State of Vermont
Agency of Human Services

Global Commitment to Health
11-W-00194/1

Section 1115
Demonstration Year: 16
(1/1/2020 – 12/31/2020)

Quarterly Report for the period
April 1, 2020 – June 30, 2020

Submitted Via PMDA Portal on September 2, 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).

The initial Global Commitment to Health (GC) and Choices for Care (CFC) demonstrations were approved in September 2005, effective October 1, 2005. The GC demonstration was extended for three years, effective January 1, 2011, and again for three years effective October 2, 2013. The GC demonstration was again renewed for five years effective January 1, 2017. The CFC demonstration was extended for 5 years effective October 1, 2010. The following amendments have been made to the GC demonstration:

- 2007: a component of the Catamount Health 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 federal poverty level (FPL), and who do not have access to cost effective employer-sponsored insurance, as determined by the State.

- 2009: the state extended Catamount Health 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.

- 2012: CMS provided authority for the State to eliminate the $75 inpatient admission copay and to implement nominal co-payments for the Vermont Health Access Plan (VHAP) as articulated in the Medicaid State Plan.

- 2013: CMS approved the extension of the GC demonstration which included sun-setting the authorities for most of the 1115 Expansion Populations because they would be eligible for Marketplace coverage beginning January 1, 2014. The renewal also added the New Adult Group to the demonstration effective January 1, 2014. Finally, the renewal also included premium subsidies for individuals enrolled in a qualified health plan whose income is at or below 300 percent of the FPL.

- 2015: As of January 30, 2015, the GC demonstration was amended to include authority for the former Choices for Care demonstration. In addition, the State received section 1115 authority to provide full Medicaid State Plan benefits to pregnant women who are determined presumptively eligible.

- 2016: On October 24, 2016 Vermont received approval for a five-year extension of the Global Commitment to Health 1115 waiver, effective from January 1, 2017 through December 31, 2021.

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

- 2019: As of December 5, 2019, the Global Commitment to Health demonstration was amended to include authority for Vermont to receive federal Medicaid funding on payments to IMDs for individuals ages 22 to 64 receiving mental health (SMI/SED) treatment for short term acute care stays that are no more than 60 days and when the statewide average length of stay meets the expectation of 30 days or less.

As Vermont's Medicaid Single State Agency and under the Terms and Conditions of the Global Commitment to Health Waiver, AHS has entered into an Inter-Governmental Agreement (IGA) with the Department of Vermont Health Access (DVHA). The AHS/DVHA IGA functions similarly to a Medicaid Managed Care contract in that it delineates program requirements and responsibilities between AHS and DVHA and according to federal Medicaid Managed Care requirements found at 42 CFR §438. DVHA also has sub-agreements with the other State entities that provide specialty care for GC enrollees (e.g., mental health services, developmental disability services, and specialized child and family services).

One of the Terms and Conditions of the Global Commitment Waiver requires the State to submit progress reports 60 days following the end of each quarter. ***This is the second quarterly report for waiver year 16, covering the period from April 1, 2020 through June 30, 2020 (QE062020).***

II. Outreach/Innovative Activities

i. Member and Provider Services

Key updates from QE062020:
- COVID-19

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.

<u>COVID-19 Response</u>

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) has 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 will ensure that reimbursement rates remain stable through the Emergency period while providers and practices may be experiencing other changes to revenue and/or expenditures as a part of their COVID-19 response. Delaying these fee schedule updates will also ensure that provider stakeholders are 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 will be postponed until October 1, 2020 include:

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

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.

During 2019, DVHA had focused on provider outreach and education to increase utilization of telemedicine in order to reduce barriers to accessing care for Medicaid members. (The Department had previously implemented reimbursement parity for Medicaid covered services delivered through telemedicine but utilization remained low.) The circumstances surrounding the COVID-19 pandemic resulted in a substantial increase in the number of health care services delivered through telemedicine, as evidenced by the count of telemedicine services.

III. Operational/Policy Developments/Issues

i. Vermont Health Connect

Key updates from QE062020:

- The Customer Support Center received more than 66,250 calls in QE0620, down 21% from the previous year.
- The State of Vermont has awarded grants to two Navigator organizations for FY'21 with two Navigators in each organization. This will increase the number of program Navigators from two to four.
- Primarily through the use of technology and partnership with contractors and other State resources, the State of Vermont Assister program has worked to continue to provide support to Vermonters and accommodate their needs during the public health emergency despite limitations to in-person visits and mobility challenges.
- Increasing numbers of customers are using self-service functions. Self-serve applications comprised over half (58%) of all applications in QE0620. In addition, 62% of customers made recurring payments in QE0620. This is a 3% growth from the previous year.

Enrollment

As of QE0620, more than 204,063 Vermonters were enrolled in Vermont Health Connect (VHC) health plans either through the marketplace or directly through an insurance carrier. This enrollment consisted of 130,250 in Medicaid for Children and Adults (MCA) and 73,812 in Qualified Health Plans (QHPs), with the latter divided between 24,811 enrolled with VHC, 7,581 direct-enrolled with their insurance carrier as individuals, and 41,420 enrolled with their small business employer.

Member Experience

In response to the COVID-19 public health emergency, Vermont is facilitating initial and continuous health care enrollment by:

- Temporarily waiving financial verifications required for those seeking to enroll in health insurance.
- Temporarily suspending non-ex parte Medicaid renewals and extending Medicaid coverage periods until after the emergency ends.
- Temporarily suspending termination of Medicaid coverage during the Emergency period, except per customer request.
- Temporarily waiving Dr. Dynasaur premiums.
- Offering a Special Enrollment Period for uninsured Vermont residents who qualify for a Qualified Health Plan (QHP). If eligible, customers may receive premium and cost-sharing assistance. This Special Enrollment Period is currently open through August 14, 2020 (eligible Vermonters can continue to apply for, and enroll in, Medicaid at any time).

Visit https://dvha.vermont.gov/covid-19 for more information on how Vermont is implementing similar changes for Long-Term Care Medicaid.

Medicaid Renewals

The first month of the quarter had Medicaid for Children and Adults (MCA) renewal applications mailed in early March, before the declaration of the COVID-19 national emergency, and due in April. Applications were fully processed for those who responded and remained eligible with no decrease in

benefits or increase in premium. For the remainder, including those who did not respond, current coverage was extended. Those renewals will be rescheduled post-emergency.

During the subsequent two months, and for the duration of the public health emergency, MCA redeterminations are processed only for cases that can be renewed ex parte. Cases that require an application have coverage extended; renewals will be rescheduled.

The passive renewal success rate for the quarter averaged 50%.

1095 Tax Forms

2019 1095B corrections started mailing on 4/15/20. As of 7/24/20 a total of 601 corrected 1095B's have been mailed. The numbers are significantly lower this year, which may be due to the change in the penalty for not having health care coverage.

Customer Support Center

Maximus continues to manage the VHC Customer Support Center (call center). The Customer Support Center serves Vermonters enrolled in both public and private health insurance coverage by providing support with phone applications, payment, basic coverage questions, and change of circumstance requests.

The Customer Support Center received more than 66,250 calls in QE0620, down 21% from the previous year. Maximus answered 90% of calls within 24 seconds in April 2020, 92% in May 2020, and 96% in June 2020. With increased staffing and lower call volumes, Maximus met the target in QE0620.

Maximus is also the entry point for individuals requiring greater levels of assistance with case resolution. Maximus representatives transfer such calls to DVHA-HAEEU for resolution and log service requests, which are escalated to the appropriate resolver group. This year has seen a decrease in the volume of calls with a slight increase in the proportion of calls that were escalated. 8% of QE0620 calls were transferred to DVHA-HAEEU staff, up from 7.18% in QE0619. Just as importantly, DVHA promptly answered the calls that were transferred; 93% of transferred calls were answered in five minutes in QE0620, compared to 97% in QE0619.

Timely Processing of Member Requests

In the spring of 2016, DVHA-HAEEU set a goal of completing 75% of member requests within ten business days by October 2016 and 85% by June 2017. In QE0316, fewer than 60% of VHC requests were completed within ten days. In QE0317, more than 90% of requests were completed within ten days. In QE0318 and again in QE0319, more than 95% of VHC requests were completed within ten days. In the most recent quarter (QE0620), more than 83% of the VHC requests were completed within the same ten-day time period.

System Performance

The system continued to operate as expected throughout QE0620, achieving 100% availability outside of scheduled maintenance in each of the three months. The average page load time for the quarter was

1.9 seconds in each of the three months – slightly under the two-second target.

In-Person Assistance

As of June 2020, DVHA was supported by 112 Assisters (106 Certified Application Counselors, 2 Navigators, and 4 Brokers), serving all of Vermont's 14 counties and located in, but not limited to, hospitals, clinics, and community-based organizations.

Outreach

Vermont Health Connect's website continued to be a key source of information for current and prospective customers alike, receiving more than 60,668 visits in the quarter – a 48% decrease over the previous quarter. The decrease from last quarter is most likely due to the programmatic changes related to the COVID-19 pandemic in which we are not actively mailing out notices that would cause website traffic.

The Plan Comparison Tool, which helps customers estimate total costs of coverage based on family members' age, health, and income, was used in more than 9,751 sessions during the quarter.

Self-Service

During QE0620, DVHA-HAEEU continued to promote self-service options for customers to pay their bills, report changes, and access tax documents and other forms. Self-service leads to an improved customer experience as Vermonters can log in at their convenience. It also has the benefit of using automation to reduce staffing expenses. Year-over-year comparisons show that more customers are using self-service functions, including both online accounts for health coverage applications and reported changes as well as the options of paying premiums through monthly recurring payments rather than one-time payments.

Self-serve applications comprised over half (58%) of all applications in QE0620. More than 6,400 customers made recurring payments per month in QE0620. Overall, 62% of total payments made per month are recurring payments.

i. Choices for Care and Traumatic Brain Injury Programs

Key updates from QE062020:

- Choices for Care Regulations adopted February 27, effective date April 15, 2020.
- DAIL responds to COVID-19 pandemic with submission of 1135 Waiver and Appendix K.

DAIL has responded to the COVID-19 pandemic by requesting increased flexibility in established Waiver. DAIL COVID-19 resources can be found online here: https://dail.vermont.gov/novel- coronavirus-information

Nursing Homes use CMP Funds to purchase technology

33 Nursing Homes in Vermont applied for and received grants of up to $3000 to purchase technology

to facilitate both social visits and telemedicine visits for residents impacted by the State of Vermont Stay Home/Stay Safe order.

Choices for Care Regulations

DAIL held a public hearing on October 4, 2019. Two people appeared in person at the hearing and no people participated by phone. DAIL also received three written comments submitted by Vermont Legal Aid, Visiting Nurses Associations of Vermont and the Vermont Health Care Association. DAIL resolved most comments regarding language recommendations with no impact on the rules. Other comments were acknowledged with an explanatory response from DAIL. DAIL submitted the final proposed regulations to the Legislative Committee on Administrative Rules and a public hearing was held in front of the committee on February 27, 2020. Choices for Care Regulations were subsequently adopted with an effective date of April 15, 2020. All comments and responses can be found on this web page, and the adopted rules can be found online here: https://humanservices.vermont.gov/sites/ahsnew/files/documents/MedicaidPolicy/HCARAdopted/7.102-Choices-for-Care.pdf

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.

Money Follows the Person (MFP)

DAIL secured federal funding for calendar year (CY) 2020 to continue this grant. The $2.8M federal dollars received should allow for the transitioning of 44 MFP participants. COVID-19 restrictions have significantly impaired DAIL's ability to transition participants safely to the community.

DAIL is in continued negotiations with CMS for more than a year to year commitment to this grant program. Currently, funds are expected to be available for MFP transitions through CY2021 and grant closeout activities scheduled for CY2022.

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

ii. Developmental Disabilities Services Division

Key updates from QE062020:

- Coronavirus 19 Response

Coronavirus 19 Response

The quarter ending 062020 was dominated by responses to the coronavirus pandemic. The Developmental Disabilities Services Division (DDSD) took immediate steps to protect the health and safety of developmental services recipients as well as introducing new means of connecting with providers, recipients and advocates. Actions taken include:

1. Immediate suspension of non-essential face to face services in order to reduce the risk of disease transmission. Non-essential services were considered to be those not essential to protect the health and safety of DS recipients, such as community supports.
2. Immediate changes to service delivery requirements supporting health and safety, including but not limited to; personal protective equipment requirements, new allowances for telehealth services, transportation guidelines, home-visiting requirements, signature requirements, and redeployment of support staff.
3. Temporary change to the DDSD HCBS daily rate payment model to a bi-weekly case rate to improve predictability and sustainability of providers during the pandemic.
4. Weekly provider video calls and twice monthly advocacy and stakeholder video town-halls.
5. New Difficulty of Care stipends for unpaid family caregivers who were providing care in lieu of typically available support services.
6. Difficult of Care stipends for shared living providers who were providing additional care in lieu of typically available support services.

New Payment Model in Development

The Developmental Disabilities Services Division (DDSD) and DVHA have initiated a project to explore a new payment model for Developmental Disabilities home and community-based services (HCBS). 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 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. 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

Work on HCBS rules implementation was paused in the quarter ending 062020 due to 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 and DDSD is waiting for review and comments from CMS. In addition, DDSD is developing policy guidance for providers to ensure compliance with the rules. The DDSD Quality Management Unit has incorporated oversight of HCBS rule requirements into their overall quality review process to ensure ongoing compliance with the rules. 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.

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

Wait List

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

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

There were no individuals who met a HCBS funding priority who were waiting for services that helps address the need related to the funding priority. As of 6/30/19, there were 276 people who requested HCBS services but were denied because they did not meet a funding priority. 23 people were waiting for FMR and 13 were waiting for FFF. There was no one waiting for TCM or PSEI. The waiting list is

monitored by providers to determine if people have a change in circumstance that makes them eligible to receive HCBS. The waiting list is also reviewed when additional funds become available for other programs.

iii. Global Commitment Register

Key updates from QE062020:

- 9 policies were posted to the GCR in Q2 2020.
- Since the Global Commitment Register (GCR) launched in November 2015, 213 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 DVHA website to ensure that policy changes are transparent to Vermonters and to provide a forum for public comments.

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

Health care policy stakeholders are notified via email every time a proposed or final policy is posted to the GCR; an email is also sent when policy clarifications are posted. Stakeholders have an opportunity to provide comments on proposed GCR policies before the policies are made final. Comments received are posted in the GCR online. The GCR emails are also distributed to members of the Medicaid and Exchange Advisory Board.

A combined total of 9 policies were posted to the GCR this past quarter. This includes 6 proposed changes and 3 final changes. Changes include updates to rates and/or rate methodologies, clinical coverage changes, administrative rulemaking notices, and policy changes stemming from the public health emergency and the COVID-19 pandemic.

The GCR can be found here: https://humanservices.vermont.gov/about-us/medicaid-administration/global-commitment-register.

iv. 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 QE062020:

- Reporting on metrics begins with the second quarter report of 2020 (QE0620).
- 10 hospitals are participating in the Recovery Coaches in the Emergency Room Program.
- The Substance Use Disorder Treatment Standards and Compliance Assessment Tool were effective January 1, 2020.
- VT Helplink launched for public use in March 2020.

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. Many treatment providers have shifted to telemedicine, while others have adjusted daily census and implemented social distancing and other strategies to continue serving patients during the COVID-19 pandemic.

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

ADAP put on hold 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. The episodic payments were adjusted for a January 1, 2020 effective date.

ADAP's centralized intake and resource center, "VT Helplink: Alcohol and Drug Support Center" launched for public use in March 2020. Major components include: 1) a call center staffed by certified Screening & Intake Specialists and licensed clinicians, 2) a website with information related to SUD and a self-screen tool, and 3) an appointment board to connect callers in need of treatment with appointments to ADAP's Preferred Provider Network. ADAP continues work to onboard SUD treatment providers into the provider portal.

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 seven times between October 2019 to July 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

Vermont launched the Recovery Coaches in the Emergency Department Program on July 1, 2018. 10 hospitals are participating in the program.

The plan for the SUD Mid-Point Assessment was determined. An internal team was established and is executing the plan. A survey of Preferred Providers was administered to collect their input regarding implementation of milestones #2 and #3 during 2019. The survey was reissued to applicable Preferred Providers during QE0620.

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.			
[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			There are no planned changes to the target population or clinical criteria.

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?			
Are there any other anticipated program changes that may impact metrics related to assessment of need and qualification for SUD services? If so, please describe these changes.			There are no anticipated program changes.
☒ The state has no implementation update to report for this reporting topic.			

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

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

Prompts	Demonstration Year (DY) and quarter first reported	Related metric (if any)	Summary
Milestone 1 Metric Trends			
Discuss any relevant trends that the data shows related to assessment of need and qualification for SUD services. At a minimum, changes (+ or -) greater than two percent should be described.			
[Add rows as needed]			
☒ The state has no metrics trends to report for this reporting topic.			
Milestone 1 Implementation Update			
Prompts: Compared to the demonstration design and operational details outlined the implementation plan, have there been any changes or does the state expect to make any changes to: a. Planned activities to improve access to SUD treatment services across the continuum of care for Medicaid beneficiaries (e.g. outpatient services, intensive outpatient services, medication assisted treatment, services in intensive residential and inpatient settings, medically supervised withdrawal management)? SUD benefit coverage under the Medicaid state plan or the Expenditure Authority, particularly for residential treatment, medically supervised withdrawal management, and medication assisted treatment services provided to individuals in IMDs?			

Summary: There are no planned changes to access SUD treatment or the SUD benefit coverage.			
Are there any other anticipated program changes that may impact metrics related to access to critical levels of care for OUD and other SUDs? If so, please describe these changes.			There are no anticipated program changes.
☒ The state has no implementation update to report for this reporting topic.			

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

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

Prompts	Demonstration Year (DY) and quarter first reported	Related metric (if any)	Summary
Milestone 2 Metric Trends			
☒ The state is not reporting any metrics related to this reporting topic.			
Milestone 2 Implementation Update			
Prompts: Compared to the demonstration design and operational details outlined the implementation plan, have there been any changes or does the state expect to make any changes to: a. Planned activities to improve providers' use of evidence-based, SUD-specific placement criteria? b. Implementation of a utilization management approach to ensure: i. Beneficiaries have access to SUD services at the appropriate level of care? ii. Interventions are appropriate for the diagnosis and level of care? iii. Use of independent process for reviewing placement in residential treatment settings? **Summary:** The current version of the Substance Use Disorder Treatment Standards is being used. The Compliance Assessment Tool has been utilized with 31 substance use disorder treatment provider locations. The Substance Use Disorder Treatment Standards and corresponding compliance assessment tool were effective January 1, 2020.			

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 put on hold 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. Vermont anticipates resuming work on the residential value-based payment model in fall of 2020 if the impact of the COVID pandemic on the residential providers and state staff involved in the project stabilizes.

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 31 substance use disorder treatment provider locations. The Substance Use Disorder Treatment Standards and corresponding compliance assessment tool were effective January 1, 2020.			
Are there any other anticipated program changes that may impact metrics related to the use of nationally recognized SUD-specific program standards to set provider qualifications for residential treatment facilities (if the state is reporting such metrics)? If so, please describe these changes.			
☐ The state has no implementation update to report for this reporting topic.			

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

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

Prompts	Demonstration Year (DY) and quarter first reported	Related metric (if any)	Summary
Milestone 4 Metric Trends			
Discuss any relevant trends that the data shows related to assessment of need and qualification for SUD services. At a minimum, changes (+ or -) greater than two			

percent should be described.			
[Add rows as needed]			
☒ The state has no metrics trends to report for this reporting topic.			
Milestone 4 Implementation Update			
Prompts: Compared to the demonstration design and operational details outlined the implementation plan, have there been any changes or does the state expect to make any changes to planned activities to assess the availability of providers enrolled in Medicaid and accepting new patients in across the continuum of SUD care? **Summary**: Vermont put on hold 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 anticipates resuming work on the residential value-based payment model in fall of 2020 if the impact of the COVID pandemic on the residential providers and state staff involved in the project stabilizes. ADAP's centralized intake and resource center "VT Helplink: Alcohol and Drug Support Center" launched for public use March 2020. Major components include: 1) a call center staffed by certified Screening & Intake Specialists and licensed clinicians, 2) a website with information related to SUD and a self-screen tool, and 3) an appointment board to connect callers in need of treatment with appointments to ADAP's Preferred Provider Network. ADAP continues work onboard SUD treatment providers into the provider portal.			
Are there any other anticipated program changes that may impact metrics related to provider capacity at critical levels of care, including for medication assisted treatment (MAT) for OUD? If so, please describe these changes.			
☐ The state has no implementation update to report for this reporting topic.			

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

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

Prompts	Demonstration Year (DY) and quarter first reported	Related metric (if any)	Summary
Milestone 5 Metric Trends			
Discuss any relevant trends that the data			

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

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

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

Prompts	Demonstration Year (DY) and quarter first reported	Related metric (if any)	Summary
Milestone 6 Metric Trends			
Discuss any relevant trends that the data shows related to assessment of need and qualification for SUD services. At a minimum, changes (+ or -) greater than two percent should be described.			

[Add rows as needed]			
☒ The state has no metrics trends to report for this reporting topic.			
Milestone 6 Implementation Update			
Prompts: Compared to the demonstration design and operational details outlined the implementation plan, have there been any changes or does the state expect to make any changes to implementation of policies supporting beneficiaries' transition from residential and inpatient facilities to community-based services and supports? **Summary**: Vermont launched the Recovery Coaches in the Emergency Department Program on July 1, 2018. 10 hospitals are participating in the program.			
Are there any other anticipated program changes that may impact metrics related to care coordination and transitions between levels of care? If so, please describe these changes.			
☐ The state has no implementation update to report for this reporting topic.			

SUD Health Information Technology (Health IT)

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

Prompts	Demonstration Year (DY) and quarter first reported	Related metric (if any)	Summary
Metric Trends			
Discuss any relevant trends that the data shows related to assessment of need and qualification for SUD services. At a minimum, changes (+ or -) greater than two percent should be described.			
[Add rows as needed]			
☒ The state has no metrics trends to report for this reporting topic.			
Implementation Update			
Prompts: Compared to the demonstration design and operational details outlined in STCs and implementation plan, have there been any changes or does the state expect to make any changes to: a. How health IT is being used to slow down the rate of growth of individuals identified with SUD? b. How health IT is being used to treat effectively individuals identified with SUD? c. How health IT is being used to effectively monitor "recovery" supports and services for individuals identified with SUD?			

d. Other aspects of the state's plan to develop the health IT infrastructure/capabilities at the state, delivery system, health plan/MCO, and individual provider levels?
e. Other aspects of the state's health IT implementation milestones?
f. The timeline for achieving health IT implementation milestones?
g. Planned activities to increase use and functionality of the state's prescription drug monitoring program?

