in OneCare's budget hearing before the Board, submitted follow-up questions to OneCare, and met separately with OneCare and Board staff to discuss questions and concerns we had about the budget submission and process. Finally, we submitted comments to the Board which reviewed our analysis of OneCare's budget. Our comments can be found by following this *link*. They focused largely on our concerns regarding OneCare's changes to its risk model, it's low investment in care management, and its lack of a clear conceptual model for measuring population health investment impacts.

Other Green Mountain Care Board and other agency workgroups

Over the last quarter, the HCA attended the Board's weekly board meetings and monthly Data Governance meetings. In addition, we began attending the Board's newly-formed Prescription Drug Technical Advisory Group meetings.

The HCA has continued to participate in a stakeholder work group run by the Department of Financial Regulation (DFR). The DFR work group dealt with ongoing regulatory issues related to the Covid-19 pandemic. We also continued to participate in the Statewide Telehealth Clinical Quality & Audio-Only Telemedicine workgroup organized by VPQHC this quarter. These weekly meetings included presentations by national and local experts who gave testimony on the many dynamics when care is delivered over audio-only and telemedicine platforms and the impacts on quality and cost.

Vaccine Implementation Advisory Committee

The COVID-19 Vaccine Implementation Advisory Committee serves in an advisory role to the Commissioner of Health. It was given the charge of assisting with four primary activities including identify and reach critical populations, promote COVID-19 vaccination, develop crisis and risk communication messaging, and to carry out the vaccine implementation plan.

The HCA reached out to the Vermont DOH early in the process to advocate for inclusion of representatives from Vermont's communities of color on this committee. The HCA has joined with the majority of the advisory committee and the Commissioner of Health to prioritize Vermont populations who are most likely to experience severe illness or death as a result of a COVID infection.

We also believe that Vermont must prioritize populations in correctional facilities and other congregate living environments where people cannot isolate from each other. In addition, we must take all available steps to offer vaccinations to BIPOC communities who are at increased risk due to a long history of systemic racism that has resulted in unequal access to our health care system and other social determinants that increase their risks.

The Medicaid and Exchange Advisory Committee

The Medicaid and Exchange Advisory Committee met two times during this quarter. The HCA participated in these meetings which had a focus on results from the Vermont Medicaid Next Generation Program (Medicaid component of the All-Payer Model Agreement), Proposed Recommendations for coverage of health care services delivered by telephone post public health emergency, Global Commitment to Health demonstration waiver and updates on open enrollment.

Legislative Advocacy

The Vermont Legislature was not in session during this quarter.

The HCA reached out to all Candidates for the General Assembly to remind them that the HCA Helpline is an important resource for the people in their communities who are experiencing any kind of access to care challenges. In addition, the HCA worked with key legislators during this time period to assist in the development of legislative strategies for 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
Blue Cross Blue Shield of Vermont
Community Catalyst
Vermont Department of Financial Regulation
Families USA
Georgetown University Health Policy Institute
IRS Taxpayer Advocate Service
MVP Health Care
National Center for Transgender Equality
NHeLP, National Health Law Program
OneCare Vermont
Outright Vermont
Pride Center of Vermont
Planned Parenthood of Northern New England

Rights and Democracy Vermont
Rural Vermont
SHIP, State Health Insurance Assistance Program
United States of Care
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
VPRIG
You First

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

* means the page moved into the top 20 this quarter

The **top-20 health pages** on our website this quarter — which was during the COVID-19 emergency:

Income Limits - Medicaid – 2,016 pageviews
Health - section home page – 1,435
Dental Services – 647
Medicare Savings Programs – 497
Medicaid – 461
News: Coronavirus and Long-Term Care – 449
Services Covered - Medicaid – 443 *
Resource Limits - Medicaid – 419
Medicaid, Dr. Dynasaur & Vermont Health Connect – 342
HCA Help Request Form – 322 pageviews and 109 online help requests
Long-term Care – 286
Advance Directive forms – 231
Medical Decisions: Advance Directives – 208

Vermont Health Connect – 207
Prescription Help – State Pharmacy Programs – 205
Choices for Care – 201
Medicaid and Medicare Dual Eligible – 178
Transportation for Health Care – 176
Dr. Dynasaur – 176 *
News: Coronavirus SEP for Vermont Health Connect – 168

We also had this timely news item: *It's Open Enrollment Time for Health Care Plans. ReviewYour Options!* – 89

The top-10 health pages **during the last week of the quarter**:

Income Limits - Medicaid – 120
Health - section home page – 78
Dental Services – 60
Services Covered - Medicaid – 34
Long-term Care – 26
Medicare Savings Programs – 23
Medicaid, Dr. Dynasaur & Vermont Health Connect – 20
Medicaid – 19
Advance Directive forms – 18
Resource Limits - Medicaid – 18

Outreach and Education

The Office of the Health Care Advocates' (HCA) ability to conduct in-person outreach activities was limited this quarter because of the COVID-19 pandemic. By using virtual platforms, we were still able to reach Vermonters with information about our office and health care programs.

October 29, the Chief Health Care Advocate, Mike Fisher, gave a presentation to a class of 25 social work policy students. He provided the audience with topical information about the health policy and advocacy in Vermont in addition to promoting the assistance that our healthcare advocates can provide to Vermonters. There was particular focus on questions about corrections populations, reproductive health, issues around homelessness, and racial justice.

October 29, the HCA's Communications Coordinator, Alicia Roderigue, collaborated with a member of our Advocacy Team to host an hour-long Town Hall event that provided views with consumer education on the Open Enrollment Period and plan design. Viewers were also given the opportunity to ask the presenters questions. This presentation received 170 views from November 1 - December 15, 2020.

December 1, Alicia Roderigue and two advocates gave an interactive presentation in collaboration with Rural Vermont, specifically geared toward providing health insurance literacy and eligibility information to members of the agricultural community. Twenty-three people attended this presentation live, and it has been subsequently viewed 128 times. This presentation also helped us develop a stronger

referral network between our office and members of the agricultural community who often face complicated questions around financial eligibility for health insurance.

December 8, Mike Fisher and the HCA's Supervising Attorney, Marjorie Stinchcombe, gave an educational presentation to the OneCare Vermont Patient and Family Advisory Committee which provided consumer education on the policy and advocacy work that our office engages in and the impact of the COVID-19 pandemic on health care programs.

We connected with 11 additional organizations from across Vermont that provide direct service to immigrants in refuges to disseminate information about the free assistance our office can offer. Health insurance eligibility rules can be complicated for this population, so we conducted this outreach in an effort to better meet the needs of this community. We also communicated with restaurants in Chittenden County and provided them with outreach material as we wanted to make an effort to connect with those who may have experienced a change in income because of COVID.

The HCA also spent a considerable amount of time this quarter providing Vermonters with consumer education about the Open Enrollment Period. In late October, we contacted candidates who were running for elected office and highlighted the upcoming Open Enrollment Period in the hopes that they would use us as a referral resource if their potential constituents experienced an issue. In addition, we used Front Porch Forum, Facebook, and listservs to connect with over 1,500 Vermonters to provide information about the Open Enrollment Period and the free help that our office can offer.

We also connected with organizations such as Planned Parenthood of Northern New England and Vermont Access to Reproductive Freedom to develop a stronger referral system.

This has helped our office connect with an array of Vermonters who often have urgent access to care questions.

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**:**

Medicaid MAGI verification
VHC Renewal Bump out letter
MABD Renewal Bump out letter
MAND Renewal Bump out letter, version #2
1095-A cover letter
1095-B cover letter
Emergency Medicaid letter