Summary:

- Vermont has a requirement and funding in the current contract with Appriss to connect VPMS to RxCheck for interstate data sharing. RxCheck is developing functionality for direct integration with EHRs and other health systems. Appriss has provided a change order to connect to RxCheck.
- VPMS, Dr. First and Appriss are in the process of testing and verifying Appriss's Gateway integration tool to enable direct population of VPMS data into Dr. First's prescription ordering section, eliminating the need for providers to navigate between systems.
- VPMS staff are engaged with the NESCSO State HIT Learning Community. This group works to create a shared understanding of Federal legislation, the current state of PDMP activities, and identifies opportunities for multi-state alignment.
- Vermont continues to offer prescriber reports on a quarterly basis.
  The centralized intake and resource Center, branded as VT Helplink: Alcohol & Drug Support Center, encompasses a call center, public-facing informational website, and a web-based appointment board. VT Helplink was launched to the public in March 2020 and continues to provide information and referral to Vermonters seeking SUD treatment and resources.

Are there any other anticipated program changes that may impact metrics related to SUD Health IT (if the state is reporting such metrics)? If so, please describe these changes.			

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

Other SUD-Related Metrics

Prompts	Demonstration Year (DY) and quarter first reported	Related metric (if any)	Summary
9.2 Other SUD-Related Metrics			
9.2.1 Metric Trends			
Discuss any relevant trends that the data shows related to assessment of need and qualification for SUD services. At a minimum, changes (+ or -) greater than two percent should be described.			

[Add rows as needed]			
☒ The state has no metrics trends to report for this reporting topic.			
9.2.2 Implementation Update			
Are there any other anticipated program changes that may impact the other SUD-related metrics? If so, please describe these changes.			
☒ The state has no implementation updates to report for this reporting topic.			

Budget Neutrality

Prompts	Demonstration Year (DY) and quarter first reported	Related metric (if any)	Summary
10.2 Budget Neutrality			
10.2.1 Current status and analysis			
Discuss the current status of budget neutrality and provide an analysis of the budget neutrality to date. If the SUD component is part of a comprehensive demonstration, the state should provide an analysis of the SUD-related budget neutrality and an analysis of budget neutrality as a whole.			Updates on Budget Neutrality can be found in 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.			

Ⅳ. Expenditure Containment Initiatives

i. Vermont Chronic Care Initiative (VCCI)

Key updates from QE062020:

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

The VCCI provides case management services to Medicaid beneficiaries throughout Vermont. The VCCI team is comprised of licensed, field-based case managers who provide clinical case management services to the complex beneficiaries within the communities they serve. Two non-licensed professional staff complement the team, with their primary role as outreach to those members new to the health plan. In QE062020, 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. The VCCI team delivers short term, intensive case management to beneficiaries with complex health needs. 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. With goal of further alignment, VCCI has been in collaborative discussion with OCV on 2020 Expanded Attribution and how VCCI can help support communities as they begin to implement this process. VCCI has shared our tools and workflows that will be utilized in part of this work, as well as beginning to have VCCI train within Care Navigator, the Accountable Care Organization's communication platform. This quarter, 6 VCCI staff have been trained and have access to Care Navigator. It is expected that the full VCCI staff will be trained in the next quarter. This will enable VCCI staff to share brief updates with other care team members on goal progression for complex members. Our team continues to receive referrals on ACO attributed members, presenting with complex health and social needs. VCCI works to stabilize members while building long term community care team.

With the COVID-19 pandemic, VCCI ceased outreach to new plan beneficiaries with goal of screening and facilitating access to medical homes, as primary care offices needed to focus efforts on serving patients on current panels in non-traditional ways. Early June, our team resumed telephonic outreach for screening of beneficiaries to facilitate access to health and health related services as primary care offices indicated increase in operations; access to dental care remains challenging as some offices remain closed or limited in operations. Face to Face visits with our complex Medicaid beneficiaries were also suspended and remains so as we continue to work with our Agency of Human Services to ensure safe resumption of in person visits. The VCCI team moved to telephonic case management, which is not ideal for members that have co-occurring medical, psychiatric and substance use disorders. Referrals to VCCI for complex care decreased initially, but has increased significantly as the State opens up, members are seeking assistance toward health improvement, and Providers are focused on member's total health picture.

Beginning in March 2020, our VCCI Team supported our state's COVID-19 response in various ways:

- Joined VDH Call Center and engaged in contract tracing
- Supported development and stand up of COVID-19 housing sites for Vermonters not able to shelter in place
- Screening of Vermonters in need of alternate housing
- Provision of case management outreach for Vermonters housed in state emergency housing who were identified in need of further health assessment, including behavioral health
- Information dissemination to healthcare providers, community partners and our members referencing DVHA updates during the pandemic to include encouragement of telehealth for healthcare visits, Pharmacy wavier of copays on certain Rx, Medicaid eligibility
- Identification of ongoing needs in community such as facial coverings for our homeless population, face shields for those not able to tolerate facial covering
- Supported Agency of Human Services at emergency food drop off sites; to aid in screening and engagement with any Vermonter in need of health-related services
- Aid in distribution of PPE for childcare centers
- Staff redeployed to VT Department of Labor

Although direct requests of VCCI have drastically decreased over the last couple of months, VCCI remains committed to aid in efforts as called upon.

VCCI anticipates resumption of other work which was suspended in March due to the pandemic over the next quarter. This includes support of sister state departments with assessment and coordination of high-tech nursing services; outreach and initial screening to beneficiaries <18; collaboration with DVHA colleagues on coordination of care on those being released from incarceration; and resumption of meeting with beneficiaries for intensive case management.

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.

ii. Blueprint for Health

Key updates from QE062020:

- The majority of Vermont's primary care practices are now Blueprint-participating Patient-Centered Medical Homes, as evidenced by 136 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 June 2020, the number of clients enrolled in Regional Opioid Treatment Programs (OTP/Hubs) was 3,503, and the average monthly number of Medicaid beneficiaries served by Office-Based Opioid Treatment (OBOT/Spoke) programs increased to 3,597.
- Vermont continues to increase access to enhanced preventative health, psychosocial screening, and comprehensive family planning services, as evidenced by the commitment of 47 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. Patient-Centered Medical Home model supports care that is patient-centered, team-based, comprehensive, coordinated, accessible, and focused on quality and safety. The model also promotes care that is provided when and where the patient needs it, and in a way that the patient understands it. Patient-Centered Medical Homes in Vermont are supported by multi-disciplinary teams of dedicated health professionals in each of the state's health service areas. These teams provide supplemental services that allow Blueprint-participating primary care practices to focus on promoting prevention, wellness, and coordinated care. The Community Health Team support primary care providers in identifying root causes of health problems, including mental health and screening for social determinants of health. They also connect patients with effective interventions, manage chronic conditions, or provide additional opportunities to support improved well-being.

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

process improvement). Quality Improvement Facilitators initially help launch patient-centered practices and secure NCQA Patient-Centered Medical Home recognition. After recognition is achieved, the facilitators regularly return to help with quality improvement efforts related to panel management and outreach, care coordination, promotion of individual health and wellness, chronic condition management, and ongoing practice transformation in alignment with State-led health care reform priorities. These include:

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

Blueprint-participating Patient-Centered Medical Homes currently serve 291,404 insurer-attributed patients, of which 96,610 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 168 full-time equivalents of Community Health Team staff.

Quarterly Highlights

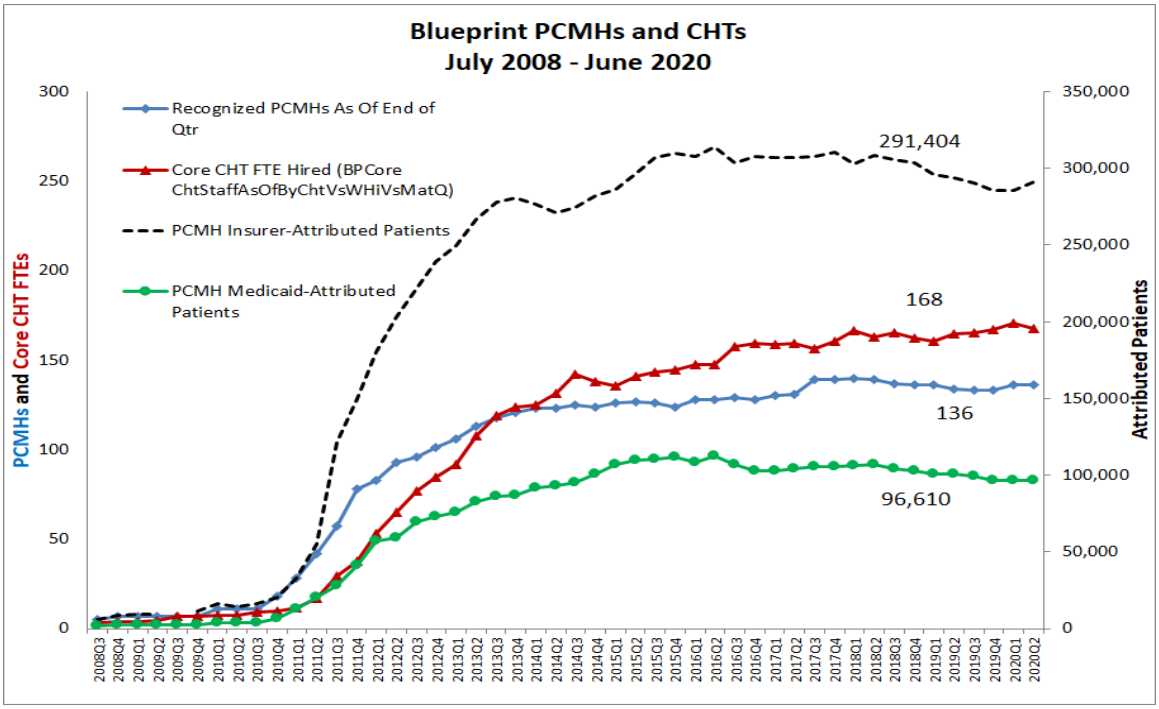
In Quarter 2 (April - June 2020), 136 Vermont practices were operating as Patient-Centered Medical Homes, thanks to the commitment of providers and staff, the support of Program Managers, and the technical assistance of Quality Improvement Facilitators. The number of practices participating in the Blueprint 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

As of March 13th, Governor Phil Scott declared a "Stay Home, Stay Safe" state of emergency in Vermont which has continued through this quarter. Patient-centered medical homes, specialty practices, and spokes acted quickly in order to provide continuity of care while still following the governor's orders. Most practices were able to provide staff with laptops and rapidly purchased technology platforms if they did not currently have one to provide telehealth services. The Blueprint approved use of funding to purchase additional licenses for online platforms. Most of the network used their electronic health records to run various reports based on a few factors of risk: Age greater then 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 team

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. Telehealth continues to be the primary vehicle for care at the beginning of the quarter, providing primary care appointments, screenings, and warm handoffs to the CHT as needed. We have seen as the quarter came to a close that our network is beginning to see more patients face-to-face with proper precautions and distancing within the practice. Some hospitals have begun outpatient surgery with safety protocols in place. Some CHT staff have been unable to return to practices in person s due to lack of space as most practices and hospitals continue to reassess how they will maintain social distancing. It was noted there was a great deal of work being done in prevention and safety, but minimal protocols when a patient was discharged after diagnosis of COVID from an emergency department or inpatient. We shared best practices as they developed with our field staff, such as SVMC's planning to ensure a clear discharge plan was made. Our 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

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

Community Health Profiles are used by the regional Accountable Communities for Health (Community Collaboratives) and other local workgroups to inform and complement Community

Health Needs Assessments and other community data products. These profiles report on the whole population of patients residing in each health service area (the closest possible approximation of "whole population" reporting from available claims data). Some measures are also broken out into three categories: patients attributed to area Blueprint-participating Patient-Centered Medical Homes, patients receiving most of their primary care in a non-Blueprint practice (such as a specialty practice or an out-of-state practice), and patients with no record of a primary care visit within the last two years. The whole-population reporting approach was new in 2018, and feedback suggests it has made the Community Health Profiles more useful. The Community Health Profiles are now part of Vermont's hospital budget approval process and Health Resource Allocation Plan, both responsibilities of the state's health care regulatory body, the Green Mountain Care Board. Onpoint Health Data produced these profiles. Practice Health Profiles and Community Health Profiles have been distributed to practices and healthcare organizations for the following data time periods:

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

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

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 2nd quarter of 2020, capacity for receiving medication-assisted treatment in Spoke settings continued to increase, as evidenced by 3597 Vermonters with Medicaid insurance receiving medication-assisted treatment for opioid use disorder from 264 prescribers and 79.15 full-time equivalent Spoke staff, working as teams, across more than 114[1] different Spoke settings (as of June 2020).

Quarterly Highlights

- Vermont continues to demonstrate increased access to medication-assisted treatment for Vermonters with opioid use disorder, as evidenced by the 3,503 clients enrolled in Regional Opioid Treatment Programs (OTP/Hubs) as of March 2020 and the monthly average of 3,597 Medicaid beneficiaries served by Office-Based Opioid Treatment (OBOT/Spoke) programs as of June 2020.

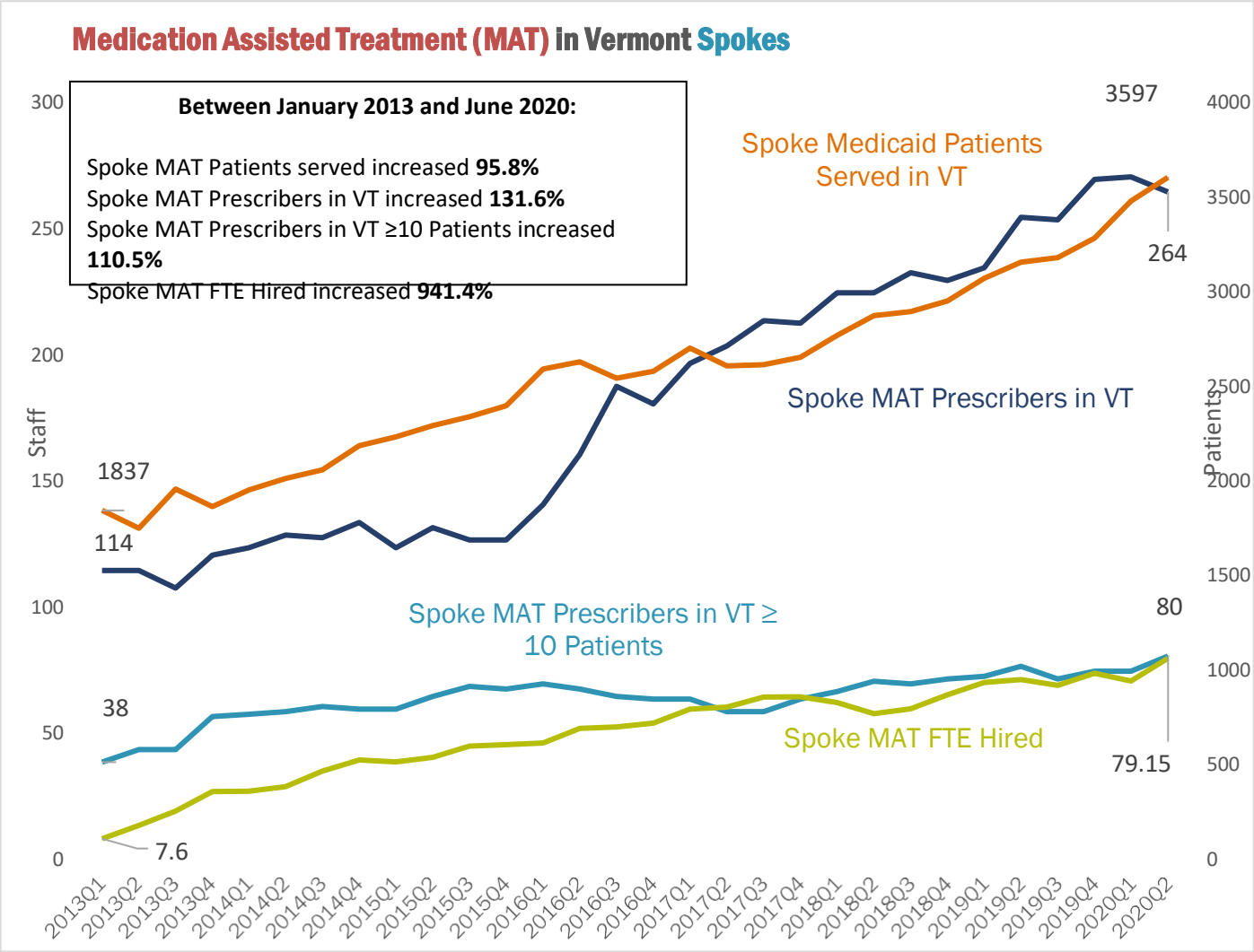
- Medication-assisted treatment for opioid use disorder is being offered across the State of Vermont by more than 114 different Spoke settings and by 264 medical doctors, nurse practitioners and physician assistants who work with 79.15 FTE licensed, registered nurses and licensed, Master's-prepared, 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 June 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 Q2 2020, many Spoke nurses were providing care in both telehealth and in-person visits, and the Spoke counselors were continuing to deliver care remotely.

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

- As of November 1, 2019, the Blueprint has a contract with Dartmouth College for the 2019-2020 MAT Learning Collaborative. The 2019-2020 MAT Learning Collaborative will include a series of five webinars, six regional in-person training sessions, and one statewide conference. For the 2nd quarter of 2020, the Learning Collaborative events 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 two webinars and one statewide virtual training session. In response to the COVID-19 pandemic and Vermont's "Stay Home, Stay Safe" emergency declaration, Dartmouth College is continuing to restructure the remainder of the Learning Collaborative to accommodate entirely virtual sessions as of June 2020.

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



Women's Health Initiative

Like the Hub & Spoke program, the Women's Health Initiative (WHI) began as a challenge from state leadership to improve the health of women and families by addressing the high percentage of unintended pregnancies. Initially, the Initiative was a design project for the Blueprint, in partnership

with the Vermont Department of Health and other policy makers, providers, and experts, and subsequently developed into a statewide intervention that now helps Vermonters with accessing evidence-based care.

The WHI offers participating providers and practices new training, staffing, payments, and community connections. With these supports, practices can now offer women enhanced preventative care, screenings and follow-up to address health and social risks, comprehensive family planning counseling, and timely access to the most effective forms of contraception, including Long Acting Reversible Contraceptives (LARC), when chosen by the patient and clinically appropriate. Women who visit WHI -participating women's health practices (OB-GYN offices, midwifery practices, and family planning clinics) and primary care practices engage in enhanced psychosocial screening for mental health and substance use disorders, interpersonal violence, and access to housing and food.

Women identified as at-risk are immediately connected to a licensed mental health clinician for brief intervention, counseling, and referral to more intensive treatment as needed. The clinicians connect women with their local network of health, social, economic and community services. Women also engage in comprehensive family planning counseling at participating practices and community-based organizations. Women who wish to become pregnant receive pre-conception counseling and services to support the healthiest pregnancies possible. For those women who indicate they do not want to have a baby in the coming year, they have access to the full spectrum of contraception options, including immediate access to LARC.

The payments associated with participating in the WHI support women's health and primary care practices in designing workflows that support the enhanced psychosocial screening, comprehensive family planning counseling, and same-day LARC insertion and support the provision of effective interventions by licensed mental health clinicians. A key aspect of the initiative is the focus on improving clinical-community linkages, which involves collaboration between participating practices and community-based organizations in order to successfully address health care and non-medical health related social needs. Communities that have practices participating in the Women's Health Initiative have developed coalitions that include the participating medical practices and community organizations in order to develop bidirectional referrals pathways that support Vermonters with accessing necessary services more efficiently.

Quarterly Highlights

- Vermont continues to increase access to enhanced preventative health, psychosocial screening, and comprehensive family planning services, as evidenced by the commitment of 47 practices (25 women's health and 22 primary care) to participate in the Women's Health Initiative as of June 2020.

- In April $11,867.62 was distributed to three new practices as a one-time payment to support the implementation of the WHI in those areas.

The WHI is approaching statewide coverage, as all but two Hospital Service Areas have a specialized women's health practice now participating in the WHI. We have had additional practices in both Springfield and Morrisville health service area join the WHI this past quarter.