Office of the Health Care Advocate

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

https://vtlawhelp.org/health

CY 2020 Investment Expenditures

Department	Receiver Suffix	Investment Description	QE 0320	QE 0620	QE 0920	QE 1220	CY 2020 Total
AHSCO	9091	Investments (STC-79) - 2-1-1 Grant (41)	113,118	113,663	75,500	113,250	**415,531**
AHSCO	9090	Investments (STC-79) - Designated Agency Underinsured Servi	1,654,744	1,639,345	1,673,017	4,996,257	**9,963,363**
AOE	n/a	Non-state plan Related Education Fund Investments					**-**
DCF	9402	Investments (STC-79) - Medical Services (55)	19,357	13,078	8,689	49,312	**90,436**
DCF	9403	Investments (STC-79) - Residential Care for Youth/Substitute Ca	1,912,130	265,814	1,200,635		**3,378,579**
DCF	9405	Investments (STC-79) - Aid to the Aged, Blind and Disabled CCL	1,044,408	474,808	1,583,997	812,608	**3,915,821**
DCF	9406	Investments (STC-79) - Aid to the Aged, Blind and Disabled Res	29,590		6,604	58,057	**94,251**
DCF	9407	Investments (STC-79) - Aid to the Aged, Blind and Disabled Res	64,468		15,322	134,259	**214,049**
DCF	9408	Investments (STC-79) - Essential Person Program (59)	219,628	209,048	196,661	188,979	**814,316**
DCF	9409	Investments (STC-79) - GA Medical Expenses (60)	51,744	47,631	38,508	52,199	**190,082**
DCF	9411	Investments (STC-79) - Therapeutic Child Care (61)	376,070	271,275	237,396	226,569	**1,111,310**
DCF	9412	Investments (STC-79) - Lund Home (2)	736,919	675,522	778,541	761,100	**2,952,082**
DCF	9413	Investments (STC-79) - Prevent Child Abuse Vermont: Shaken B	aby (33)				**-**
DCF	9414	Investments (STC-79) - Prevent Child Abuse Vermont: Nurturing	60,572	(60,572	8,683	34,332	**43,015**
DCF	9415	Investments (STC-79) - Challenges for Change: DCF (9)	53,402		8,757	131,122	**193,281**
DCF	9416	Investments (STC-79) - Strengthening Families (26)	273,766	219,326	225,256	206,024	**924,371**
DCF	9417	Investments (STC-79) - Lamoille Valley Community Justice Proj	39,744	57,461	71,948	49,723	**218,876**
DCF	9418	Investments (STC-79) - Building Bright Futures (35)	67,756	140,506	67,209	128,553	**404,023**
DDAIL	9602	Investments (STC-79) - Mobility Training/Other Svcs.-Elderly Vis	91,642	92,368	93,734	34,308	**312,053**
DDAIL	9603	Investments (STC-79) - DS Special Payments for Medical Servic	1,857,013	310,534	808,478	(239,405	**2,736,619**
DDAIL	9604	Investments (STC-79) - Flexible Family/Respite Funding (27)	983,521		75,281	503,660	**1,562,461**
DDAIL	9605	Investments (STC-79) - Quality Review of Home Health Agencie	s (42)				**-**
DDAIL	9606	Investments (STC-79) - Support and Services at Home (SASH)	204,345	281,716	245,070	245,633	**976,764**
DDAIL	9607	Investments (STC-79) - HomeSharing (77)	77,635	77,592	81,580	69,603	**306,410**
DDAIL	9608	Investments (STC-79) - Self-Neglect Initiative (78)	75,990	75,447	64,026		**215,462**
DDAIL	9609	Investments (STC-79) - Seriously Functionally Impaired: DAIL (6	12,503	11,735		2,969	**27,207**
DMH	9501	Investments (STC-79) - Special Payments for Treatment Plan S	35,672	21,303	16,620	24,413	**98,007**
DMH	9502	Investments (STC-79) - MH Outpatient Services for Adults (66)	1,610,793	32,902	398,193	988,212	**3,030,100**
DMH	9504	Investments (STC-79) - Mental Health Consumer Support Progr	166,746	61,620	91,959	117,989	**438,314**
DMH	9505	Investments (STC-79) - Mental Health CRT Community Support	1,113,801	771,062	1,086,396	3,305,248	**6,276,507**
DMH	9506	Investments (STC-79) - Mental Health Children's Community Se	1,375,069	301,214	403,388	1,123,124	**3,202,795**
DMH	9507	Investments (STC-79) - Emergency Mental Health for Children a	6,186,457		1,217,902	3,496,515	**10,900,875**
DMH	9508	Investments (STC-79) - Respite Services for Youth with SED an	813,840		168,260	502,874	**1,484,974**
DMH	9510	Investments (STC-79) - Emergency Support Fund (22)	376,000		68,296	223,564	**667,861**
DMH	9511	Investments (STC-79) - Institution for Mental Disease Servcies:	5,575,018	3,147,877	3,392,466	5,692,426	**17,807,787**
DMH	9512	Investments (STC-79) - Institution for Mental Disease Servcies:	2,453,215	2,409,092	1,260,479	884,829	**7,007,616**
DMH	9514	Investments (STC-79) - Seriously Functionally Impaired: DMH (6	18,855	8,803	80,661	17,626	**125,945**
DMH	9516	Investments (STC-79) - Acute Psychiatric Inpatient Services (13	788,263	766,198	93,629	338,561	**1,986,650**
DOC	n/a	Return House	138,725	90,306	85,638	90,560	**405,229**
DOC	n/a	Northern Lights	98,438	98,438	98,438	89,426	**384,740**
DOC	n/a	Pathways to Housing - Transitional Housing	254,634	259,415	221,855	143,794	**879,698**
DOC	n/a	St. Albans and United Counseling Service Transitional Housing (	67,477	67,641	44,619	52,721	**232,457**
DOC	n/a	Northeast Kingdom Community Action					**-**
DOC	n/a	Intensive Substance Abuse Program (ISAP)					**-**
DOC	n/a	Intensive Domestic Violence Program					**-**
DOC	n/a	Community Rehabilitative Care		1,268,475		867,917	**2,136,392**
DOC	n/a	Intensive Sexual Abuse Program					**-**
DOC	n/a	Vermont Achievment Center		172,674	102,059	138,316	**413,049**
DVHA	9101	Investments (STC-79) - Vermont Information Technology Leader	s/HIT/HIE/HCR (8)				**-**
DVHA	9102	Investments (STC-79) - Vermont Blueprint for Health (51)	791,428	757,323	713,879	709,911	**2,972,541**
DVHA	9103	Investments (STC-79) - Buy-In (52)	11,704	11,984	10,845	17,236	**51,768**
DVHA	9104	Investments (STC-79) - HIV Drug Coverage (53)	682	1,154	1,074	2,025	**4,935**
DVHA	9106	Investments (STC-79) - Patient Safety Net Services (18)	(2,817)		60	41,402	**38,645**
DVHA	9107	Investments (STC-79) - Institution for Mental Disease Services:	837,327	34,627	18,923		**890,877**
DVHA	9108	Investments (STC-79) - Family Supports (72)					**-**
DVHA	9109	DSR Investment (STC-83) – One Care VT ACO Quality & Health	-				**-**
DVHA	9110	DSR Investment (STC-83) – One Care VT ACO Advanced Com	-		1,399,689	2,500,313	**3,900,002**
DVHA	9111	DSR Investment (STC-83) - One Care VT ACO Primary Prevent	-				**-**
GMCB	n/a	Green Mountain Care Board					**-**
UVM	n/a	Vermont Physician Training	505,932	674,582	505,934	54,105	**1,740,553**
VAAFM	n/a	Agriculture Public Health Initiatives					**-**
VDH	9201	Investments (STC-79) - Emergency Medical Services (19)	156,190	90,293	79,105	100,648	**426,235**
VDH	9203	Investments (STC-79) - TB Medical Services (74)	670	12,234	22	490	**13,416**
VDH	9204	Investments (STC-79) - Epidemiology (40)	283,856	160,267	54,144	24,286	**522,552**
VDH	9205	Investments (STC-79) - Health Research and Statistics (39)	341,770	226,815	216,102	215,603	**1,000,290**
VDH	9206	Investments (STC-79) - Health Laboratory (31)	812,356	221,215	345,646	468,065	**1,847,283**
VDH	9207	Investments (STC-79) - Tobacco Cessation: Community Coalitio	329,282	499,626	335,187	262,994	**1,427,089**
VDH	9208	Investments (STC-79) - Statewide Tobacco Cessation (76)					**-**
VDH	9209	Investments (STC-79) - Family Planning (75)	394,479	284,428	237,205	425,972	**1,342,084**
VDH	9210	Investments (STC-79) - Physician/Dentist Loan Repayment Prog	ram (25)	354,600	86,300	312,511	**753,411**
VDH	9211	Investments (STC-79) - Renal Disease (73)					**-**
VDH	9213	Investments (STC-79) - WIC Coverage (37)	949,286	325,995		410	**1,275,691**
VDH	9214	Investments (STC-79) - Area Health Education Centers (AHEC)	108,295		443,419		**551,715**