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

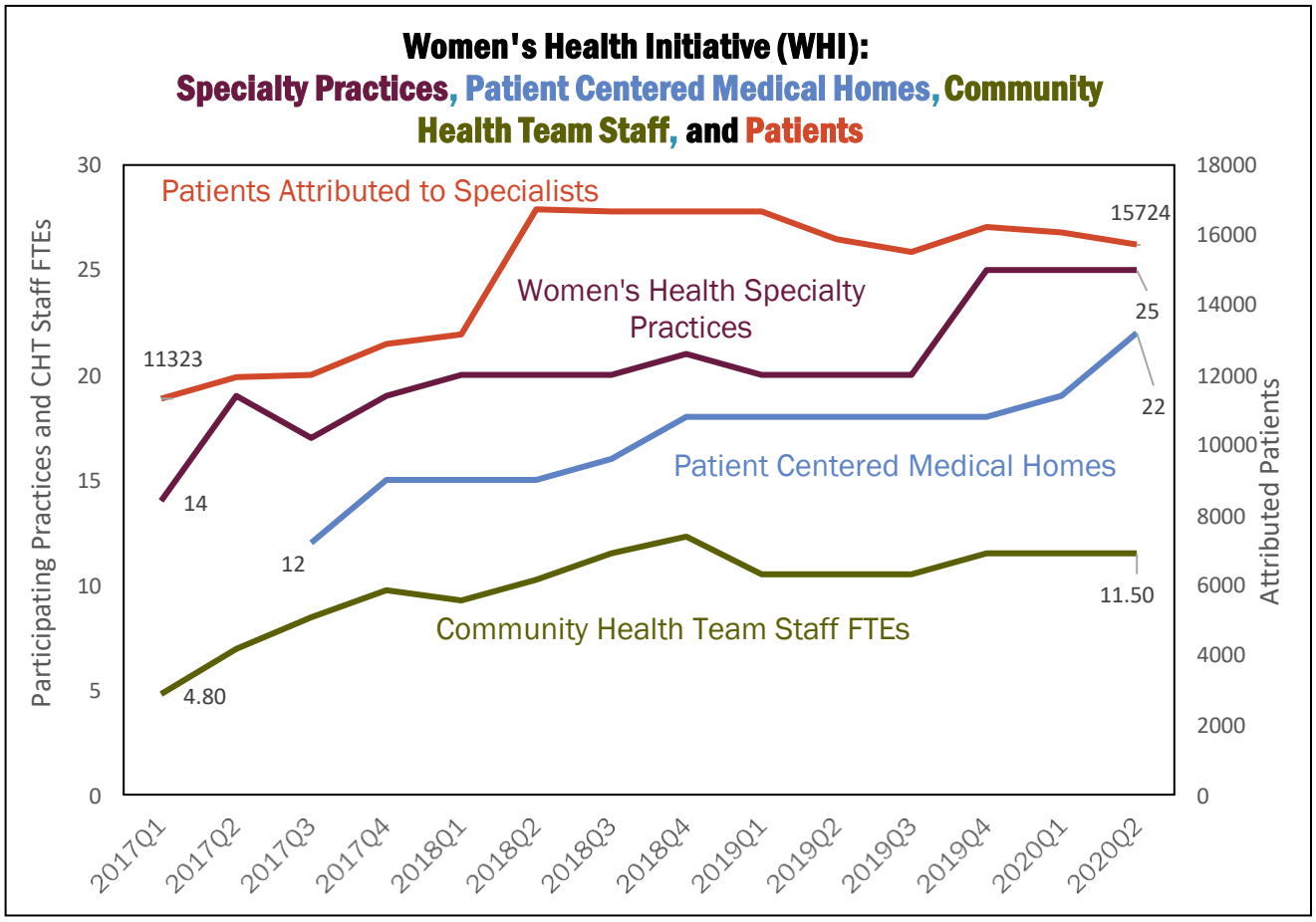


Table 4. Women's Health Implementation by Region

Health Service Area / Team	WHI Specialist Practices as of June 2020	WHI PCMH Practices as of June 2020	WHI CHT Staff FTE Hired as of June 2020	WHI Specialist Quarterly Attributed** Medicaid Beneficiaries as of June 2020	WHI PCMH Quarterly Attributed** Medicaid Beneficiaries as of June 2020
Barre	1	1	1.00	749	508
Bennington	1	2	0.50	989	276
Brattleboro	1	0	1.00	813	0
Burlington	3	6	3.00	2635	4260
Middlebury	2	0	0.75	1114	0
Morrisville	1	4	0.50	510	1310
Newport	0	0	0.00	0	0
Randolph	2	0	0.50	535	0
Rutland	2	1	1.50	1434	164
Springfield	1	5	1.00	0	1733
St. Albans	1	0	0.00	1077	0
St. Johnsbury	1	2	0.75	863	720
Windsor*	0	0	0.00	0	0
Planned Parenthood (Statewide)	12	0	1	5006	0
Total	25	22	11.5	15724	8971

*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.

iii. Behavioral Health

Key updates from QE062020:

- Team Care program revisions
- 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 other departments to support coordination of care. The team refers members to VCCI services and helps ensure continuity of care for beneficiaries already enrolled with VCCI

admitted to inpatient or residential care facilities. In recognition of the inherent challenges in providing strong clinical documentation to justify admission and continued stay within 24 hours of admission, over the past two years DVHA has engaged in a pilot project in which there is automatic initial authorization of 5 days for all beneficiaries meeting the acute level of care criteria at the Brattleboro Retreat. This practice allows time for the assessment and formulation of an individualized plan of care and discharge plan for each beneficiary admitted. The team has engaged in quarterly reviews of admissions of 5 days or less to determine whether authorization would have been given without the pilot. For each quarter greater than 90% of the admissions and stays would have been authorized with strict adherence to the criteria.

The 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. Placements have reopened and the need for extensions has dissipated. 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. All reviews have been completed for the SFY. New data mining has begun.

Team members participate in the SFI Interagency Team and the Youth Service System Enhancement Council (a collaborative with ADAP, DMH, VCRIP, Vocation Rehabilitation, DCF, and more). Team members are active in ensuring that beneficiaries with multi-department involvement are getting appropriate services delivered in the most efficient manner. This is accomplished through participation in state interagency team meetings, the Mobile Crisis Response Initiative, by attending monthly CRC meetings, participating in weekly case review, and development of protocols for cross departmental service delivery. Our unit worked with other departments on developing a system to notify DVHA regarding all children with Medicaid that are awaiting placement in Emergency Departments 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 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.

Bi-annual site visits/audits with ABA providers who are enrolled with Vermont Medicaid and providing services to Medicaid members began in January 2020. Due to the COVID -19 pandemic, site visits were put on hold in March 2020. We plan to resume site visits/audits once restrictions on social distancing are lifted. The purpose of these visits/audits is to assure that members are receiving quality care, that providers are accurately reimbursed for services that they are providing, assuring that required documentation is included in members charts, and that documentation of services is being completed and is thorough and of quality.

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. The Quality Unit will resume assisting VCCI once there is more clarity regarding how the pandemic is impacting this project.

iv. Mental Health System of Care

Key updates from QE062020:

- Activities related to the COVID-19 pandemic
- Integrating Family Services Activity
- Implementation of DMH 10-Year Plan | Vision 2030: An Integrated and Holistic System of Care

<u>System Overview</u>

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

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

• Children, Youth, and Family Services, including children who have a serious emotional disturbance and their families.

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

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

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

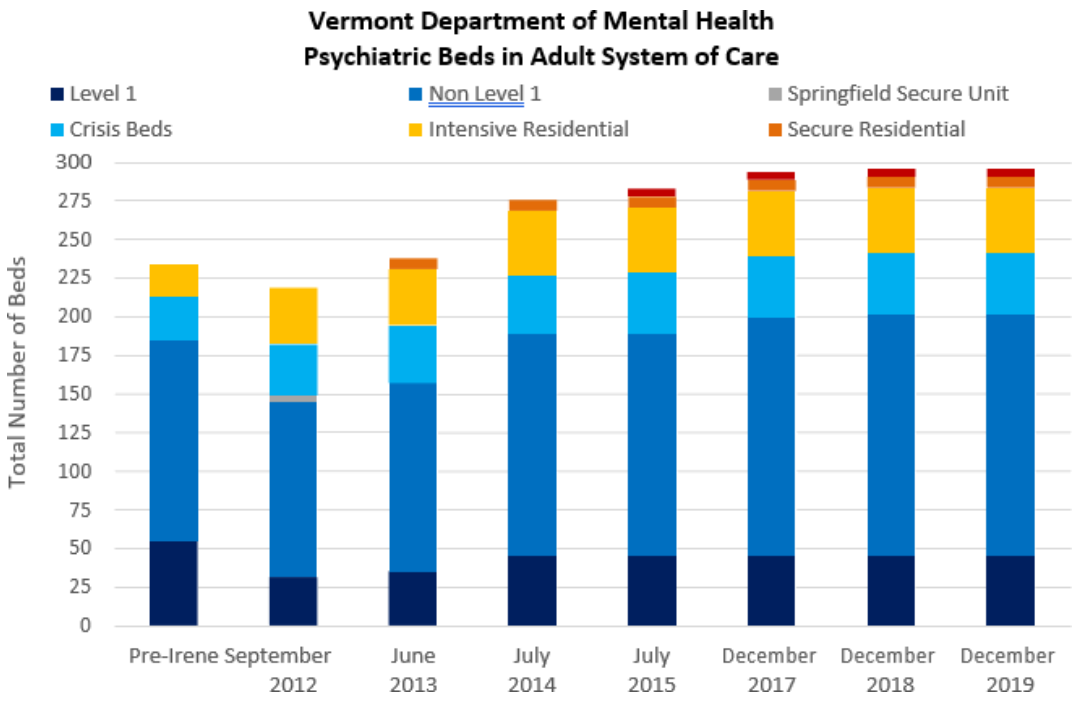
There are a number of policy and programmatic updates below related to the COVID pandemic. The Governor of Vermont, Phil Scott, declared a state of emergency on March 13, 2020 that has recently been extended to July 15, 2020. As well, on March 24, 2020 Governor Scott issued a "Stay Home, Stay Safe" order 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 through DMH:

<u>Hospital Services</u>

- There are 45 Level 1 beds and a total of 199 adult psychiatric inpatient beds across the system of care. During the COVID pandemic, a number of beds closed due to low staffing, converting double occupancy rooms to single occupancy, and an initial decrease in individuals presenting with a need for a higher level of care. Vermont anticipates staffing levels and beds that were needed prior to the pandemic will become a necessity again as we have been seeing a steady increase in the number of individuals presenting with a need for hospital level of care over the past month.
- Act 190 (2018) provided $5.5 million dollars for the development of 12 inpatient Level I beds at the Brattleboro Retreat. This work is continuing but has been delayed due to the COVID-19 pandemic. These beds are expected to come on line in January 2021.
- With the COVID-19 pandemic creating pressure on different parts of the adult system of care, a new partnership has been established and a contract has been signed with the Windham Center, which is a part of the Springfield Hospital System in Southern Vermont. The Windham Center is converting their 10 bed unit for adults into a COVID + adult unit for people who test positive for COVID 19 and require psychiatric hospital level of care. This unit will be available August 2020. During the construction of the Windham Center, Springfield Hospital has agreed to allow DMH to use its two Behavioral Health rooms in their Emergency Department for individuals testing positive for COVID 19 and are in need of psychiatric hospitalization. To date, we have served two individuals at this location.

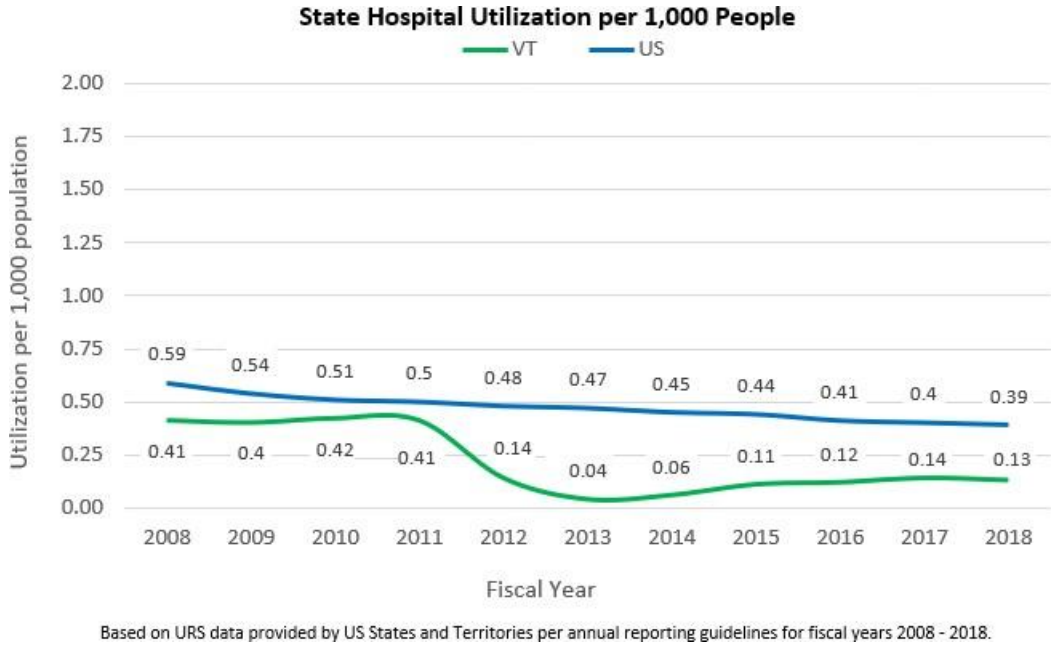
Figure 3. Vermont DMH Psychiatric Beds in Adult System of Care



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

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

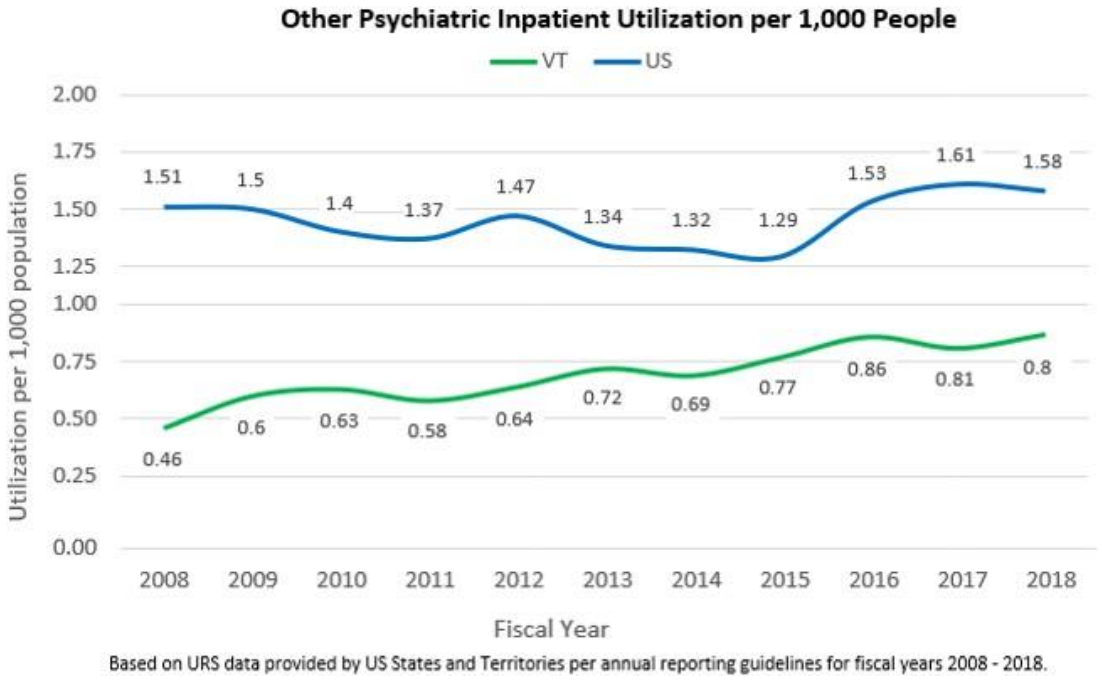
Figure 4. State Hospital Utilization per 1,000 people (in Vermont and the United States)



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

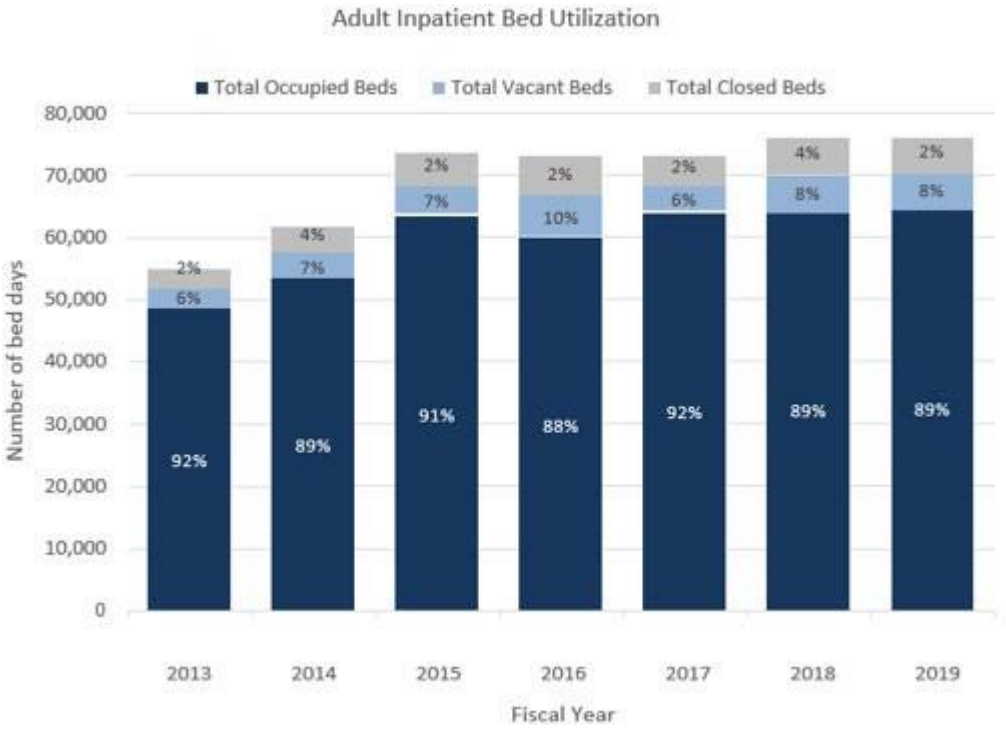
The national rate of state hospital utilization continues to decline year-over-year. Vermont Psychiatric Care Hospital opened in FY 2015 with 25 beds and Vermont's rate of inpatient utilization continues to be lower than the national average in the United States. The significant decrease from FY 2011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

Figure 5. Other Psychiatric Hospital Utilization per 1,000 people (in Vermont and the United States)



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

Figure 6. Adult Inpatient Utilization and Bed Closures



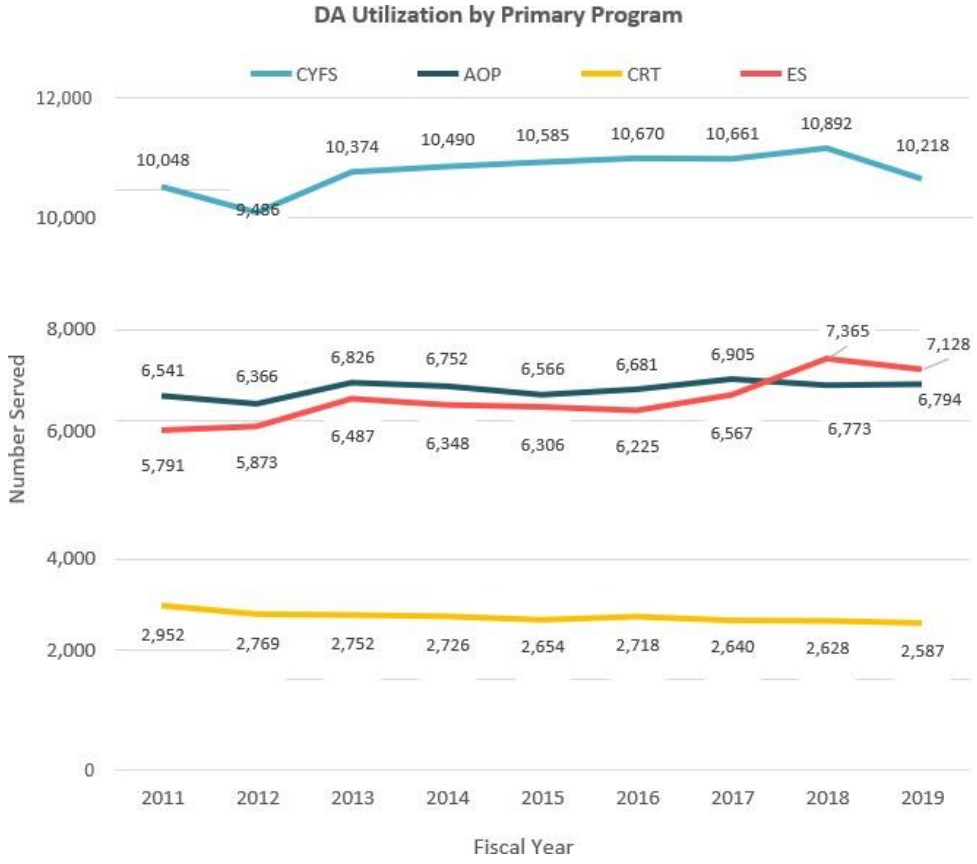
This chart depicts the total bed day capacity across the Vermont Designated Hospital system through FY 2019. The total bed day availability across the system has remained relatively constant in 2018 and 2019 with new bed capacity coming online in 2020. In 2019, bed closures represented 2% of adult inpatient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

<u>Community Services</u>

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

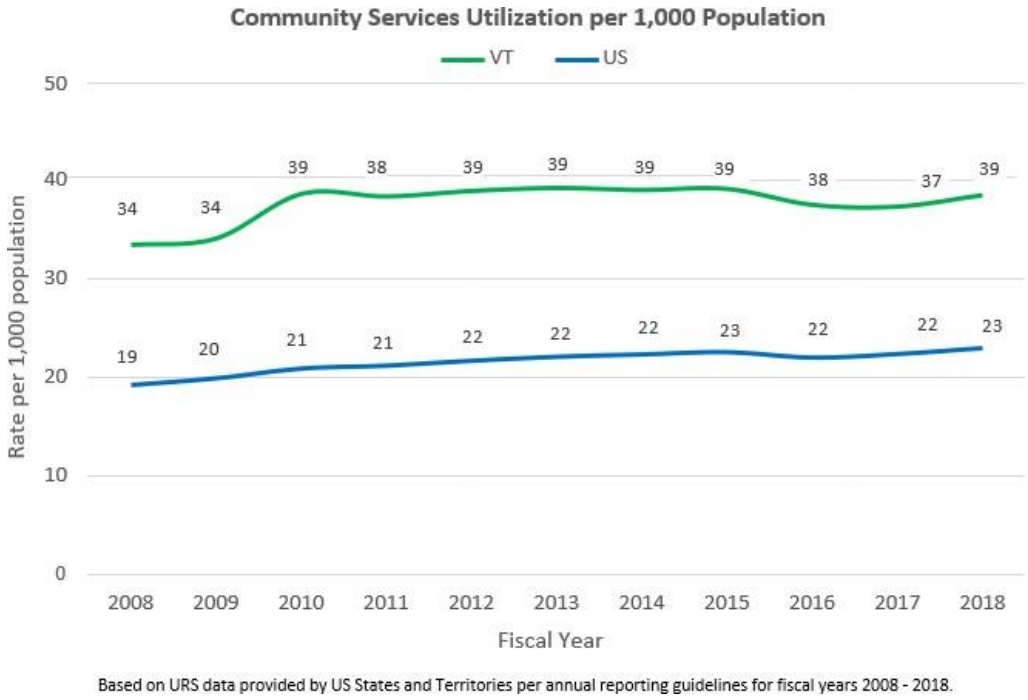
Enhanced community services funding provided by the legislature through increased appropriations to key mental health programs in the community over the last several years has helped, but staff recruitment and retention necessary to meet and expand these service capacities continues to be a struggle. 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