VDH	9217	Investments (STC-79) - Patient Safety - Adverse Events (47)	12,770	8,563	120	1,744	**23,196**
VDH	9219	Investments (STC-79) - Substance Use Disorder Treatment (30)	1,230,889	1,380,046	418,216	124,445	**3,153,596**
VDH	9220	Investments (STC-79) - Recovery Centers (17)	427,012	487,183	66,974	537,787	**1,518,956**
VDH	9221	Investments (STC-79) - Enhanced Immunization (46)	99,642	16,046	17,825	81,081	**214,594**
VDH	9222	Investments (STC-79) - Poison Control (48)		61,918	32,501		**94,419**
VDH	9223	Investments (STC-79) - Public Inebriate Services, C for C (23)	475,043	263,300	301,322	57,670	**1,097,335**
VDH	9224	Investments (STC-79) - Fluoride Treatment (38)	8,505	11,641	6,661	5,032	**31,838**
VDH	9225	Investments (STC-79) - Medicaid Vaccines (24)					**-**
VDH	9226	Investments (STC-79) - Healthy Homes and Lead Poisoning Pre	47,836	88,019	23,686	19,903	**179,444**
VDH	9228	Investments (STC-79) - VT Blueprint for Health (44)	269,056	95,931	198,824	67,323	**631,135**
VSC	n/a	Health Professional Training	204,730		102,365	307,096	**614,191**
VVH	n/a	Vermont Veterans Home					**-**

Blueprint for Health

BP Investment

Budget Information

What We Do

The Vermont Blueprint for Health is a state-led, nationally-recognized initiative that helps health care providers meet the medical and social needs of people in their communities. The Blueprint's aim is constant: better care, better health, and better control of health care costs.

The Blueprint encourages initiatives to support and improve health care delivery. It promotes innovative initiatives aimed at improving health outcomes, increasing preventive health approaches, addressing quality of life concerns, and increasing access to quality care through patient-centered medical homes and community health teams.

Who We Serve

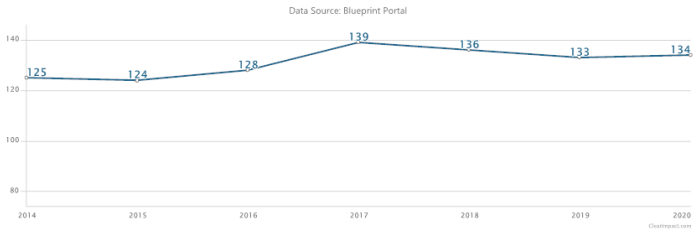
The Blueprint for Health serves all Vermonters.

How We Impact

Investment Objective:

Encourage the formation and maintenance of public-private partnerships in health care, including initiatives to support and improve the health care delivery system.

Measures	Most Recent Period	Current Actual Value	Current Target Value	True	Current Trend	Baseline % Change
PM BP # of primary care practices participating in the Blueprint	2020	134			1	72%
	2019	133			2	71%
	2018	136			1	74%
	2017	139			2	78%
	2016	128			1	64%
	2015	124			1	59%
	2014	125			3	60%
	2013	121			2	55%
	2012	101			1	29%



Notes on Methodology

- The number of participating practices per quarter is generated from data stored in the Blueprint portal (https://blueprintforhealthportal.vermont.gov/). The Blueprint Data Analyst manages information stored in the Blueprint portal.
- The goal figure for this measure was obtained by identifying all primary care practices in the Area Health Education Center (AHEC) survey database and immunization registry database, validating these primary care practices with our Blueprint Program Managers, and eliminating from the count practices with 1 FTE or less of a provider.

Partners

The Local Blueprint Transformation Network, which includes:

- Quality Improvement (QI) Facilitators
- Community Health Team leaders
- Program Managers

Story Behind the Curve

The data points in the above graph show the number of primary care practices who meet the NCQA standards for patient-centered medical home (PCMH) recognition and who participate in Blueprint initiatives.