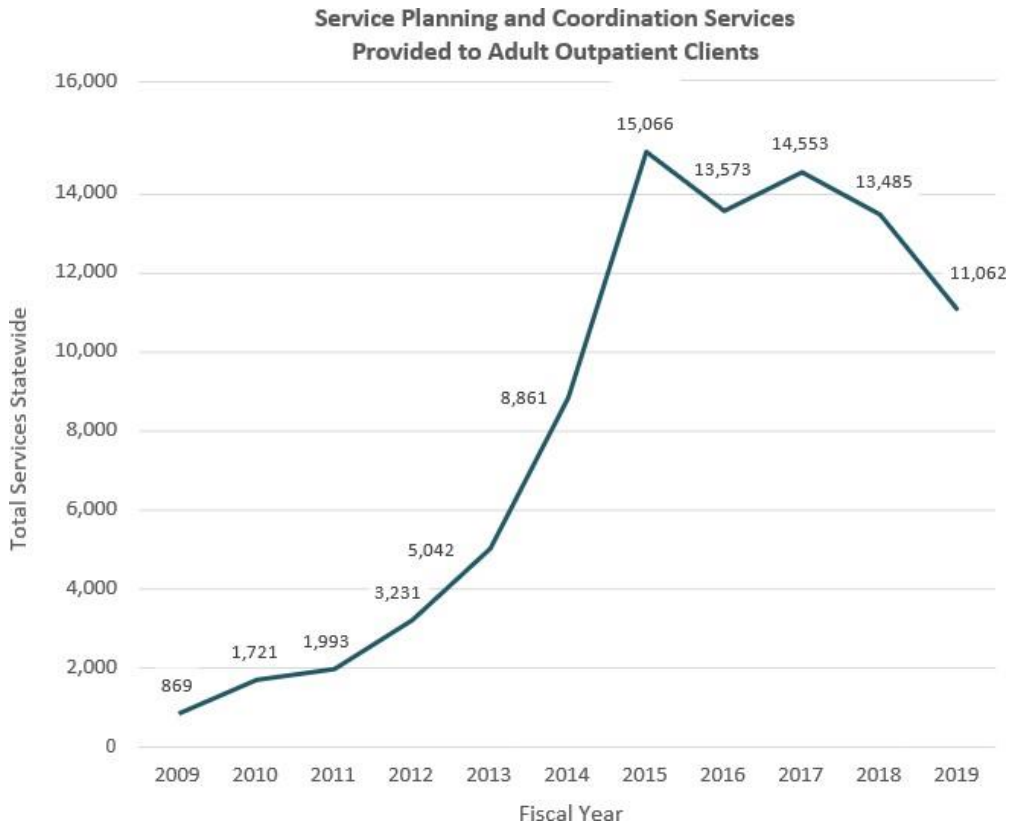
The highest number of persons served by programs offered by the Designated Agencies (DAs) continues to be in services for children, youth, and families. This program has until FY 2019 shown a slow upward trend for a seven-year period with FY 2019 showing a nearly 6% decrease in numbers served. The Emergency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

Figure 8. Community Utilization per 1,000 Populations



The Vermont community mental health system serves nearly 40 out of every 1,000 Vermonters, which is substantially higher than the national figure. The most recent national data available through 2018 shows that Vermont has a strong and fairly consistent record of service delivery in community-based programs. While the progress appears to be static, data shown in Figure 9 below, indicates that significantly higher rates of service are being provided to fewer numbers of clients who may otherwise have needed hospital levels of care. This number however is also showing a downward trend since 2015.

Figure 9. Service Delivery: Planning and Coordination

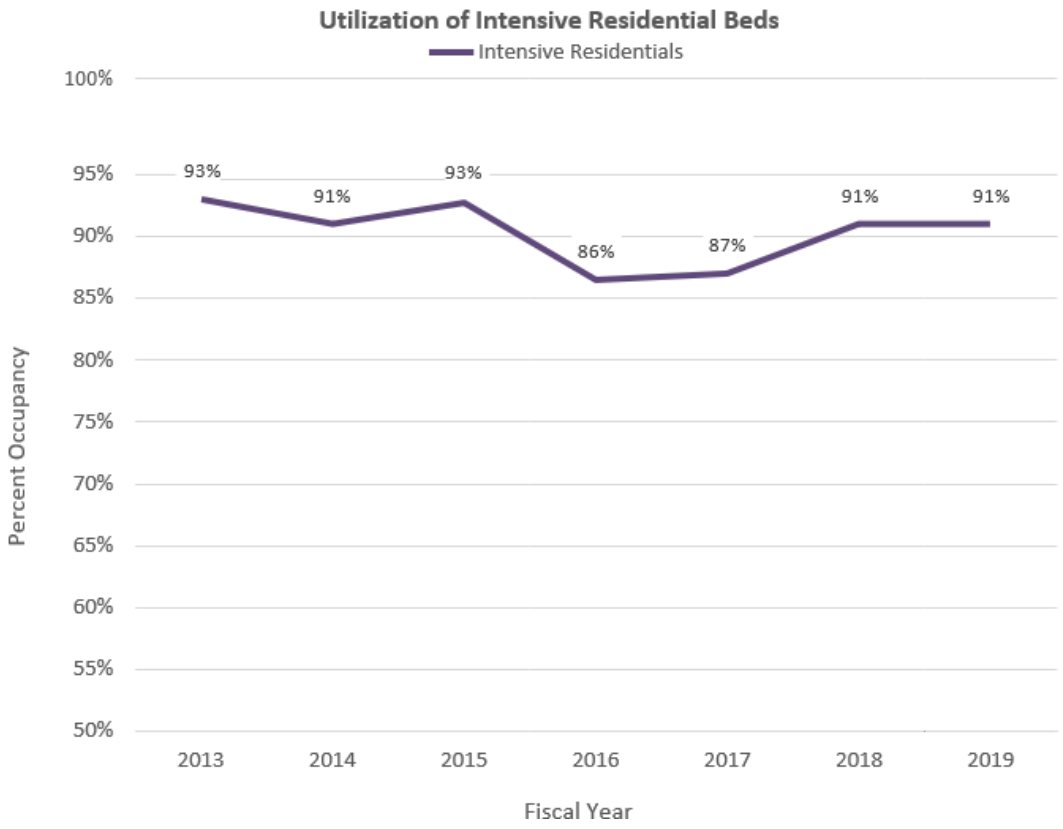


The support of non-categorical case management led to a steady increase in the number of services provided to adult outpatient clients allowing additional support to those in need but ineligible for case management through Community Rehabilitation and Treatment services through FY 2015. Levels remain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

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.

<u>Residential and Transitional Services</u>

Figure 10. Intensive Residential Bed Utilization



The secure residential recovery program, the Middlesex Therapeutic Community Residence, has the capacity to serve 7 individuals at a time and has served 45 individuals since opening. In late-March, the individuals who resided at MTCR were moved to the Vermont Psychiatric Care Hospital-on a separate wing and with allowances that maintained the flexibilities they had when living situation at MTCR. This change was made due to low staffing availability at MTCR and VPCH resulting from the impacts of COVID 19. As well, the one secure juvenile rehabilitation center (Woodside) in Vermont needed a place for the youth who resided there as Woodside was reconfigured by DMH to create a facility that would be appropriate for positive COVID individuals who also needed an inpatient treatment facility. Because Vermont did not see a surge of patients needing this level of care, the youth returned to Woodside and the individuals who resided at MTCR will return there as soon as staffing levels return to a safe and stable level.

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

Performance and Reporting

- Along with AHS, DMH has adopted the Results-Based Accountability (RBA) framework for assessing performance of providers via grants and contracts.
    - Creation of a "Vermont Psychiatric Care Hospital Outcomes" scorecard to meet legislative reporting requirements
    - Migration of the "DMH Snapshot" and the "DMH continued reporting" report to the RBA scorecard reporting tool
- Exploration of visualization tools to create more responsive reporting
- Participation in development of the Agency of Human Services Community profiles
- 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 quarter 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 is working toward having several—if not all—children's mental health programs in a model similar to Integrating Family Services. Work is underway on a similar initiative for adult mental health services. The goal of this work is to move toward a simple, but accountable system that reduces the complexities of payment and shifts the focus of the providers and the department on outcomes and quality. DMH is committed to reforming the system to better serve Vermont's population and continue to move towards full integration.

Integrating Family Services

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

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

Both IFS regions 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 through supports and services children/youth are increasing in their strengths and decreasing needs. The caveat to this is that for children involved in the child welfare system it is taking longer to see positive results; not surprising given the fact that these children experience high levels of trauma, exposure to substances, and/or abuse and neglect—this data also follows national trends in data analysis for this subset of the population.

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.

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

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

In June 2020 legislation was passed in Vermont (H.960/Act 140) to enact a Mental Health Integration Council which is charged with overseeing and advising the implementation of the Vision 2030 plan. The Council will convene every month from October 2020 through July 2023.

v. Pharmacy Program

Key updates from QE062020:

- The Drug Utilization Review Board (DURB) held three meetings this quarter.
- Pharmacy Provider Communications

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, controlling pharmacy expenditures through managing cost, brand, and generic utilization, and reducing state administrative costs. The State of Vermont utilizes the pharmacy benefit management company, Change Healthcare (CHC), to provide a full complement of operational, clinical, and programmatic support in addition to managing a call center in South Burlington, Vermont, 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 - enforcing coverage rules for various pharmacy benefits
- Pharmacy provider assistance - DVHA, Change Healthcare Clinical Call Centers.
- Liaison to Coordination of Benefits Unit/Part D Plan Team/Eligibility/Member Call Center to resolve issues.
- Liaison to Vermont Department of Health (VDH)-Vaccine Program, Substance Use Disorder/Opioid Treatment Program, Asthma Program, Smoking Cessation Program, and Department of Mental Health (DMH) management of antipsychotics.
- Works with Vermont Medication Assistance Program (VMAP)and Children with Special Health Needs (CSHN) to assist in the management of the programs.

Clinical

- Manages drug utilization and cost
    - Federal, State, Supplemental rebate programs
    - Preferred Drug list
    - 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

Pharmacy Communications Issued

COVID-19 Emergency Response communications sent to providers:

- Members can request early refills of medication up to a 90-day supply as needed.
- The days' supply limit for Suboxone Film has been extended up to 30-days. The non-preferred buprenorphine formulations days' supply limit has also been extended up to 30-days.
- Co-pays have been waived for medications that may be used to treat the symptoms of COVID-19.
    - This includes antihistamines, cough suppressants, anti-febrile/analgesic medications, cough & cold combination products, inhalers, and leukotriene receptor antagonists.
- Providers can override the 90-day supply requirement for select medications, this will allow pharmacies to better manage their inventory and avoid any drug shortages.
- The signature requirement, upon receipt of medications at pharmacies has been waived.
- DVHA has lifted the prior authorization requirements for Albuterol HFA, all formulations. Also, prior authorization requirements have been waived for DME & supplies, including Continuous Glucose Monitors for ease of access to members.
- A list of pharmacies that home deliver was sent to providers to instruct members to utilize this service if preferred.
- 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).

Additional communications:

- 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.

- 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", when this is not an insurance. Medicaid is then billed as secondary payor and is paying most of the cost of the drug.

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 requiring the DVHA Commissioner establish a pharmacy best practice and cost control program, 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 to a six - year term. 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.

Drug Utilization Review Board Meetings

Drug Utilization Review Board meetings occur seven times per year. In QE0620, the DURB held three meetings. The DURB is scheduled to hold one meeting next quarter. Information on the DURB and its activities in 2020 is available at this link: https://dvha.vermont.gov/advisory-boards/drug-utilization-review-board

vi. All Payer Model: Vermont Medicaid Next Generation Program

Key updates from QE062020:

- Continued conducting financial reconciliation activities for the 2019 performance year, in order to determine financial and quality performance. Results will be available in early Q3 2020.
- Continue consideration of programmatic adjustments to address impacts of COVID-19 on contractual obligations and OneCare provider network.
- 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-

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

DVHA began conducting financial reconciliation activities for its 2019 performance year in Q1 2020. Reconciliation activities will determine the ACO's spend as compared to their financial target and quality performance for the 2019 performance year. Reconciliation activities will continue through Q2 2020, and final results will be available by the end of Q3 2020.

DVHA and OneCare began exploring options for flexibility in the VMNG program to hold providers harmless for negative impacts related to the COVID-19 pandemic and State of Emergency. DVHA identified opportunities for aligning with the Medicare Next Generation ACO program changes due to COVID-19, which it will implement in a contract amendment in Q3 of 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.

V. Financial/Budget Neutrality Development/Issues

As is the monthly process, AHS paid DVHA 1/12th of the legislative budget for Global Commitment on the first business day of each month during the June 2020 quarter (April through June 2020). This payment served as the proxy by which to draw down Federal funds for Global Commitment (GC).

As is the process after each quarterly submission of the CMS-64, AHS reconciled the quarterly amount claimed on the CMS-64 with the monthly payments made to DVHA. The State prepared the CMS-64 based upon actual allowable Medicaid expenditures (program, investments, and administration) for the given quarter. AHS submitted and certified the CMS64 report for QE0620 on July 30, 2020, as is normal.

Overall, the budget neutrality exercise indicates that for June 2020 quarter, the State's total "With

Waiver" expenditures were 15.61% ($57,407,156) lower than the total "Without Waiver" amount (caseloads multiplied by the Budget Neutrality PMPMs). This is a significant change from last quarter when the expenditures were 2.3% ($8,312,341) lower than the "Without Waiver" amount. A decrease in expenditures is consistent with expectations that utilization of health care services would decrease during the COVID public health emergency.

For the supplemental budget neutrality tests, no categories are showing a cumulative annual deficit. When analyzed on a quarter-to-quarter basis (QE0320 and QE0620), we are observing:

Supplemental Test: New Adult: While there was a deficit in QE0320 of $7,346,817, in QE0620, there was a surplus of $18,014,703. This illustrates decreased utilization for this population.

Supplemental Test: IMD SUD: Claims reporting indicate a significant decrease in enrollment in the IMD SUD eligibility groups (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. At present, there is a $52,394 cumulative surplus.

AHS continues to actively monitor Investment spending. The total Investment spending for QE 0620 was $22,514,309, which is within expectations. In addition, in QE0620, a prior quarter adjustment of -$831,250 from QE 0320 was made. This was to correct an erroneously reported amount for Delivery System Reform Investments in QE0320. (Note: CY2020 marks the second year in which room and board and physician training program investments must be phased down by 33%.) The HIT and non-State plan related Education fund Investments have already been fully phased down.

COVID's effect on budget neutrality will become clearer during the quarter ending September 30, 2020. As expected, the State experienced significant decreased utilization during the QE 0620. In addition, while of minimal impact, the state has ceased some copayments for the duration of the public health emergency.

Another impact of COVID has been the State's ongoing work to implement the reporting requirements required for federal financial participation for Institution for Mental Diseases (IMD) services provided to Vermont Medicaid members with Severe Mental Illness (SMI). This was approved by CMS in December 2019. SMI reporting was intended to go into effect for QE0320, but due to resource challenges the State was unable to report any SMI expenses. The State will report prior quarter adjustments retro to 1/1/20 when the reporting mechanisms are expected to go live in QE 0920.

VI. 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 QE0620 of CY2020 and includes the unduplicated count of member months for SUD IMD stays. CY2019 and CY 2018 member months are also reported in the tables below.

Table 1. Member Month Reporting – Calendar Year 2020, QE0320 and QE0620, *subject to revision,* with CY2019 and CY2018

Demonstration Population	Medicaid Eligibility Group	Total CY 2020 (QE 03/20 and QE 06/20)	Total CY 2019	Total CY2018
1, 4*, 5*	ABD - Non-Medicare - Adult	39,941	81,306	83,071
	SUD - IMD - ABD	65	149	78
	SMI - IMD - ABD			
1	ABD - Non-Medicare - Child	10,067	23,854	25,577
1, 4*, 5*	ABD - Dual	128,672	257,810	257,263
	SUD - IMD - ABD Dual	84	158	78
	SMI - IMD - ABD Dual			
2	Non ABD - Non-Medicare - Adult	50,193	104,127	143,377
	SUD - IMD - Non ABD	100	222	187
	SMI - IMD - Non ABD			
2	Non ABD - Non-Medicare - Child	349,907	703,925	723,120
	Medicaid Expansion			
7	Global RX	38,701	77,498	79,488
8	Global RX	20,783	44,169	46,792
6	Moderate Needs	1,051	2,211	2,319
	New Adults			
3	New Adult without Child	213,712	423,147	471,886
	SUD - IMD New Adult w/o Child	659	1,352	791
	SMI - IMD New Adult w/o Child			
3	New Adult with Child	125,315	233,285	223,882
	SUD - IMD New Adult with Child	118	259	114
	SMI - IMD New Adult with Child			
	Total	979,368	1,953,472	2,058,023

* Long Term Care Group	LTC Medicaid Eligibility Group	Total CY 2020	Total CY 2019	Total CY 2018
4 only	ABD Long Term Care Highest Need	18,107	35,585	34856
5 only	ABD Long Term Care High Need	8,205	15,463	14055

Table 2. PMPM Capitated Rates CY 2020 (January 1, 2020 – December 31, 2020)

PMPM Budget Neutrality	
Medicaid Eligibility Group	**DY 15 PMPM CY2020**
ABD - Non-Medicare - Adult	$ 1,683.54
SUD - IMD ABD	$ 3,674.05
SMI - IMD ABD	$ 15,587.00
ABD - Non-Medicare - Child	$ 3,297.72
ABD - Dual	$ 2,899.02
SUD - IMD ABD Dual	$ 2,849.83
SMI - IMD ABD Dual	$ 18,896.00
Non ABD - Non-Medicare - Adult	$ 743.60
SUD - IMD Non ABD	$ 2,852.36
SMI- IMD Non ABD	$ 10,056.00
Non ABD - Non-Medicare - Child	$ 614.97
New Adult Group	$ 586.34
SUD - IMD - New Adult	$ 3,024.09
SMI - IMD - New Adult	$ 11,669.00

Table 3. Medicaid Non-BN Rates Effective CY 2020

Medicaid Non-BN Rates Effective 1/1/20 - 12/31/20	Per Member Month
Still awaiting approval by CMS	CY 2020
ABD Adult	$ 2,386.28
ABD Child	$ 3,062.78
ABD Dual	$ 2,089.93
Global Rx	$ 107.13
Moderate Needs	$ 682.52
New Adult	$ 499.41
Non-ABD Adult	$ 666.60
Non-ABD Child	$ 531.99

VII. Consumer Issues

AHS and DVHA have several mechanisms whereby consumer issues are tracked and summarized. The first is through Health Access Member Services. This is a contracted function for providing information on health care programs, assisting with the eligibility process, and helping beneficiaries to understand the benefits and responsibilities of their particular program. The complaints received by Member Services are reported to DVHA (see Attachment 3). Member Services works to resolve the issues raised by beneficiaries, and the reports are seen by several management staff at DVHA.

The second mechanism to assess trends in beneficiary issues is the Managed Care Grievance and Appeal report. This report is based on data entered by grievance and appeal coordinators in various locations across the MCE. The database into which they enter information helps them track the timeframes for responding to the grievances and appeals, as well as assists DVHA and AHS in monitoring compliance and assessing if there are trends that may benefit from a performance improvement project.

The third mechanism to track consumer issues is the Office of the Health Care Advocate (HCA) report which is a comprehensive report of all contacts with beneficiaries (see Attachment 5). These include inquiries, requests for information, and requests for assistance. The HCA's role is to advocate for all Vermonters by providing individual consumer assistance and consumer advocacy on issues related to health insurance and health care.

VIII. Quality Improvement

Key updates from QE062020:

- The Clinical Services Team completed the 3-year cycle for a formal CMS PIP project focused on improving substance use disorder treatment through the promotion of telehealth services.
- The Clinical Services Team worked with our NCQA-certified vendor to complete the HEDIS 2020 season's quality measure production. This includes the full set of HEDIS administrative measures and medical record retrieval and abstraction for five hybrid measures.

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 during QE0620 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 reporting period, the Quality Committee continued to fine tune changes to DVHA's Global Commitment to Health (GC) Core Measure Set, reviewed summary reports on two QI projects (see below) and discussed new opportunities for evaluation of quality and appropriateness of care for special health needs populations through engagement in delivery system reform efforts.

Formal CMS Performance Improvement Project (PIP)

The Director of Quality Management continued to coordinate VT Medicaid's formal CMS Performance Improvement Project (PIP) during the QE0620 – the topic of which is substance use disorder treatment. The cross-departmental PIP team focused on a multi-pronged telehealth-related intervention. Targeted communications about telehealth were dispersed via provider banners and newsletter articles during 2019.

Interim indicator data on telehealth use was collected to monitor progress. Data points included: number of telehealth episodes of care, number of unduplicated providers billing for telehealth and number of unduplicated members receiving telehealth services. There was an increase in all metrics from the baseline of Q2 SFY 18. Additionally, the team's overall study indicator, the HEDIS IET Initiation rate, was produced for CY 2019 during QE0620 and demonstrated a statistically significant increase over CY 2018's rate. These results were included in an annual PIP Summary Report which was prepared for our EQRO during this reporting period.

Submission of the PIP Summary Report marked the completion of a 3-year cycle for this study topic. However, DVHA's work on both substance use disorder treatment and telehealth expansion continues. Members of this PIP team remain engaged with various stakeholder groups on both topics. The Clinical Services Team will begin researching a new formal PIP topic during QE0920.

Other Collaborative Quality Improvement Projects

The Quality Unit staff completed two informal quality improvement projects during 2019. The topics were chlamydia screening (CHL) and adults' access to ambulatory/preventive services (AAP), the results of which were presented to the Quality Committee during this reporting period.

The Quality Improvement & Clinical Integrity Unit merged with two other units (Clinical Operations and Pharmacy) during the QE0320. The new combined group is called the Clinical Services Team. Goals of this new team include realizing efficiencies, aligning priorities and reducing redundancies. During QE0620 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. As the year progresses, additional focus areas will be chosen and QI tools and methodology will be incorporated into these efforts.

Quality Measure Reporting

- CMS Medicaid Quality Core Measure Sets - During the last reporting period DVHA received Seeking More Information (SMI) requests based on our most recent Adult and Child Core Set reporting. Responses were logged during QE0620.

- HEDIS measure production – The Clinical Services Team worked with our NCQA-certified vendor to complete the HEDIS 2020 season's quality measure production throughout QE0620. This includes the full set of HEDIS administrative measures and medical record retrieval and abstraction for five hybrid measures.