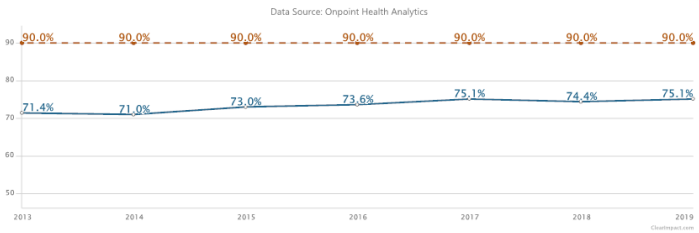
This measure is fundamental in assessing the reach of the Blueprint program. As larger numbers of practices qualify as PCMHs and are supported by Blueprint payments and field staff, high quality primary care becomes more available to Vermonters. The trend line above clearly highlights the rapid increase in practice participation in the Blueprint as NCQA-recognized PCMHs beginning in 2011. The initial rapid increase is the result of a coordinated effort by the Blueprint team to comply with the enactment of Act 128 in May 2010 by the Vermont General Assembly. The Act mandated the statewide expansion of the Blueprint, including practice recognition as PCMHs. Evidence of this expansion required a minimum of two primary care practices in each health service area (HSA) becoming PCMHs by July 2011. The Act additionally required the involvement of all willing primary care providers in Vermont have the opportunity to participate by October 2013, thereby achieving a statewide presence. A significant achievement in 2010 that paved the way towards compliance with Act 128 was the Blueprint's successful application for the Centers for Medicare & Medicaid Services' Multi-Payer Advanced Primary Care Practice (MAPCP) Demonstration Project. In mid-July, Medicare joined all other major insurers in Vermont in contributing to the financial payments to PCMHs.

Since 2013, Blueprint Quality Improvement Facilitators and Program Managers have continued to engage providers across the State to encourage and inspire participation. Quality Improvement facilitators, highly skilled and intensively trained clinical and process coaches, work with primary care practices throughout the state to guide them as they make quality improvement changes on the path towards becoming PCMHs and after to ensure practices continue to provide high quality healthcare and well-coordinated health services.

The Blueprint has approached a saturation point where the program has recruited most of the available primary care practices in the state, and the rate of onboarding of new practices has generally plateaued. Recent fluctuation in the number is often due to practices closing or merging. In the 10 years since the beginning of the program expansion, only 3 practices have dropped out primarily due to reporting requirements or because their patient panel was not a good fit for PCMH recognition. However, with changes to the NCQA recognition process that has made it less burdensome, the vast majority of practices have stayed in the program and additional practices have joined in recent years due to the outreach efforts of the Blueprint Quality Improvement Facilitators and Program Managers. Generally, the practices that are continuing to join the Blueprint are independent and naturopathic practices.

Narrative last updated: 3/24/2020

PM BP % of patients served by patient-centered medical homes (PCMHs)



2019	75.1%	90.0%		1	55%
2018	74.4%	90.0%		1	53%
2017	75.1%	90.0%		3	55%
2016	73.6%	90.0%		2	51%
2015	73.0%	90.0%		1	50%
2014	71.0%	90.0%		1	46%
2013	71.4%	90.0%		2	47%
2012	60.3%	90.0%		1	24%

Notes on Methodology

The percentage of Blueprint patients from the population of VHCURES members with a primary care visit is generated by Onpoint Health Analytics, the statewide administrator of the All-Payer Claims Dataset. Onpoint updates this percentage every 12 months.

The trend line for this measure should increase as additional practices join the Blueprint.

Partners

- The local Blueprint Transformation Network, which includes: QI Facilitators, Community Health Team leaders, and Project Managers
- Staff at Blueprint Patient-Centered Medical Homes (PCMHs)
- Green Mountain Care Board (GMCB)

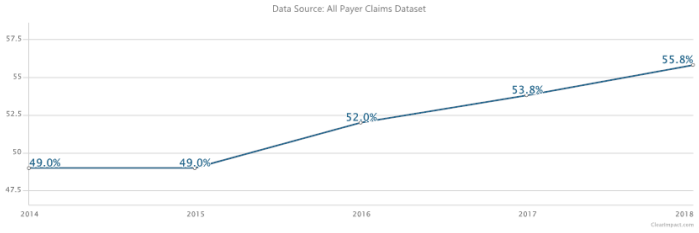
Story Behind the Curve

This is a measure of the percentage of Vermonters who receive their primary care from a Blueprint PCMH from the population of VHCURES members with a primary care visit. PCMHs provide top-quality primary care centered on several key evidence-based standards.

The trend line above indicates Vermont has seen a continued growth in the number of patients receiving care at patient-centered medical homes (PCMH). The growth in the percentage is primarily a reflection of an increase in the number of practices receiving NCQA recognition as a PCMH, with the largest increase occurring between 2011 and 2013. This period saw a broad coordinated effort to support practices in achieving PCMH recognition and to meet the legislative mandate that all willing primary care providers in Vermont to participate in the Blueprint by October 2013. Some of the more recent fluctuations in the proportion can be attributed to two factors: 1) the closing and merging of practices; and 2) changes in the data available through the all-payer claims database, VHCURES, such as when self-insured plans start or stop contributing data to the database. Nevertheless, the Blueprint for Health Quality Improvement Facilitators and Program Managers continue to encourage participation.