- Clinical Services Team staff continued conversations with staff from Vermont Information Technology Leaders (VITL) to explore using the data stored in the Vermont Health Information Exchange (VHIE) for hybrid measure production in the future. Initial system testing will be performed during QE0920.

- The Director of Quality Management formed an RFP team for the HEDIS/Quality Measures contract during the QE0320. The team finalized the scope of this contract during QE0620. The RFP will be posted and a vendor selected during QE0920.

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 Core Measure scorecard, Experience of Care, and other performance budgeting scorecards. Scorecards that were newly developed or actively maintained during this reporting period include the following initiatives: DVHA Dental Program, Applied Behavior Analysis (ABA),Early & Periodic Screening, Diagnosis and Treatment (EPSDT) and an overall DVHA performance accountability scorecard - which includes key performance measures for each unit within the Department for use by the Management Team to evaluate programs and services.

The Clinical Services Team also maintained their Green Belt status during QE0620 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.

Vermont Next Generation Medicaid ACO

During the QE0620 the DVHA's Director of Quality Management received, reviewed and approved the quarterly VMNG ACO quality management reports. Quality and Clinical staff from DVHA and the VMNG ACO meet quarterly with a focus on quality measurement and ongoing QI efforts. Our next scheduled joint meeting is during QE0920.

AHS Performance Accountability Committee

During this quarter, the state continued to review the meeting cadence of the group. Getting the meeting cadence right makes a huge difference in how well the team performs. The following factors were reviewed this quarter: urgency and importance of goals, tenure of participants, relevancy of topics, and interdependence. The latter factor was reviewed in light of the role/responsibilities of the compliance committee. The discussion was focused on how best to accomplish reciprocal strengthening of each others functions. The state will continue to explore their interactions and how they both contribute to achieving the goals of the agency.

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 of the investment, the activities being supported, and information on how they are provided), performance measures (i.e., the data being collected and analyzed to determine if the investment is achieving its desired goal), results (performance measure rates for most recent reporting period), and an interpretation of the results (i.e., comparing actual to expected rates using performance targets and/or benchmarks and to characterize trends or patterns in the data). During this most recent quarter, DCF and DOC highlighted the performance of a subset of their investments. The Clear Impact Scorecards for these investments is included in this report as Attachment 7.

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).

During this most recent quarter, DVHA highlighted the performance of its Vermont Medicaid Next Generation (VMNG) Accountable Care Organization (ACO) payment model. The Clear Impact Scorecard for this payment model is included in this report as Attachment 8.

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

The CQS/STP public comment period started on February 19, 2020 – and originally ran through March 20, 2020.

Due to the COVID-19 pandemic, the comment period was extended from 30 to 60 days. The comment period ended this quarter. 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. This version includes 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),

The state anticipates receiving CMS feedback during the next quarter.

SUD Monitoring Protocol

The SUD Monitoring Protocol specifies the methods of data collection and timeframes for reporting on the state's progress on required measures as part of the general reporting requirements described in STC 49 of the demonstration. These metrics consist of (1) established quality measures endorsed by NQF or included in other Medicaid Quality Measures measure sets, (2) CMS-constructed implementation performance metrics and (3) state-defined Health Information Technology (HIT) metrics. For each performance measure, the SUD Monitoring Protocol 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 this quarter. 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. The group has confirmed that they are on track to deliver ALL overdue rates with the next quarterly report on or before 8/29/20. After this period of modified reporting, 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. The state asked CMS to set up slots for reporting the measures separately on the PMDA - beginning with the broader 1115 waiver DY4 Q3 reporting requirements. Having the deliverables highlighted in this manner will not only communicate clear deadlines for our SUD measure deliverables - but it will also help us to prioritize their production/submission.

SMI 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. As per the STCs, the Monitoring

Protocol Template was submitted to CMS during this quarter. Components of the Monitoring Protocol included the following: 1) an assurance of the state's commitment and ability to report information relevant to each of the program implementation areas listed in STC 103(c) and STC 104(c), reporting relevant information to the state's SMI/SED financing plan described in Attachment C, and reporting relevant information to the state's Health IT plans described in STC 104(d); 2) a description of the methods of data collection and timeframes for reporting on the state's progress on required measures as part of the general reporting requirements described in Section IX of the demonstration; and 3) a description of baselines and targets to be achieved by the end of the demonstration. The state anticipates receiving CMS feedback during the next quarter.

IX. **Demonstration Evaluation Activities** (*including SUD & SMI*)

During this quarter, the state continued to work with their independent evaluator to incorporate the Serious Mental Illness (SMI) amendment provisions into the existing Global Commitment to Health demonstration evaluation design. Specifically, the document was revised to meet the requirements specified by 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 quarter and was submitted to CMS. The state anticipates receiving CMS feedback during the next quarter.

Also, during this quarter, the state continued to work with the evaluator to implement Substance Use Disorder (SUD) evaluation activities. Time was spent finalizing the list of preferred providers that would be surveyed during the second round of inquiry. The state also continued to work with the evaluator to identify 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. Unfortunately, responding to data requests brought about by the COVID-19 pandemic prevented the data team from initiating SUD measure reporting as planned. The group has confirmed that they are on track to deliver ALL necessary rates with the next quarterly report.

X. **Compliance**

Key updates from QE062020:

- DVHA is preparing subject matter experts for this year's EQRO Audit.
- AHS and DVHA are developing new structures to manage compliance activities.
- Compliance Committee review continues.

During the last quarter, 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 itemed the PMV timeline, a document request letter, a rate reporting template, and HEDIS roadmap. Review of Compliance with Standards items included a document request letter as well as desk and documentation review forms. All letters and materials are were sent to DVHA during this quarter. Due to the COVID-19 pandemic,

the methodology of both on-site reviews (i.e., Review of compliance with standards & performance measure validation) have been changed from in-person to remote. The state will work with EQRO staff to shift the content to an on-line platform and support all staff impacted by the change.

Updates to Agency Approach to Medicaid Compliance

DVHA and AHS continue to discuss 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.

Compliance Committee

During this quarter, the state continued 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 looked at included, but were 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.

XI. Reported Purposes for Capitated Revenue Expenditures

Provided that DVHA's contractual obligation to the populations covered under the Demonstration is met, any revenue from capitation payments related to the beneficiaries covered under this Demonstration may be used for the following purposes:

- Reduce the rate of uninsured and/or underinsured in Vermont;
- Increase the access of quality health care to uninsured, underinsured, and Medicaid beneficiaries;
- Provide public health approaches and other innovative programs to improve the health outcomes, health status and the quality of life for uninsured, underinsured and Medicaid-eligible individuals in Vermont; and
- Encourage the formation and maintenance of public-private partnerships in health care, including initiatives to support and improve the health care delivery system and promote transformation to value-based and integrated models of care.

Attachment 6 is a summary of Investments, with applicable category identified, for QE062020.

XII. Enclosures/Attachments

Attachment 1: Budget Neutrality Workbook
Attachment 2: Enrollment and Expenditures Report
Attachment 3: Complaints to Member Services
Attachment 4: Medicaid Grievance and Appeal Reports
Attachment 5: Office of the Health Care Advocate Report
Attachment 6: QE062020 GC Investments

Attachment 7: Investment Scorecard
Attachment 8: Payment Model Scorecard

XIII. State Contact(s)

Fiscal:	Sarah Clark, CFO	
	VT Agency of Human Services	802-505-0285 (P)
	280 State Drive	802-241-0450 (F)
	Waterbury, VT 05671-1000	sarah.clark@vermont.gov
Policy/Program:	Ashley Berliner, Director of Health Care Policy & Planning	
	VT Agency of Human Services	802-578-9305 (P)
	280 State Drive, Center Building	802-241-0958 (F)
	Waterbury, VT 05671-1000	ashley.berliner@vermont.gov
Managed Care Entity:	Cory Gustafson, Commissioner	
	Department of VT Health Access	802-241-0147 (P)
	280 State Drive, NOB 1 South	802-879-5962 (F)
	Waterbury, VT 05671-1010	cory.gustafson@vermont.gov

Date Submitted to CMS: September 2, 2020

ATTACHMENTS

Attachment 1 - Budget Neutrality

State of Vermont Global Commitment to Health
Budget Neutrality PMPM Projection vs 64 Actuals Summary
August 14, 2020

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	$ 131,997,852	$ 67,242,271	$ -	$ 472,151,551
ABD - Non-Medicare - Child	$ 85,359,001	$ 78,434,428	$ 75,857,151	$ 33,198,147	$ -	$ 272,848,727
ABD - Dual	$ 664,153,383	$ 693,539,886	$ 720,728,480	$ 373,022,701	$ -	$ 2,451,444,450
Non ABD - Non-Medicare - Adult	$ 101,757,250	$ 96,887,008	$ 73,811,465	$ 37,323,515	$ -	$ 309,779,237
Non ABD - Non-Medicare - Child	$ 392,665,288	$ 406,444,058	$ 413,858,625	$ 215,182,308	$ -	$ 1,428,150,280
Total Expenditures Without Waiver	**$ 1,386,795,376**	**$ 1,405,356,354**	**$ 1,416,253,573**	**$ 725,968,942**	**$ -**	**$ 4,934,374,246**
With Waiver						
ABD Non Medicare Adult	$ 162,602,154	$ 162,728,372	$ 168,382,861	$ 94,057,967	$ -	$ 587,771,354
ABD - Non-Medicare - Child	$ 66,593,208	$ 60,077,015	$ 58,176,676	$ 31,037,663	$ -	$ 215,884,561
ABD - Dual	$ 445,847,909	$ 461,739,496	$ 484,543,363	$ 244,281,026	$ -	$ 1,636,411,793
Non ABD - Non-Medicare - Adult	$ 84,040,228	$ 84,275,155	$ 67,221,781	$ 35,534,470	$ -	$ 271,071,633
Non ABD - Non-Medicare - Child	$ 305,543,574	$ 335,706,591	$ 350,804,595	$ 184,741,426	$ -	$ 1,176,796,187
Premium Offsets	$ (655,991)	$ (772,935)	$ (774,152)	$ (256,518)	$ -	$ (2,459,595)
Moderate Needs Group	$ 1,488,408	$ 1,378,915	$ 1,429,868	$ 503,077	$ -	$ 4,800,268
Marketplace Subsidy	$ 6,355,286	$ 6,242,717	$ 5,915,336	$ 3,054,449	$ -	$ 21,567,789
VT Global Rx	$ 13,824,166	$ 15,300,919	$ 10,692,124	$ 951,327	$ -	$ 40,768,536
VT Global Expansion VHAP	$ 414,824	$ (0)	$ 0	$ -	$ -	$ 414,824
CRT DSHP	$ 10,331,787	$ 9,240,772	$ 6,787,058	$ 3,066,707	$ -	$ 29,426,324
Investments	$ 142,332,671	$ 148,500,000	$ 119,133,231	$ 63,277,851	$ -	$ 473,243,753
Total Expenditures With Waiver	**$ 1,238,718,223**	**$ 1,284,417,019**	**$ 1,272,312,740**	**$ 660,249,445**	**$ -**	**$ 4,455,697,427**
Supplemental Test: New Adult (Gross)						
Limit New Adult	$ 370,689,611	$ 375,735,593	$ 369,380,851	$ 198,785,091	$ -	$ 1,314,591,146
Without Waiver SUD - IMD New Adult Expenditures		$ 2,704,249	$ 4,842,747	$ 2,349,718	$ -	$ 9,896,713
Without Waiver SMI - IMD New Adult Expenditures				$ -	$ -	$ -
With Waiver New Adult Expenditures	$ 295,620,340	$ 312,104,578	$ 315,241,704	$ 188,348,900	$ -	$ 1,111,315,521
With Waiver SUD - IMD New Adult Expenditures		$ 2,826,119	$ 5,869,169	$ 2,118,023	$ -	$ 10,813,311
With Waiver SMI - IMD New Adult Expenditures				$ -	$ -	$ -
Surplus (Deficit)	*$ 75,069,271*	*$ 63,509,145*	*$ 53,112,725*	*$ 10,667,886*	$ -	$ 202,359,027
Supplemental Test: IMD SUD (Gross)						
SUD - IMD ABD - Non-Medicare - Adult		$ 268,039	$ 529,433	$ 238,813	$ -	$ 1,036,285
SUD - IMD ABD - Dual		$ 214,495	$ 442,312	$ 239,386	$ -	$ 896,193
SUD - IMD Non ABD - Non-Medicare - Adult		$ 533,391	$ 633,224	$ 285,236	$ -	$ 1,451,851
Limit SUD IMD Without Waiver		**$ 1,015,926**	**$ 1,604,968**	**$ 763,435**	**$ -**	**$ 3,384,329**
SUD - IMD ABD Non Medicare Adult		$ 249,820	$ 646,440	$ 235,083	$ -	$ 1,131,344
SUD - IMD ABD - Dual		$ 199,224	$ 545,837	$ 172,122	$ -	$ 917,183
SUD - IMD Non ABD - Non-Medicare - Adult		$ 540,841	$ 803,762	$ 303,836	$ -	$ 1,648,440
Limit SUD IMD With Waiver		**$ 989,886**	**$ 1,996,039**	**$ 711,041**	**$ -**	**$ 3,696,966**
Surplus (Deficit)		*$ 26,040*	*$ (391,071)*	*$ 52,394*	$ -	$ (312,637)
Supplemental Test: IMD SMI (Gross)						
SMI - IMD ABD - Non-Medicare - Adult				$ -	$ -	$ -
SMI - IMD ABD - Dual				$ -	$ -	$ -
SMI - IMD Non ABD - Non-Medicare - Adult				$ -	$ -	$ -
Limit SMI IMD Without Waiver		**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
SMI - IMD ABD Non Medicare Adult				$ -	$ -	$ -
SMI - IMD ABD - Dual				$ -	$ -	$ -
SMI - IMD Non ABD - Non-Medicare - Adult				$ -	$ -	$ -
Limit SMI IMD With Waiver		**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
Surplus (Deficit)		*$ -*	*$ -*	*$ -*	*$ -*	$ -
Waiver Savings Summary						
Annual Savings	$ 148,077,153	$ 120,939,335	$ 143,940,833	$ 65,719,497	$ -	$ 478,676,819
Shared Savings Percentage	30%	25%	25%	25%	25%	
Shared Annual Savings	$ 44,423,146	$ 30,234,834	$ 35,985,208	$ 16,429,874	$ -	$ 127,073,062
Total Savings	$ 44,423,146	$ 30,234,834	$ 35,985,208	$ 16,429,874	$ -	$ 127,073,062
Cumulative Savings	***$ 44,423,146***	***$ 74,657,980***	***$ 110,643,188***	***$ 127,073,062***	***$ 127,073,062***	***$ 127,073,062***
	11%	9%	10%	9%		

$ 10,711,916
$ -

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 13 – PMPM**				**DY 14 – PMPM**				**DY 15 – PMPM**			
	QE 0318	**QE 0618**	**QE 0918**	**QE 1218**	**QE 0319**	**QE 0619**	**QE 0919**	**QE 1219**	**QE 0320**	**QE 0620**	**QE 0920**	**QE 1220**
(A) New Adult Group PMPM Projection	$540.03	$540.03	$540.03	$540.03	$562.71	$562.71	$562.71	$562.71	$586.34	$586.34	$586.34	$586.34
(B-1) eligible member months w/ Child	55,583	55,408	55,889	57,002	57,969	58,516	58,610	58,190	60,039	65,276		
(B-2) eligible member months w/o Child	120,870	119,755	116,895	114,366	110,736	106,927	103,710	101,774	102,706	111,006		
(C-1 = (A x B-1) Supplemental Cap 1 w/ Child	$ 30,016,487.49	$ 29,921,982.24	$ 30,181,736.67	$ 30,782,790.06	$ 32,619,735.99	$ 32,927,538.36	$ 32,980,433.10	$ 32,744,094.90	$ 35,203,267.26	$ 38,273,929.84		
(C-2 = (A x B-2) Supplemental Cap 1 w/o Child	$ 65,273,426.10	$ 64,671,292.65	$ 63,126,806.85	$ 61,761,070.98	$ 62,312,254.56	$60,168,892.17	$58,358,654.10	$57,269,247.54	$60,220,636.04	$ 65,087,258.04		
(D-1) New Adult FMAP w/ Child	53.47%	53.47%	53.47%	53.89%	53.89%	53.89%	53.89%	53.86%	60.06%	60.06%		
(D-2) New Adult FMAP w/o Child	89.95%	89.95%	89.95%	89.99%	93.00%	93.00%	93.00%	93.00%	90%	90%		
(E-1 = C-1 x D-1) Federal Share of Supplemental Cap 1 w/ Child	$ 16,049,815.86	$ 15,999,283.90	$ 16,138,174.60	$ 16,588,845.56	$ 17,578,775.73	$ 17,744,650.42	$ 17,773,155.40	$ 17,635,969.51	$ 21,143,082.32	$ 22,987,322.26		
(E-2 = C2 x D-2) Federal Share of Supplemental Cap 1 w/o Child	$ 58,713,446.78	$ 58,171,827.74	$ 56,782,562.76	$ 55,578,787.77	$ 57,950,396.74	$ 55,957,069.72	$ 54,273,548.31	$ 53,260,400.21	$ 54,198,572.44	$ 58,578,532.24		
Subtotal Federal Share Supplemental Cap 1	$ 74,763,262.64	$ 74,171,111.64	$ 72,920,737.36	$ 72,167,633.34	$ 75,529,172.47	$ 73,701,720.14	$ 72,046,703.71	$ 70,896,369.73	$ 75,341,654.75	$ 81,565,854.50		
Total FFP reported for New Adult Group	$ 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	$ 82,218,290.81	$ 68,092,015.38		
Supplemental Budget Neutrality Test 1 over/(under) - report any negative # under main GC budget neutrality	$ 12,580,217.20	$ 10,414,960.88	$ 10,254,400.88	$ 10,897,956.21	$ 7,674,337.60	$ 5,113,127.88	$ 8,770,147.88	$16,651,104.99	$ (6,876,636.06)	$ 13,473,839.11		

Report to
The Vermont Legislature

Medicaid Program Enrollment and Expenditures Quarterly Report

In Accordance with 33 V.S.A. § 1901f

Submitted to: The General Assembly

Submitted by: Mike Smith, Secretary
Agency of Human Services

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

Report Date: June 1st, 2020

TABLE OF CONTENTS

BACKGROUND

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

KEY TERMS

Caseload: Average monthly member enrollment

PMPM: Per Member Per Month

MEG: Medicaid Eligibility Group

ABD Adult: Beneficiaries age 19 or older; categorized as aged, blind, disabled, and/or medically needy

ABD Dual: Beneficiaries eligible for both Medicare and Medicaid; categorized as aged, blind, disabled, and/or medically needy

General Adult: Beneficiaries age 19 or older; pregnant women or parents/caretaker relatives of minor children receiving cash assistance and those receiving transitional Medicaid after the receipt of cash assistance

New Adult Childless: Beneficiaries age 19 or older and under 65; who are at or below 133% of the FPL who do not have dependent children

New Adult w/Child: Beneficiaries age 19 or older and under 65; who are at or below 133% of the FPL who have dependent children

BD Child: Beneficiaries under age 19; categorized as blind, disabled, and/or medically needy

General Child: Beneficiaries under age 19, and below the protected income level, categorized as those eligible for cash assistance including Reach Up (Title V) and foster care payments (Title IV-E)

Underinsured Child: Beneficiaries under age 19 with household income 237-312% FPL with other (primary) insurance

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

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

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

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

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

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

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

MEDICAID PROGRAM ENROLLMENT AND EXPENDITURES

The Department of Vermont Health Access

Caseload and Expenditure Report
All AHS and AOE YTD SFY'20

Medicaid Eligibility Group	SFY'20 BAA Caseload	SFY'20 BAA Budget	SFY'20 BAA PMPM	SFY'20 Actuals Thru March 31, 2020 Caseload	SFY'20 Actuals Thru March 31, 2020 Expenses	SFY'20 Actuals Thru March 31, 2020 PMPM	% of Expenses to Budget Line Item
ABD Adult	6,031	$ 175,544,699	$ 2,425.59	6,313	$ 107,664,363	$ 1,894.97	61.33%
ABD Dual	17,804	$ 301,421,679	$ 1,410.83	17,465	$ 171,223,548	$ 1,089.30	56.81%
General Adult	12,867	$ 95,051,392	$ 615.60	7,961	$ 48,346,898	$ 674.75	50.86%
New Adult Childless	39,273	$ 243,282,915	$ 516.22	34,094	$ 170,313,356	$ 555.05	70.01%
New Adult w/Child	18,813	$ 95,772,884	$ 424.23	19,480	$ 82,609,793	$ 471.18	86.26%
BD Child	2,112	$ 75,704,269	$ 2,987.07	1,784	$ 41,389,119	$ 2,577.16	54.67%
General Child	59,708	$ 420,404,906	$ 586.75	57,240	$ 258,410,755	$ 501.61	61.47%
Underinsured Child	584	$ 1,863,809	$ 265.95	553	$ 818,934	$ 164.54	43.94%
CHIP	4,697	$ 10,270,816	$ 182.22	4,570	$ 10,653,781	$ 259.04	103.73%
Vermont Premium Assistance	19,951	$ 6,914,219	$ 28.88	16,249	$ 4,239,688	$ 28.99	61.32%
Vermont Cost Sharing	4,052	$ 1,314,872	$ 27.04	3,591	$ 881,837	$ 27.28	67.07%
Pharmacy Only	10,125	$ 7,465,318	$ 61.44	9,989	$ 2,117,961	$ 23.56	28.37%
Choices for Care - Traditional	4,390	$ 213,712,634	$ 4,056.81	4,414	$ 163,895,364	$ 4,125.33	76.69%
Choices for Care - Acute	4,390	$ 36,638,466	$ 695.49	4,414	$ 30,248,044	$ 761.36	82.56%
Total Medicaid	196,355	$ 1,685,362,877	$ 715.27	180,114	$ 1,092,813,441	$ 674.15	64.84%

The Department of Vermont Health Access

Caseload and Expenditure Report
All AHS YTD SFY'20

Medicaid Eligibility Group	SFY'20 BAA Caseload	SFY'20 BAA Budget	SFY'20 BAA PMPM	SFY'20 Actuals Thru March 31, 2020 Caseload	SFY'20 Actuals Thru March 31, 2020 Expenses	SFY'20 Actuals Thru March 31, 2020 PMPM	% of Expenses to Budget Line Item
ABD Adult	6,031	$ 187,483,359	$ 2,590.55	6,313	$ 106,796,910	$ 1,879.70	56.96%
ABD Dual	17,804	$ 348,702,373	$ 1,632.13	17,465	$ 171,104,921	$ 1,088.54	49.07%
General Adult	12,867	$ 114,605,155	$ 742.24	7,961	$ 48,186,666	$ 672.51	42.05%
New Adult Childless	39,273	$ 227,950,480	$ 483.69	34,094	$ 170,229,743	$ 554.77	74.68%
New Adult w/Child	18,813	$ 71,770,133	$ 317.91	19,480	$ 82,609,079	$ 471.18	115.10%
BD Child	2,112	$ 64,078,056	$ 2,528.33	1,784	$ 31,913,571	$ 1,987.15	49.80%
General Child	59,708	$ 368,825,569	$ 514.76	57,240	$ 232,600,090	$ 451.51	63.07%
Underinsured Child	584	$ 1,518,973	$ 216.75	553	$ 636,629	$ 127.91	41.91%
CHIP	4,697	$ 14,649,058	$ 259.90	4,570	$ 9,490,314	$ 230.75	64.78%
Vermont Premium Assistance	19,951	$ 6,914,219	$ 28.88	16,249	$ 4,239,688	$ 28.99	61.32%
Vermont Cost Sharing	4,052	$ 1,314,872	$ 27.04	3,591	$ 881,837	$ 27.28	67.07%
Pharmacy Only	10,125	$ 7,465,318	$ 61.44	9,989	$ 2,117,961	$ 23.56	28.37%
Choices for Care - Traditional	4,390	$ 213,712,634	$ 4,056.81	4,414	$ 163,895,364	$ 4,125.33	76.69%
Choices for Care - Acute	4,390	$ 28,908,329	$ 548.75	4,414	$ 30,229,764	$ 760.90	104.57%
Total Medicaid	196,355	$ 1,657,898,527	$ 703.61	180,114	$ 1,054,932,538	$ 650.78	63.63%

The Department of Vermont Health Access

Caseload and Expenditure Report

DVHA Only YTD SFY'20

Medicaid Eligibility Group	SFY'20 BAA Caseload	SFY'20 BAA Budget	SFY'20 BAA PMPM	SFY'20 Actuals Thru March 31, 2020 Caseload	SFY'20 Actuals Thru March 31, 2020 Expenses	SFY'20 Actuals Thru March 31, 2020 PMPM	% of Expenses to Budget Line Item
ABD Adult	6,031	$ 53,364,028	$ 737.36	6,313	$ 42,960,016	$ 756.13	80.50%
ABD Dual	17,804	$ 56,831,305	$ 266.00	17,465	$ 42,598,967	$ 271.01	74.96%
General Adult	12,867	$ 72,488,541	$ 469.47	7,961	$ 38,359,780	$ 535.36	52.92%
New Adult Childless	39,273	$ 195,378,448	$ 414.57	34,094	$ 144,329,080	$ 470.36	73.87%
New Adult w/Child	18,813	$ 78,136,341	$ 346.11	19,480	$ 73,283,514	$ 417.99	93.79%
BD Child	2,112	$ 19,287,093	$ 761.01	1,784	$ 15,729,932	$ 979.45	81.56%
General Child	59,708	$ 150,490,908	$ 210.04	57,240	$ 125,284,222	$ 243.19	83.25%
Underinsured Child	584	$ 490,900	$ 70.05	553	$ 355,049	$ 71.34	72.33%
CHIP	4,697	$ 8,439,212	$ 149.73	4,570	$ 7,221,596	$ 175.59	85.57%
Vermont Premium Assistance	19,951	$ 6,914,219	$ 28.88	16,249	$ 4,239,688	$ 28.99	61.32%
Vermont Cost Sharing	4,052	$ 1,314,872	$ 27.04	3,591	$ 881,837	$ 27.28	67.07%
Pharmacy Only	10,125	$ 7,465,318	$ 61.44	9,989	$ 2,117,961	$ 23.56	28.37%
Choices for Care - Traditional	4,390	$ -	$ -	4,414	$ -	$ -	0.00%
Choices for Care - Acute	4,390	$ 28,269,908	$ 536.63	4,414	$ 26,322,059	$ 662.54	93.11%
Total Medicaid	196,355	$ 678,871,092	$ 288.11	180,114	$ 523,683,701	$ 323.06	77.14%

VERMONT

State of Vermont *Agency of Human Services*
Department of Vermont Health Access [Phone] 802-879-5900
280 State Drive, NOB 1 South
Waterbury, VT 05671-1010
dvha.vermont.gov

Questions, Complaints and Concerns Received by Health Access Member Services
April 1, 2020 – June 30, 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.

April 2020:

- No issues to report

May 2020:

- Anonymous wanted to give negative feedback on a methadone clinic: Girlfriend goes to the methadone clinic in Brattleboro (unknown name of clinic.) Has been going to the clinic for a long time. Went to the clinic this morning, had 6 take home. The clinic received a call that she was abusing this and drug tested her, and withdrew the take-home for it. Stating this is due to hear say. This is inconvenient that she now has to go there every day, when a person goes to the clinic and does what she is supposed to. States upon the checkup they reviewed her meds and completed a drug test. After this they revoked her take home, and not have to go into the clinic. States she knows his girlfriend is doing the right thing. Caller thinks a lot of people are being mistreated by this clinic for people need help. Understands there is a process to earn this take home program. But the clinic takes hear-say seriously, and he wants to make sure that because Medicaid is paying for these services, and would like someone to look into it. States he is worried if his girlfriend speaks up to the clinic that they won't treat her anymore. CSR apologized for their experience and frustration and offered to document their feedback.

June 2020:

- Caller wanted to submit negative feedback about our Prior Authorization process. Caller states she got a

Prior Approval (PA) for a prescription, but the doctor's office also got the same notice. Caller suggests that the copy of the PA notices sent to patients should state that the doctor's office also got the notice and it should be stated clearly that the information being requested is what the doctor needs to provide, not the patient. CSR apologized for the confusion, explained the process to her and offered to document her feedback.

VERMONT

Agency of Human Services

Grievance and Appeal Quarterly Report
Medicaid Managed Care Model
All Departments Combined Data
April 1, 2020 – June 30, 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 Managed Care Model are the Designated Agencies (DA) and Specialized Service Agencies (SSA) that provide service authorizations for DMH and DAIL. Each entity should have at least one assigned grievance and appeal coordinator who enters data into the centralized grievance and appeals database. This report is based on data compiled on August 26, 2020 from the centralized database that were filed from April 1, 2020 through June 30, 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 2 grievances filed; neither were 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 DVHA, DAIL, DCF or VDH during this quarter.

Grievances were filed for service category mental health services.

There were no Grievance Reviews filed this quarter.

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

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

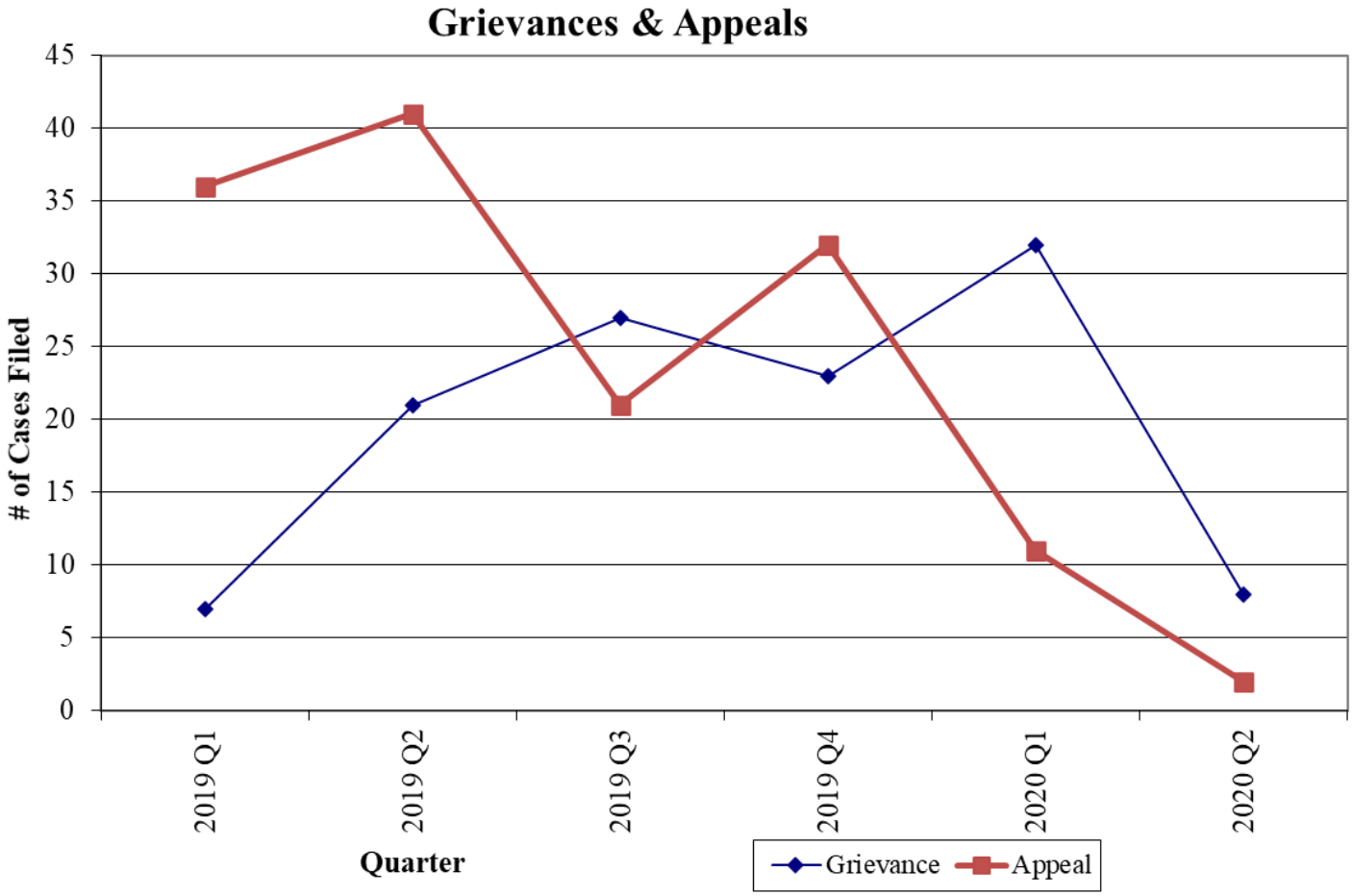
During this quarter, there were 8 appeals filed. Of these 8 appeals, 6 were resolved (75%).

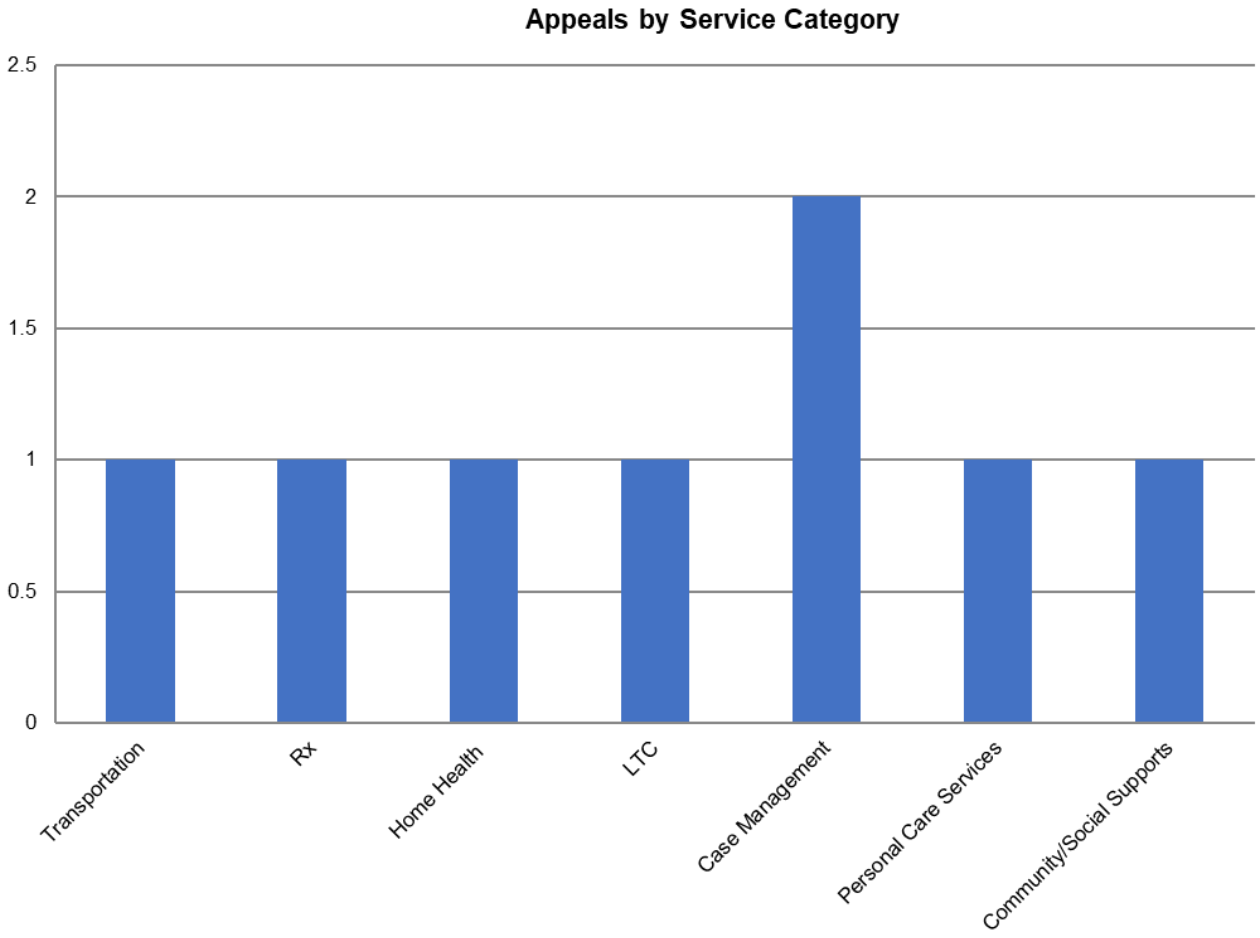
Of the 8 appeals that were resolved this quarter, 100% were resolved within the statutory time frame of 30 days. The average number of days it took to resolve these cases was 15 days. Acknowledgement letters of the receipt of an appeal must be sent within five days; the average was two days.

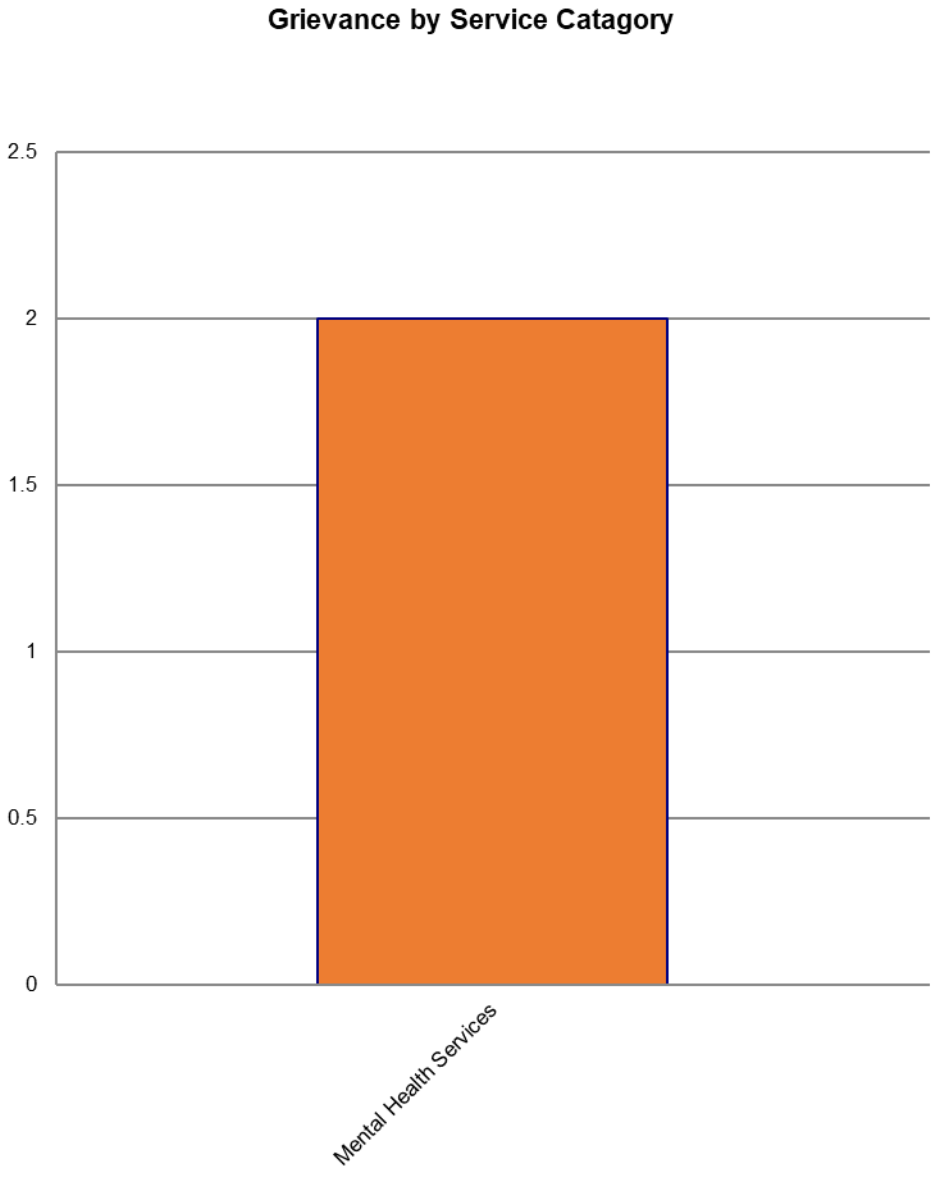
Of the 8 appeals filed, DVHA had 2 appeals filed (25%), DAIL had 2 (25%), VDH had 1 (13%) and DMH had 3 (37%).

The appeals filed were for service categories; case management, transportation, personal care, long term care, prescriptions, and community/social supports.

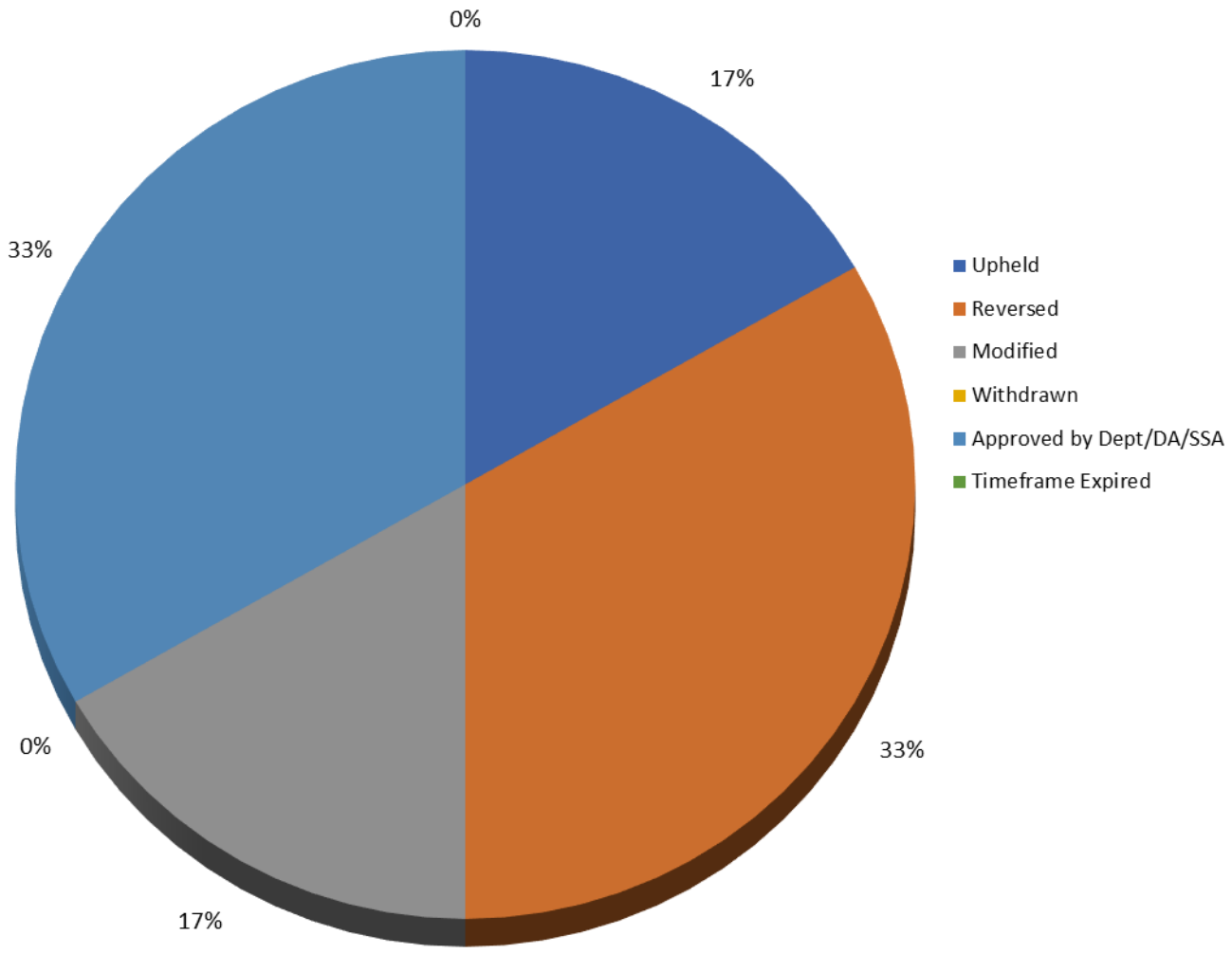
Beneficiaries must exhaust the internal appeal process before they can file a fair hearing if their appeal is not decided in their favor. There was no fair hearing filed this quarter.