Narrative last updated: 3/24/2020

PM BP Statewide average % for Adolescent Well-Care Visits



2018	55.8%	3	14%
2017	53.8%	2	10%
2016	52.0%	1	6%
2015	49.0%	1	0%
2014	49.0%	0	0%

Notes on Methodology

- The statewide average percentage of the Adolescent Well-Child Visit performance measure was generated by Onpoint Health Data. The statewide average percentage of the Adolescent Well-Child Visit performance measure was listed in every Health Service Area Pediatric profile, which can be found here: (https://blueprintforhealth.vermont.gov/community-health-profiles).
- The statewide average percentage of the Adolescent Well-Child Visit performance measure is a claim-based measure pertaining only to a subset of the Vermont population - insured patients who received the majority of their primary care from a Blueprint practice. This measure is not a Vermont population-level estimate.

Partners

- The local Blueprint Transformation Network, which includes: QI Facilitators, Community Health Team leaders, and Project Managers
- Staff at Blueprint Patient-Centered Medical Homes
- Green Mountain Care Board (GMCB)

Story Behind the Curve

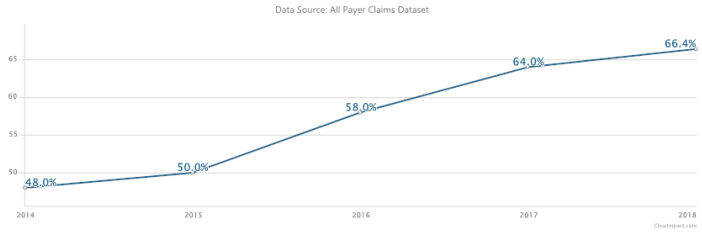
This measure is important because the Adolescent Well-Care (AWC) measure is the first of the four key indicators of quality health care. This measure assesses the statewide average percentage of members, ages 12–21 years, who had at least one well-care visit with a primary care practitioner or OB/GYN during the measurement year.

The Blueprint includes performance-based payments to encourage providers to participate in population and community health improvement initiatives with the goal of greater collaboration. These are key indicators that are in alignment with the All Payer Model core quality measures. Improvements in these areas are indicative of an evolving and improving system of care.

The trend line above, while moving towards the right direction, suggests an opportunity for improvement. The Blueprint implemented the pay for performance model on this measure in January 2016. This measure was chosen for payment because it reflected a priority of the provider network (ACO) in Vermont, it could be generated at the Health Service Area level using Vermont's centralized data source without any need for additional data collection or reporting by providers, it was tied to prevalent underlying health concern s involving complex medical and social determinants, and it could be imp roved through better coordination, outreach, and transitions between medical and non-medical providers. Since the implementation of the pay for performance model, a number of Health Service Areas have developed quality improvement policies on this measure.

Narrative last updated: 12/04/2020

PM BP Statewide average % for Developmental Screening in the First Three Years of Life



2018	66.4%	4	38%
2017	64.0%	3	33%
2016	58.0%	2	21%
2015	50.0%	1	4%
2014	48.0%	0	0%

Notes on Methodology

- The statewide average percentage of the Developmental Screening in the First Three Years of Life performance measure was gene rated by Onpoint Health Data, the statewide administrator of the All-Payer Claims Dataset. Onpoint updated this measure every six months, accounting for the next 6-month time period. The statewide average percentage of the Developmental Screening in the First Three Years of Life performance measure was listed in every Health Service Area Pediatric profile, which can be found here (https://blueprintforhealth.vermont.gov/community-health-profiles).
- The statewide average percentage of the Developmental Screening in the First Three Years of Life performance measure is a claim-based measure pertaining only to a subset of the Vermont population - insured patients who received the majority of their primary care from a Blueprint practice. This measure is not a Vermont population-level estimate.
- Since HEDIS does not produce national benchmarks on this measure, the goal has been identified as the Blueprint's metric of improvement in the Blueprint performance payment methodology, which is an increase of 5% each study period. The Blueprint performance payment methodology can be found here (https://blueprintforhealth.vermont.gov/implementation-materials)

Partners

- The local Blueprint Transformation Network, which includes: QI Facilitators, Community Health Team leaders, and Project Managers
- Staff at Blueprint Patient-Centered Medical Homes (PCMHs)
- Vermont Department of Health (VDH)
- Vermont Child Health Improvement Program (VCHIP)
- Green Mountain Care Board (GMBC)

Story Behind the Curve

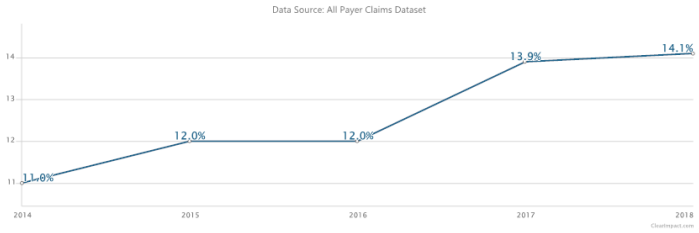
This measure is important because the Developmental Screening in the First Three Years of life (DEV) measure is the second of the four key indicators of quality health care. This measure assesses the percentage of children screened for risk of developmental, behavioral, and social delays using a standardized screening tool in the 12 months preceding their first, second, or third birthday.

The Blueprint includes performance-based payments to encourage providers to participate in population and community health improvement initiatives with the goal of greater collaboration. These are key indicators that are in alignment with the All Payer Model core quality measures. Improvements in these areas are indicative of an evolving and improving system of care.