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
Quarter
Grievance
Appeal


Appeals by Service Category
2.5
2
1.5
1
0.5
0
Transportation
Rx
Home Health
LTC
Case Management
Personal Care Services
Community/Social Supports


Grievance by Service Catagory
2.5
2
1.5
1
0.5
0
Mental Health Services

Appeal Resolutions
1/1/2020 thru 6/30/2020



Vermont Legal Aid

Office of the Health Care Advocate

Quarterly Report

April 1, 2020 - June 30, 2020

to the

Agency of Administration

submitted by

Michael Fisher, Chief Health Care Advocate

Office of the Health Care Advocate

July 21, 2020

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. The HCA helpline continues to advocate and resolve issues during this crisis.

Because of the ongoing crisis, we are submitting a significantly condensed Quarterly Report.

The HCA undertook significant consumer outreach during this quarter. The HCA conducted an online survey to find out how COVID-19 was impacting access to healthcare during the COVID crisis. We had 2,501 responses to the survey. The responses gave us insight into how Vermonters were dealing with the crisis and helped inform our policy advocacy. We also conducted a "virtual town hall" to educate consumers and answer questions. The HCA advocate presenting at the town hall answered questions from consumers about Medicaid eligibility, transitioning to Medicare, COVID testing, accessing medical care, and Special Enrollment periods. We had more than 20 people watching the town hall live, and over 322 watched it later, on YouTube and Facebook.

The HCA again focused on making Vermonters aware of their healthcare coverage options. This quarter we talked to 29 households about the COVID Special Enrollment Period (SEP). The COVID SEP allows uninsured Vermonters to enroll in a Qualified Health Plan (QHP). It has been extended to August 15, 2020. The HCA had over 1,100 pageviews on its website about the COVID SEP. We also talked to 49 additional households about other Special Enrollment Periods. We advised 87 households about eligibility for Medicaid for Children and Adults and 38 households for Medicaid for Aged, Blind and Disabled. We had 1,694 pageviews on the website on Medicaid eligibility.

Sarah's Story:

Sarah called the HCA because she had no health insurance and needed medical care. She had been on a Vermont Health Connect (VHC) plan in the past, but it had not been affordable for her. Because of the COVID Special Enrollment Period (SEP), Sarah now had the opportunity to enroll in coverage. The COVID-SEP allows uninsured Vermonters to enroll in a plan on VHC. Normally, consumers must enroll during Open Enrollment, or if they have a qualifying event such as the birth of a child or a move.

The advocate discovered that Sarah would be eligible for an Advance Premium Tax Credit (APTC) based on her income, but she needed to file her taxes. Advance Premium Tax Credit is a monthly subsidy that reduces a person's insurance premium, but in order to be eligible for it, they need to have filed their taxes. Sarah had not filed taxes, so VHC initially determined her to be ineligible for APTC. Without APTC, Sarah would not have been able to afford coverage.

She quickly filed her taxes and was determined eligible for a substantial amount of APTC. Sarah was then able to use the COVID-SEP to enroll in a VHC plan.

We continued to do regular, periodic outreach on social media and post ads on Front Porch Forum to reach more consumers.

The HCA helpline has seen reduced calls during this quarter. During the COVID-19 crisis, the State of Vermont has not been conducting Medicaid reviews or closing state health care programs. Additionally, individuals on Vermont Health Connect plans are not being closed for non-payment. Medicaid eligibility

is typically a top issue for the HCA, so it is not surprising to see a decrease in calls when closures and reviews are not happening. We expect an increase of calls when the State of Vermont resumes reviews and renewals, and as consumers start to receive information about Open Enrollment for 2021 VHC plans.

During this quarter, Vermont Legal Aid also suffered a computer network incident during the first week of May. This meant we had limited access to our database until it was fully restored at the end of June. The helpline continued to serve Vermonters during this time period, and our database has now been restored.

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 and the stimulus checks created in the CARES ACT. The HCA is also working with the Disability Law Project at Vermont Legal Aid to make sure that Vermonters on 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 continues to advocate for accessible COVID testing.

During this quarter the HCA continued to advocate for health care consumers in the Vermont Legislature. We supported efforts to move the COVID Relief Funds quickly into the health care sector to protect Vermont providers during this very challenging time. We also unsuccessfully promoted the allocation of some of these funds to be available to Vermonters who have lost significant income as a result of the COVID crisis and who had significant out of pocket health care expenses. This proved difficult to accomplish in the rush to pass the legislation and have these monies spent before the end of the calendar year.

In an advocacy partnership with the HCA, DVHA and UVMMC, we worked to support the passage of an update to the VPharm program that, once approved by the Federal Government, will expand prescription drug supports for low income, older, and disabled Vermonters.

As Vermont continues to grapple with the COVID-19 crisis, we will continue to advocate for accessible and affordable coverage for all.

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 508 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:

- **21.85%** about **Access to Care**
- **11.02%** about **Billing/Coverage**
- **3.54%** about **Buying Insurance**
- **10.04%** about **Complaints**
- **13.19%** about **Consumer Education**
- **29.53%** about **Eligibility** for state and federal programs
- **9.52**% were categorized as **Other**, which includes Medicare Part D, communication problems with providers or health benefit plans, access to medical records, changing providers or plans, confidentiality issues, and complaints about insurance premium rates, as well as other issues.

We have a customized case management system that allows us to track more than one issue per case. This enables us to see the total number of calls that involved multiple issues. For example, although 150 of our cases had eligibility for state and federal healthcare programs listed as the primary issue, an additional 303 cases had eligibility listed as a secondary concern.

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

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

The full quarterly report for April-June 2020, includes:

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

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

- **All Calls/All Coverages**: 508
- **Department of Vermont Health Access (DVHA) beneficiaries**: 145
- **Commercial Plan Beneficiaries**: 114
- **Uninsured Vermonters**: 49
- **Vermont Health Connect (VHC)**: 145
- **Reportable Activities (Summary & Detail)**: 24 activities and 1 document

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:

1. *Health* – section home page – 2,246 *pageviews*
2. *Income Limits – Medicaid* – 1,694
3. *News: Coronavirus SEP for Vermont Health Connect* – 1,149
4. *News: Coronavirus and Long-Term Care* – 765*
5. *Medicaid* – 570
6. *News: Health Insurance Premium Increases Public Comment* – 506*
7. *Resource Limits – Medicaid* – 364
8. *Medicare Savings Programs* – 334*
9. *HCA Help Request Form* – 333 pageviews and 56 online help requests (form was down for a time due to our network incident problem)
10. *Long-term Care* – 327
11. *Dental Services* – 311
12. *Choices for Care* – 293
13. *Services Covered by Medicaid* – 284
14. *Medicaid, Dr. Dynasaur & Vermont Health Connect* – 221
15. *Advance Directive forms* – 199
16. *Medical Decisions: Advance Directives* – 190
17. *Medicaid and Medicare Dual Eligible* – 187
18. *Vermont Long-Term Care Ombudsman Project* – 184*
19. *Prescription Help – State Pharmacy Programs* – 173
20. *Choices for Care income limits* – 152

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

1. *News: Health Insurance Premium Increases Public Comment* – 327
2. *Income Limits – Medicaid* – 105
3. *Health* – section home page – 91
4. *News: Coronavirus and Long-Term Care* – 78
5. *Dental Services* – 29
6. *Services Covered by Medicaid* – 29
7. *Medicaid* – 28
8. *Choices for Care* – 27
9. *News: Coronavirus SEP for Vermont Health Connect* – 20
10. *Medicare Savings Programs* – 19

Outreach and Education

Survey: Health Care Access During the Early Crisis, April 12 to April 26, 2020. The Office of the Health Care Advocate fielded an online survey from Sunday April 12, 2020 through Sunday April 26, 2020, to gain a better understanding of how the COVID-19 pandemic was impacting Vermonters. 2,501 persons responded to the survey. The HCA shared the results widely, to help Vermont policy makers understand the impact of the pandemic on health care access and the health care affordability crisis. See a summary of the results of the survey here.

Public Service Announcements on Front Porch Forum, March 29 to June 27, 2020. The HCA published a series of ten public service announcements in state-wide Front Porch Forum posts, reaching 180,000 Vermont households with a variety of health care access and health insurance messages.

3/29/20 - 4/4/20

A. Lost Income? What to Do About Health Insurance?

PORCH. LY/ VTLEGALAIDHEALTHCAREADVOCATE/ D 8 X44

PAID AD

Lost income? You may be able to get lower-cost or free health insurance through VT Health Connect. Even if you already have health insurance, your costs might go down. For free help, call the Health Care Advocate at 800-917-7787 or visit us online.

LEARN MORE

4/5/20 - 4/11/20

B. Help for Vermonters on Medicare

PORCH. LY/ VTLEGALAIDMEDICARE/ DAQVC

PAID AD

Need help paying your Medicare premiums? Need help paying for prescription drugs? If you have lost income you may get more help with Medicare costs and drug costs. Contact the Health Care Advocate at 800-917-7787 or *HCA@vtlegalaid.org* for free help.

LEARN MORE

4/12/20 -4/18/20

C. HCA Survey: Covid-19 Crisis and Your Health Care

PORCH. LY/ VERMONTLEGALAIDHCASURVEY/ DCJ 31

PAID AD

VT's Office of the Health Care Advocate asks you to complete a 5 minute survey to help us learn about Vermonters' health needs during the Covid-19 crisis. We will raffle off six $50 Visa gift cards as a thank you. Questions? Email *HCA@vtlegalaid.org*

COMPLETE THE SURVEY

4/19/20 - 4/25/20

D. Need Health Insurance? Sign Up for VHC by May 15!

PORCH. LY/ VTLEGALAIDVHCMAY/ DEBJS

PAID AD

Uninsured? Call VT Health Connect at 855-899-9600 to sign up for health insurance. The new deadline to sign up is May 15. Many Vermonters can get help paying premiums. Questions? Call the Health Care Advocate at 800-917-7787 for free help.

LEARN MORE

4/26/20 - 4/29/20:

E. VT Legal Aid Town Hall: Health Insurance, Medicaid

PORCH. LY/ VTLEGALAIDTOWNHALL/ DG 1 BD

PAID AD

You're invited to a 30-Minute Town Hall and Q&A session with the Office of the Health Care Advocate on Thursday, April 30 at 10am. Attend online: *https://bit.ly/HCATownHall* or on VLA's Facebook. Or listen by phone: 1-888-788-0099 (ID: 923-1186-6366).

LEARN MORE

4/30/20 - 5/2/20

F. Need Health Insurance? Sign Up for VHC by May 15!

PORCH. LY/ VTLEGALAIDHEALTHINSURANCESIGNUP/ DG 1BE

PAID AD

Uninsured? Call VT Health Connect at 855-899-9600 to sign up for health insurance. The new deadline to sign up is May 15. Many Vermonters can get help paying premiums. Questions? Call the Health Care Advocate at 800-917-7787 for free help.

LEARN MORE

5/10/20 - 5/11/20

G. Lost Income? What to Do About Health Insurance?

PORCH. LY/ VTLEGALAIDHEALTHCAREADVOCATE/ D 8 X44

PAID AD

Lost income? You may be able to get lower-cost or free health insurance through VT Health Connect. Even if you already have health insurance, your costs might go down. For free help, call the Health Care Advocate at 800-917-7787 or visit us online.

LEARN MORE

5/12/20 - 5/16/20

H. Uninsured? Losing insurance? You Can Get Help.

PORCH. LY/ VTLEGALAIDEXTENDEDDEADLINE/ DKFWH

PAID AD

Sign up for VT Health Connect by phone at 855-899-9600 or online at *www.VermontHealthConnect.gov* The new deadline to sign up is JUNE 15. If you lost insurance recently or you lose insurance in the future you may get even more time to sign up.

LEARN MORE

6/14/20 - 6/20/20

I. Health Care Advocate: Lower Your Health Care Costs

Paid Ad

You and your family may now qualify for Medicaid. If not, you may qualify for more financial help with VT Health Connect. Everyone uninsured can sign up now. Learn more about VT's Health Care Advocate (free!) HelpLine and how we can help your family.

Learn More

6/21/20 - 6/27/20

J. Needed: Your Input on 2021 Health Insurance Prices

Paid Ad

Blue Cross Blue Shield of Vermont proposed a 6.3% price increase for next year. And MVP Health Care proposed a 7.3% increase. How would these increases affect you and your family? Submit your public comment here: *www.bit.ly/SubmitAPublicComment*.

Learn More or Submit Comment

Virtual Town Halls and Q&A Sessions from April 16 to June 11, 2020. The Office of the Health Care Advocate hosted seven town halls on a variety of timely health care topics and social determinants of health topics.

4/16/20: stimulus checks, including explaining what these payments mean for Vermonters with Medicaid, APTC, and other health programs

4/23/20: unemployment benefits, including how they affect eligibility for Medicaid, APTC, and other health programs

4/30/20: health insurance and access to care

5/7/20: housing and evictions, and how to stay housed during the pandemic

5/28/20: - debt and problems paying bills and how to stay financially stable during the pandemic

6/4/20: home health and long-term care

6/11/20: disability and special education and support for students with disabilities

Anti-Discrimination Advocacy and Outreach, May 21, 2020 to June 23, 2020. The HCA submitted comments opposing changes to ACA section 1557 that would weaken important consumer protections for LGBTQ Americans and Americans with limited English proficiency, and other vulnerable Americans in health care and health insurance settings. When the changes were finalized, the HCA coordinated a united response from Vermont health care leaders in opposition to health care discrimination. The HCA shared the resulting statement on social media, reaching 1,677 people through Facebook. The statement was also distributed to the press, and is available here: *https://vtdigger.org/press_release/health-care-leaders-lgbtq-discrimination-has-no-place-in-vermont/*

Vermont Legal Aid and our Office of the Health Care Advocate fought against federal guidance that tries to strip protections from lesbian, gay, bisexual, transgender, and queer (LGBTQ) people. Read the full statement here, co-signed by health care leaders: https://vtdigger.org/…/health-care-leaders-lgbtq-discrimin…/

Office of the Health Care Advocate

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

https://vtlawhelp.org/health

Attachment 6 - GC Investments

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			**226,781**
AHSCO	9090	Investments (STC-79) - Designated Agency Underinsured Services (54)	1,654,744	1,639,345			**3,294,089**
AOE	n/a	Non-state plan Related Education Fund Investments					**-**
DCF	9402	Investments (STC-79) - Medical Services (55)	19,357	13,078			**32,436**
DCF	9403	Investments (STC-79) - Residential Care for Youth/Substitute Care (1)	1,912,130	265,814			**2,177,944**
DCF	9405	Investments (STC-79) - Aid to the Aged, Blind and Disabled CCL Level III (56)	1,044,408	474,808			**1,519,216**
DCF	9406	Investments (STC-79) - Aid to the Aged, Blind and Disabled Res Care Level III (57)	29,590				**29,590**
DCF	9407	Investments (STC-79) - Aid to the Aged, Blind and Disabled Res Care Level IV (58)	64,468				**64,468**
DCF	9408	Investments (STC-79) - Essential Person Program (59)	219,628	209,048			**428,676**
DCF	9409	Investments (STC-79) - GA Medical Expenses (60)	51,744	47,631			**99,375**
DCF	9411	Investments (STC-79) - Therapeutic Child Care (61)	376,070	271,275			**647,345**
DCF	9412	Investments (STC-79) - Lund Home (2)	736,919	675,522			**1,412,441**
DCF	9413	Investments (STC-79) - Prevent Child Abuse Vermont: Shaken Baby (33)					**-**
DCF	9414	Investments (STC-79) - Prevent Child Abuse Vermont: Nurturing Parent (34)	60,572	(60,572)			**-**
DCF	9415	Investments (STC-79) - Challenges for Change: DCF (9)	53,402				**53,402**
DCF	9416	Investments (STC-79) - Strengthening Families (26)	273,766	219,326			**493,092**
DCF	9417	Investments (STC-79) - Lamoille Valley Community Justice Project (62)	39,744	57,461			**97,205**
DCF	9418	Investments (STC-79) - Building Bright Futures (35)	67,756	140,506			**208,262**
DDAIL	9602	Investments (STC-79) - Mobility Training/Other Svcs.-Elderly Visually Impaired (63)	91,642	92,368			**184,010**
DDAIL	9603	Investments (STC-79) - DS Special Payments for Medical Services (64)	1,857,013	310,534			**2,167,547**
DDAIL	9604	Investments (STC-79) - Flexible Family/Respite Funding (27)	983,521				**983,521**
DDAIL	9605	Investments (STC-79) - Quality Review of Home Health Agencies (42)					**-**
DDAIL	9606	Investments (STC-79) - Support and Services at Home (SASH) (43)	204,345	281,716			**486,061**
DDAIL	9607	Investments (STC-79) - HomeSharing (77)	77,635	77,592			**155,227**
DDAIL	9608	Investments (STC-79) - Self-Neglect Initiative (78)	75,990	75,447			**151,436**
DDAIL	9609	Investments (STC-79) - Seriously Functionally Impaired: DAIL (65)	12,503	11,735			**24,238**
DMH	9501	Investments (STC-79) - Special Payments for Treatment Plan Services (28)	35,672	21,303			**56,975**
DMH	9502	Investments (STC-79) - MH Outpatient Services for Adults (66)	1,610,793	32,902			**1,643,695**
DMH	9504	Investments (STC-79) - Mental Health Consumer Support Programs (79)	166,746	61,620			**228,366**
DMH	9505	Investments (STC-79) - Mental Health CRT Community Support Services (16)	1,118,798	788,832			**1,907,631**
DMH	9506	Investments (STC-79) - Mental Health Children's Community Services (12)	1,375,069	301,214			**1,676,283**
DMH	9507	Investments (STC-79) - Emergency Mental Health for Children and Adults (29)	6,186,457				**6,186,457**
DMH	9508	Investments (STC-79) - Respite Services for Youth with SED and their Families (67)	813,840				**813,840**
DMH	9510	Investments (STC-79) - Emergency Support Fund (22)	376,000				**376,000**
DMH	9511	Investments (STC-79) - Institution for Mental Disease Servcies: DMH (3) - VPCH	5,575,018	3,273,157			**8,848,175**
DMH	9512	Investments (STC-79) - Institution for Mental Disease Servcies: DMH (3) - BR	2,555,765	2,946,260			**5,502,025**
DMH	9514	Investments (STC-79) - Seriously Functionally Impaired: DMH (68)	18,855	8,803			**27,658**
DMH	9516	Investments (STC-79) - Acute Psychiatric Inpatient Services (13)	788,263	766,198			**1,554,460**
DOC	n/a	Return House	138,725	90,306			**229,031**
DOC	n/a	Northern Lights	98,438	98,438			**196,876**
DOC	n/a	Pathways to Housing - Transitional Housing	254,634	259,415			**514,049**
DOC	n/a	St. Albans and United Counseling Service Transitional Housing (Challenges for Change)	67,477	67,641			**135,117**
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			**1,268,475**
DOC	n/a	Intensive Sexual Abuse Program					**-**
DOC	n/a	Vermont Achievment Center		172,674			**172,674**
DVHA	9101	Investments (STC-79) - Vermont Information Technology Leaders/HIT/HIE/HCR (8)					**-**
DVHA	9102	Investments (STC-79) - Vermont Blueprint for Health (51)	791,428	757,323			**1,548,751**
DVHA	9103	Investments (STC-79) - Buy-In (52)	11,704	11,984			**23,687**
DVHA	9104	Investments (STC-79) - HIV Drug Coverage (53)	682	1,154			**1,836**
DVHA	9106	Investments (STC-79) - Patient Safety Net Services (18)	(2,817)				**(2,817)**
DVHA	9107	Investments (STC-79) - Institution for Mental Disease Services: DVHA (7)	2,104,330	1,407,614			**3,511,944**
DVHA	9108	Investments (STC-79) - Family Supports (72)					**-**
DVHA	9109	DSR Investment (STC-83) – One Care VT ACO Quality & Health Management (81)	-				**-**
DVHA	9110	DSR Investment (STC-83) – One Care VT ACO Advanced Community Care Coordination	-				**-**
DVHA	9111	DSR Investment (STC-83) - One Care VT ACO Primary Prevention Development (83)	-				**-**
GMCB	n/a	Green Mountain Care Board					**-**
UVM	n/a	Vermont Physician Training	505,932	674,582			**1,180,514**
VAAFM	n/a	Agriculture Public Health Initiatives					**-**
VDH	9201	Investments (STC-79) - Emergency Medical Services (19)	156,190	90,293			**246,483**
VDH	9203	Investments (STC-79) - TB Medical Services (74)	670	12,234			**12,904**
VDH	9204	Investments (STC-79) - Epidemiology (40)	283,856	160,267			**444,123**
VDH	9205	Investments (STC-79) - Health Research and Statistics (39)	341,770	226,815			**568,585**
VDH	9206	Investments (STC-79) - Health Laboratory (31)	812,356	221,215			**1,033,571**
VDH	9207	Investments (STC-79) - Tobacco Cessation: Community Coalitions (50)	329,282	499,626			**828,908**
VDH	9208	Investments (STC-79) - Statewide Tobacco Cessation (76)					**-**
VDH	9209	Investments (STC-79) - Family Planning (75)	394,479	284,428			**678,907**
VDH	9210	Investments (STC-79) - Physician/Dentist Loan Repayment Program (25)		354,600			**354,600**
VDH	9211	Investments (STC-79) - Renal Disease (73)					**-**
VDH	9213	Investments (STC-79) - WIC Coverage (37)	949,286	325,995			**1,275,281**
VDH	9214	Investments (STC-79) - Area Health Education Centers (AHEC) (21)	108,295				**108,295**
VDH	9217	Investments (STC-79) - Patient Safety - Adverse Events (47)	12,770	8,563			**21,332**
VDH	9219	Investments (STC-79) - Substance Use Disorder Treatment (30)	1,230,889	1,380,046			**2,610,935**
VDH	9220	Investments (STC-79) - Recovery Centers (17)	427,012	487,183			**914,195**
VDH	9221	Investments (STC-79) - Enhanced Immunization (46)	99,642	16,046			**115,689**
VDH	9222	Investments (STC-79) - Poison Control (48)		61,918			**61,918**
VDH	9223	Investments (STC-79) - Public Inebriate Services, C for C (23)	475,043	263,300			**738,343**
VDH	9224	Investments (STC-79) - Fluoride Treatment (38)	8,505	11,641			**20,145**
VDH	9225	Investments (STC-79) - Medicaid Vaccines (24)					**-**
VDH	9226	Investments (STC-79) - Healthy Homes and Lead Poisoning Prevention Program (49)	47,836	88,019			**135,855**
VDH	9228	Investments (STC-79) - VT Blueprint for Health (44)	269,056	95,931			**364,988**
VSC	n/a	Health Professional Training	204,730				**204,730**
VVH	n/a	Vermont Veterans Home					**-**
			40,763,542	**22,514,309**	**-**	**-**	**63,277,851**

Housing Opportunity Program

OEO HOP

Attachment 7 - Investment Scorecard

What We Do

The Housing Opportunity Grant Program supports basic operations and essential services at 39 emergency shelters in Vermont.