The trend line above shows that there has been significant improvement on this measure due to the coordinated efforts of internal and external partners. The Blueprint implemented the pay for performance model on this measure in July 2015. This measure was chosen for payment because it reflected a priority of the provider network (ACO) in Vermont, it could be generated at the Health Service Area level using Vermont's centralized data source without any need for additional data collection or reporting by providers, it was tied to prevalent underlying health concerns involving complex medical and social determinants, and it could be improved through better coordination, outreach, and transitions between medical and non-medical providers.

Narrative last updated: 12/04/2020

PM BP Statewide average % for Diabetes in Poor Control



2018	14.1%	2	28%
2017	13.9%	1	26%
2016	12.0%	1	9%
2015	12.0%	1	9%
2014	11.0%	0	0%

Notes on Methodology

The statewide average percentage of the Diabetes in Poor Control performance measure was generated by Onpoint Health Data, the statewide administrator of the All-Payer Claims Dataset. Onpoint linked claims in the APCD to clinical records stored by Capitol Health Associates in the Clinical Registry. Onpoint updated this measure every six months, accounting for the next 6-month time period. The statewide average percentage of the Diabetes in Poor Control performance measure was listed in every Health Service Area Adult profile, which can be found here (https://blueprintforhealth.vermont.gov/community-health-profiles). This relies on data from the state's Clinical Registry and therefore is influenced when practices interrupt their data feed to the Clinical Registry. The outcomes described here are estimated using data only from individuals for whom claims data could be linked with valid Clinical Registry data. This non-random sampling variability is not accounted for in the measure.

Partners

- The local Blueprint Transformation Network, which includes: QI Facilitators, Community Health Team leaders, and Program Managers
- Staff at Blueprint Patient-Centered Medical Home
- Green Mountain Care Board (GMBC)

Story Behind the Curve

This measure is important because it is the third of 4 key indicators of quality health care. The Diabetes in Poor Control (i.e., Hemoglobin A1c>9%) assesses the percentage of continuously enrolled members with diabetes, ages 18–75 years, whose last recorded hemoglobin A1c test in the Clinical Registry was in poor control (>9%). This is a mixed methods measure relying both on claims and clinical data.

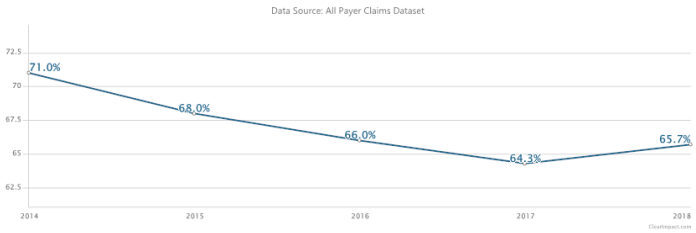
The Blueprint includes performance-based payments to encourage providers to participate in population and community health improvement initiatives with the goal of greater collaboration. These are key indicators that are in alignment with the All Payer Model core quality measures. Improvements in these areas are indicative of an evolving and improving system of care.

The trend line above suggests an opportunity for improvement given that the data is not moving in the right direction.

Across the network, practices are starting to implement concrete workflows to address diabetes management. For example, in Morrisville community in October 2019, both Stowe Family Practice and Morrisville Family Health Care planned the process to enhance their diabetic workflow, follow-up, and self-management assessment needs. In addition to supporting individuals with diabetes, those practices are now running registry reports for those identified as pre-diabetic based on preestablished criteria and reaching out to this group with information about the diabetes prevention self-management classes. Finally, they have incorporated improved data management and follow-up in a new electronic tracking system called ENLI with the goal of closely monitoring evidence-based follow-up care and self-management needs.
The community health team staff will assess and track the effectiveness of the outreach by performing in-depth chart reviews and ensuing notification of follow-up appointments and referrals.

Narrative last updated: 12/04/2020

PM BP Statewide average % of Blood Pressure in Control



2018	65.7%	1	-7%
2017	64.3%	3	-9%
2016	66.0%	2	-7%
2015	68.0%	1	-4%
2014	71.0%	0	0%

Notes on Methodology

The statewide average % for the Blood Pressure in Control performance measure was generated by Onpoint Health Data, the statewide administrator of the All-Payer Claims Dataset. Onpoint linked claims in the APCD to clinical records stored by Capitol Health Associates in the Clinical Registry. Onpoint updated this measure every six months, accounting for the next 6-month time-period. The statewide average percentage of the Hypertension in Control performance measure was listed in every Health Service Area Adult profile, which can be found here (https://blueprintforhealth.vermont.gov/community-health-profiles). This relies on data from the state's Clinical Registry and therefore is influenced when practices interrupt their data feed to the Clinical Registry. The outcomes described here are estimated using data only from individuals for whom claims data could be linked with valid Clinical Registry data. This non-random sampling variability is not accounted for in the measure.

Partners

- The local Blueprint Transformation Network, which includes: QI Facilitators, Community Health Team leaders, and Program Managers
- Staff at Blueprint Patient-Centered Medical Homes
- Vermont Department of Health
- OneCare Vermont
- Green Mountain Care Board (GMBC)

Story Behind the Curve

This measure is important because the measure is the fourth of the 4 key indicators of quality health care. The Blood Pressure in Control measure assesses the percentage of continuously enrolled members with hypertension, ages 18-85 years, whose last recorded systolic blood pressure was less than 140 mm/Hg and whose last recorded diastolic blood pressure was less than 90 mm/Hg.

The Blueprint includes performance-based payments to encourage providers to participate in population and community health improvement initiatives with the goal of greater collaboration. These are key indicators that are in alignment with the All Payer Model core quality measures. Improvements in these areas are indicative of an evolving and improving system of care.

The trend line above suggests an opportunity for improvement given that the data is not moving in the right direction. Managing hypertension has been chosen as the next formal DVHA Performance Improvement Project topic and a Blueprint representative is a standing member on that implementation team.

Narrative last updated: 12/04/2020

Actions

Name	Assigned To	Status	Due Date	Progress

File Attachments

File Name

Attachment 8: Payment Model Scorecard

P Integrating Family Services
CMS FS

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.

***Due to ongoing issues with transition to Electronic Health Records data available for reporting is based on fiscal year rather than calendar 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.

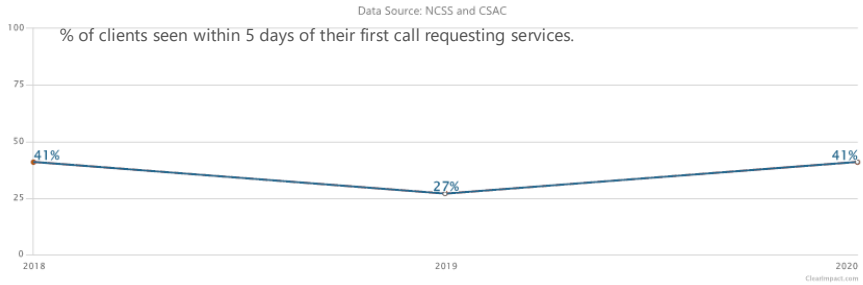
IFS providers are expected to serve a minimum caseload for the target population each year.

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.

Special Note related to COVID Pandemic: On March 24, 2020 Governor Scott issued a "Stay Home, Stay Safe" order that ordered Vermonters to restrict and minimize activities outside of the home and directed non-essential businesses and non—profits to cease in person operations. These orders have had a tremendous impact on the service delivery of mental health services throughout Vermont in all community-based settings and inpatient facilities.

Measures	Most Recent Period	Current Actual Value	Current Target Value	Current Trend
% of clients seen within 5 days of their first call requesting services.	2020	41%	41%	1
	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.

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.

For both of these agencies, as is true for the entire mental health system in Vermont and nationwide the COVID pandemic has put tremendous stress on the system. Due to that fact, DMH is not surprised by fluctuations in data which is being experienced in all agencies.

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

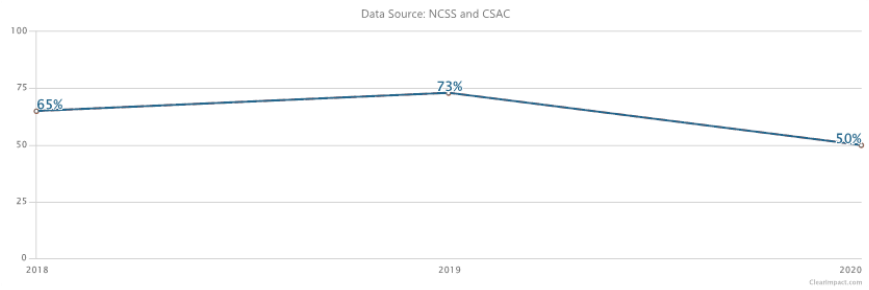
NCSS and CSAC

Notes on Methodology

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

Denominator: Total number of inactive clients requesting services.

PM CMS % of eligible clients with a CANS administered



2020	50%	50%	1
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.

For both of these agencies, as is true for the entire mental health system in Vermont and nationwide the COVID pandemic has put tremendous stress on the system. Due to that fact, DMH is not surprised by fluctuations in data which is being experienced in all mental health agencies across the state.

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

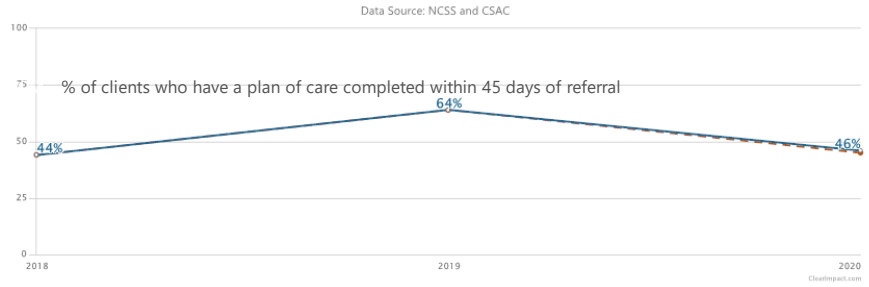
Partners

NCSS and CSAC.

Notes on Methodology

Numerator: All children with a first CANS administered

Denominator: All children eligible for a CANS receiving services



2020	46%	45%	1
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.

For both of these agencies, as is true for the entire mental health system in Vermont and nationwide the COVID pandemic has put tremendous stress on the system. Due to that fact, DMH is not surprised by fluctuations in data which is being experienced in all mental health agencies in Vermont.

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

Actions

Name	Assigned To	Status	Due Date	Progress

File Attachments

File Name