Who We Serve

Individuals and families who become homeless are served through a network of homeless shelters, domestic and sexual violence shelters and motels.

How We Impact

Individuals and families who come into shelter are provided support services, housing navigation services and referrals to housing supports such voucher programs and other forms of economic assistance so they can find permanent affordable housing.

Measures	Most Recent Period	Current Actual Value	Current Target Value	Current Trend	Baseline % Change
PM OEO # of persons sheltered in emergency homeless shelters	2019	3,709		4	-13%
PM OEO Shelter bednights	2019	193,864		1	26%
PM OEO Average length of stay in days in emergency homeless shelters	2019	52		6	44%
PM OEO # of households who achieved housing stability from HOP-funded programs such as housing support services and financial assistance	2019	1,755		1	162%

Actions

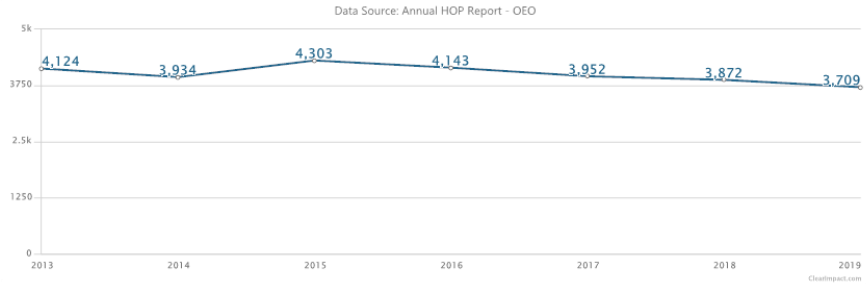
Name	Assigned To	Status	Due Date	Progress

Hope Challenges for Change

Housing Opportunity Program

		Most Recent Period	Current Actual Value	Current Trend	Baseline % Change
O InvestmentGoal	Encourage the formation and maintenance of public-private partnerships in health care, including initiatives to support and improve the health care delivery system				

		Most Recent Period	Current Actual Value	Current Trend	Baseline % Change
P OEO	Housing Opportunity Program				
PM OEO	# of persons sheltered in emergency homeless shelters	2019	3,709	4	-13%

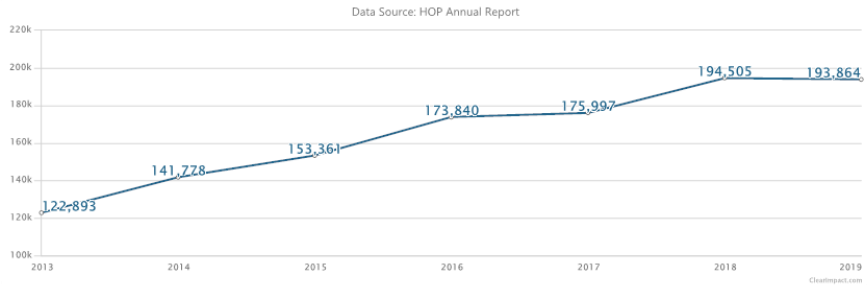


2018	3,872	3	-9%
2017	3,952	2	-7%
2016	4,143	1	-2%
2015	4,303	1	1%
2014	3,934	2	-7%
2013	4,124	1	-3%
2012	4,244	0	0%

Story Behind the Curve

Housing Opportunity Grant Program funds support basic operations and essential services at 36 overnight emergency shelters, including 9 warming shelters open only during cold weather months and 9 shelters for persons fleeing domestic/sexual violence. Additionally, 8 programs provided emergency shelter in scattered site apartments, ranging in size from 1 to 3 bedrooms. Shelters range in size from only a few rooms for families to more than 37 beds for single adults. The number of persons needing shelter has decreased by 14% since 2015. The Department of Children and Families (DCF) has made significant investments to address homelessness in communities since 2015 which is having a positive impact.

Shelter bednights	2019	193,864	1	26%

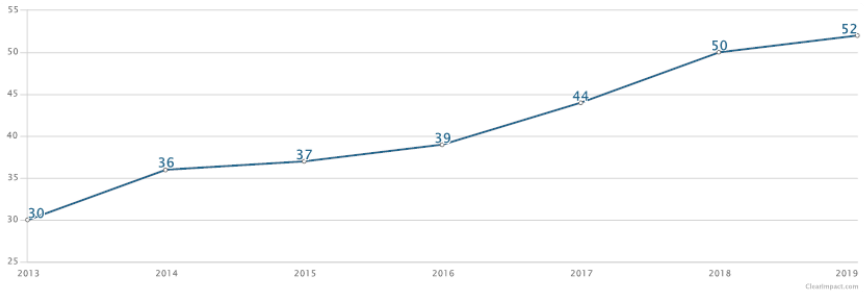


2018	194,505	5	26%
2017	175,997	4	14%
2016	173,840	3	13%
2015	153,361	2	0%
2014	141,778	1	-8%
2013	122,893	1	-20%
2012	154,129	0	0%

Story Behind the Curve

Shelter Bednights: number of people housed times number of nights they were housed at emergency shelters. For example, a family of 3 stayed 4 nights at shelter = 12 shelter bednights. Shelter bednights have steadily increased due to the lack of affordable housing stock. Individuals and families who become homeless stay in shelters longer because it takes longer to find permanent, affordable housing.

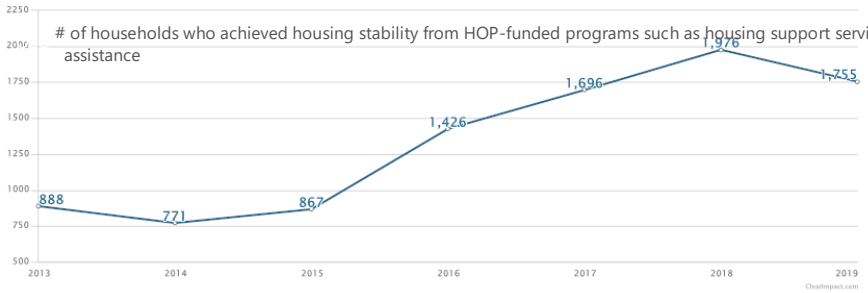
Average length of stay in days in emergency homeless shelters	2019	52	6	44%



2018	50	5	39%
2017	44	4	22%
2016	39	3	8%
2015	37	2	3%
2014	36	1	0%
2013	30	1	-17%
2012	36	0	0%

Story Behind the Curve

The average length of stay in shelters has increased significantly and is at its highest level in more than 15 years. There continues to be significant barriers for shelter quests to move out of emergency settings into housing. Lack of available rentals, the high cost of apartments, very low incomes, and tenant history are driving factors in the abillity to quickly re-stabilize into housing.



2019	1,755	1	162%
2018	1,976	4	195%
2017	1,696	3	153%
2016	1,426	2	113%
2015	867	1	29%
2014	771	1	15%
2013	888	1	33%
2012	670	0	0%

Story Behind the Curve

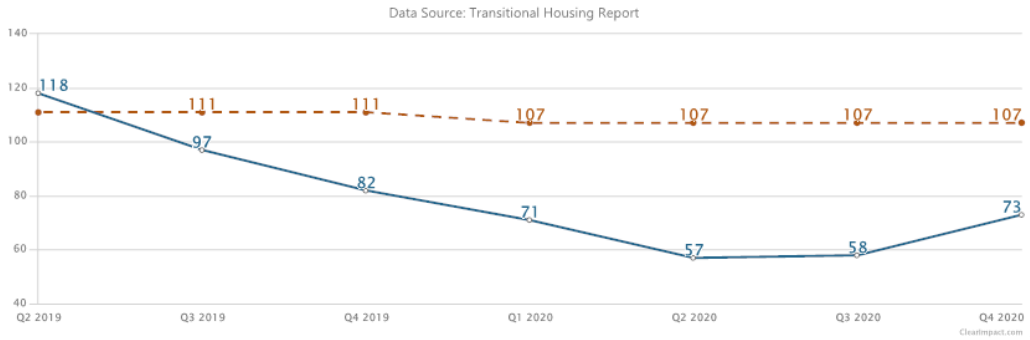
Description: Housing Stability means housing relocation and stabilization support such as housing search and placement, landlord-tenant mediation, housing case management, follow-up or supportive services to help maintain housing, money management, and financial assistance such as security deposits, utility payments and deposits, moving costs, rental arrearages and short-term rental assistance. Since FY 2015, the Department of Children and Families (DCF) has made significant investments to address homelessness in communities resulting in many more Vermonters accessing these critical services.

Transitional Housing

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

P GCI Transitional Housing Services

PM GCI Number of Individuals Served



Most Recent Period	Current Actual Value
Q4 2020	73
Q3 2020	58
Q2 2020	57
Q1 2020	71
Q4 2019	82
Q3 2019	97
Q2 2019	118
Q1 2019	113
Q4 2018	108

Story Behind the Curve

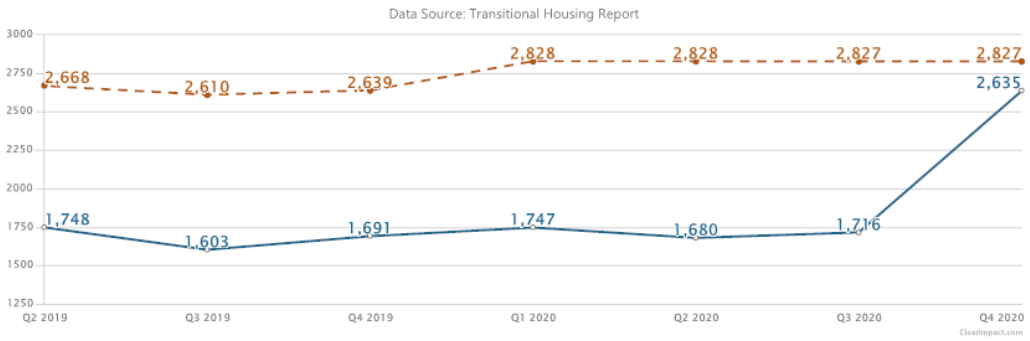
The number of individuals served can fluctuate over time depending on the circumstance of people in the program and the circumstance of people scheduled for release. The quarterly target (FY 20) for number of people served was 107; the actual number of people served in FY20 was consistently below this target. Beginning Q3 of FY20, there was a 20% reduction on the number of people served due to COVID-19. The decrease in the number of people served between FY19 Q2 and FY19 Q3 was due to a program closure. The decrease in the number of people served between FY18 and FY19 was due to program closures, limited clinical staff, and updated data reporting techniques.

Partners

What Works

Action Plan

PM HW Bed Days Utilized



Most Recent Period	Current Actual Value
Q4 2020	2,635
Q3 2020	1,716
Q2 2020	1,680
Q1 2020	1,747
Q4 2019	1,691
Q3 2019	1,603
Q2 2019	1,748
Q1 2019	1,420
Q4 2018	1,660

Story Behind the Curve

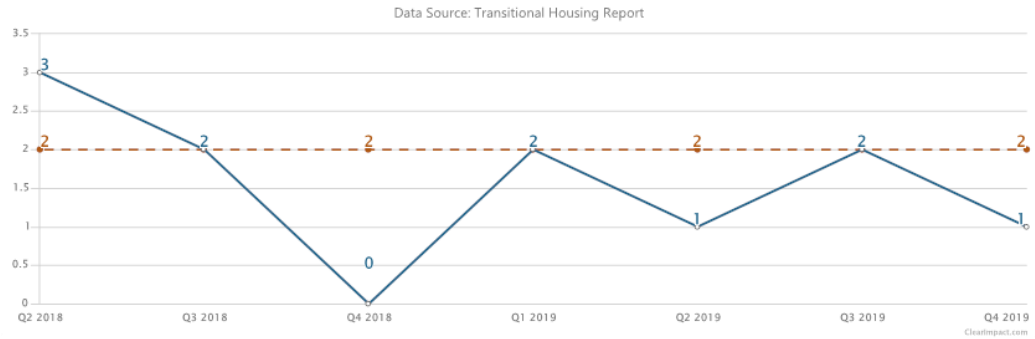
Bed utilization fluctuates each quarter because of the variability in individuals' circumstances. The bed days for FY20 totaled 7,778, which was 69% of our annual target (11,310). The quarterly target for FY20 is 2,827/2,828. While we are below our annual targets, every quarter we are meeting at minimum 59% of our target bed days utilized.

Partners

What Works

Action Plan

PM HM Individuals Housed (Search and Retention Services)



Q4 2019	1
Q3 2019	2
Q2 2019	1
Q1 2019	2
Q4 2018	0
Q3 2018	2
Q2 2018	3
Q1 2018	1

Story Behind the Curve

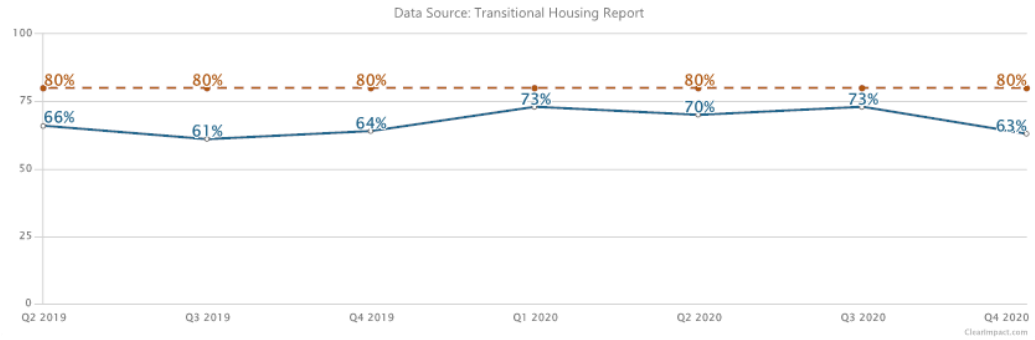
The number of individuals housed (search and retention services) flutuates each quarter because of variability in individuals' circumstances. We have met or exceeded our quarterly target of housing 2 individiuals (search and retention services) every quarter except FY18 Q4 amd FY19 Q2 (67% of the time).

Partners

What Works

Action Plan

PM HW Percent of Beds Utilized



Q4 2020	63%
Q3 2020	73%
Q2 2020	70%
Q1 2020	73%
Q4 2019	64%
Q3 2019	61%
Q2 2019	66%
Q1 2019	53%
Q4 2018	63%

Story Behind the Curve

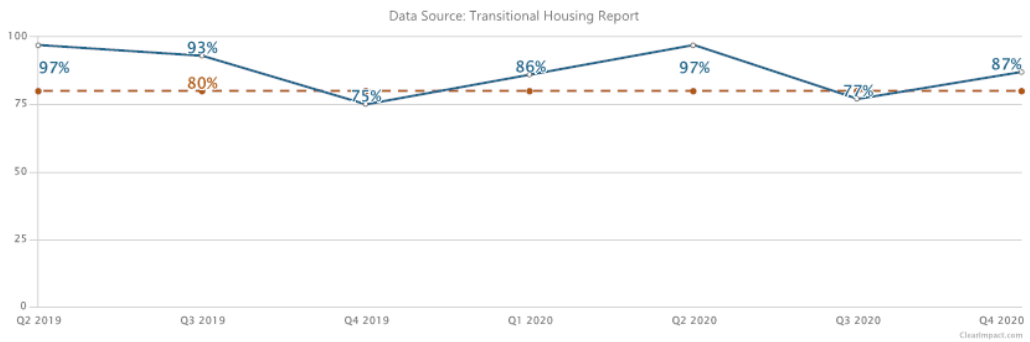
Overall utilization for FY20 was 70%. The target for FY20 was 80%; thus, we were below the target percent of beds utilized by an average of 10% for FY20.

Partners

What Works

Action Plan

PM HW Percent of Referrals Accepted



Q4 2020	87%
Q3 2020	77%
Q2 2020	97%
Q1 2020	86%
Q4 2019	75%
Q3 2019	93%
Q2 2019	97%
Q1 2019	95%
Q4 2018	100%

Story Behind the Curve

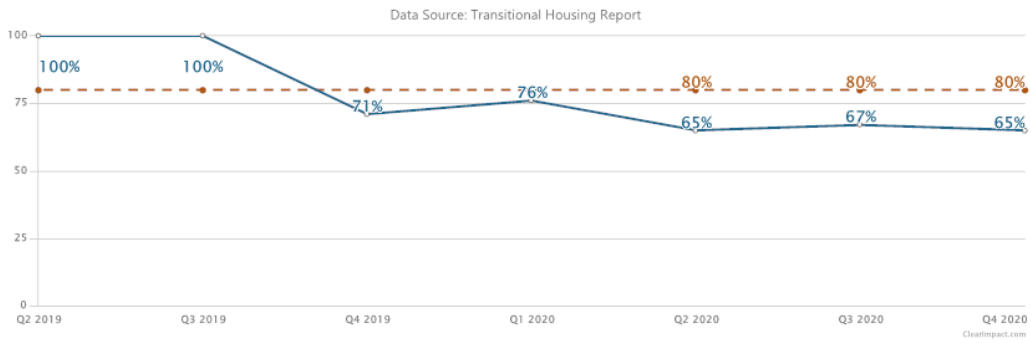
Overall percent of referrals accepted for FY20 was above target, at 87%. In Q4 of FY20, we were above our quarterly target for percent of referrals accepted by 7%.

Partners

What Works

Action Plan

PM BO Percent of Participants Employed/Enrolled in an Educational/Training Program or Receiving Benefits at Exit



Q4 2020	65%
Q3 2020	67%
Q2 2020	65%
Q1 2020	76%
Q4 2019	71%
Q3 2019	100%
Q2 2019	100%
Q1 2019	71%
Q4 2018	70%

Story Behind the Curve

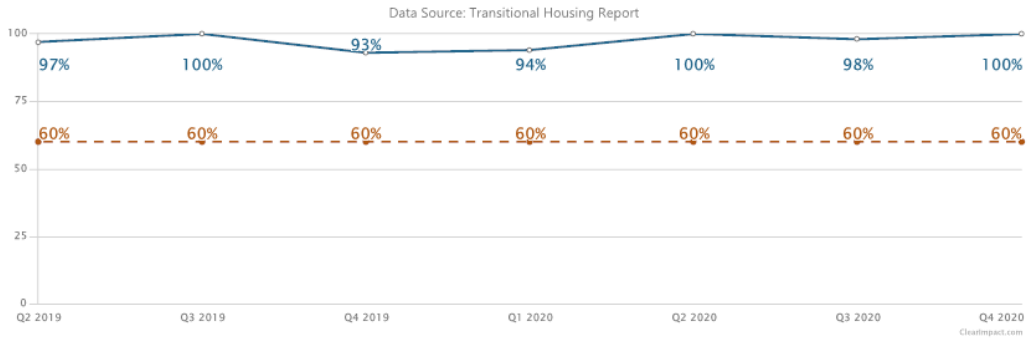
Overall the percent of participants employed, enrolled in an educational/training program, or receiving benefits at exit for FY20 was 65%, which is 15% below our annual target of 80%. In FY20, we were below the target value on average 12% with an average percent of participants employed, enrolled in an edxucation/training program of 68%.

Partners

What Works

Action Plan

PM BO Percent of Offenders Remaining Crime-Free While in Program



Q4 2020	100%
Q3 2020	98%
Q2 2020	100%
Q1 2020	94%
Q4 2019	93%
Q3 2019	100%
Q2 2019	97%
Q1 2019	96%
Q4 2018	93%

Story Behind the Curve

Remaining crime free is significantly associated with successful reentry. In FY20, an average of 98% of program participants remained crime free while in the program (well above our 60% annual target). We have been consistently above our FY20 quarterly target (60%); most recently, 100% of individuals in our programs have remained crime free for Q4 of FY20.

Partners

What Works

Action Plan

Percent of Participants Exiting to Permanent Housing

Q4 2020	45%

Attachment 8 - Payment Model Scorecard

VERMONT
AGENCY OF HUMAN SERVICES
DEPARTMENT OF VERMONT HEALTH ACCESS

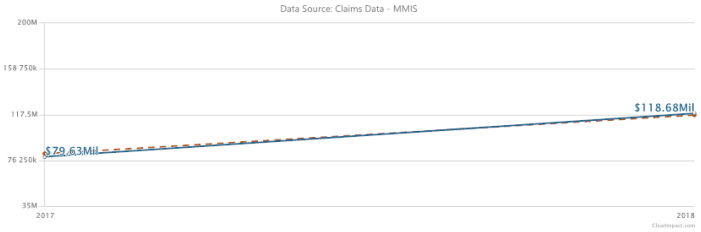
P Vermont Medicaid Next Generation (VMNG) Accountable Care Organization (ACO)

DVHA ACO

What We Do

The Vermont Medicaid Next Generation (VMNG) ACO program is a pilot program for a risk-bearing ACO to receive prospective payment and assume accountability for the costs and quality of care for prospectively-attributed Medicaid members. The VMNG model is structured similarly to the Medicare Next Generation ACO Model, but has been modified to address the needs of the Medicaid population in Vermont. Medicaid issues a prospective All-Inclusive Population Based Payment (AIPBP) to the ACO on a Per-Member-Per-Month basis according to a member's Medicaid Eligibility Group. Performance monitoring on the ACO's defined measure set occurs at least annually.

Measures	Most Recent Period	Current Actual Value	Current Target Value	True	Current Trend	Baseline % Change
PM DVH Expected and Actual Total Cost of Care for Medicaid enrollees aligned with an ACO	2018	$118.68Mil	$117.14Mil		? 1	49% ?
	2017	$79.63Mil	$82.32Mil		? 0	0% ?



Notes on Methodology

The expected total cost of care (ETCOC) for ACO(s) in the VMNG program is derived based on actuarial projections of the cost of care in the calendar year for the population of prospectively attributed Medicaid members, using claims history for the two years prior to the calendar year for the attributed members as a baseline and trending it forward to the performance year.

The actual total cost of care (ATCOC) for the ACO is the sum of the Fixed Prospective Payment (FPP) paid to the ACO and the total actual Fee-For-Service expenditures paid by DVHA on behalf of the ACO to its providers for services not covered by the FPP.

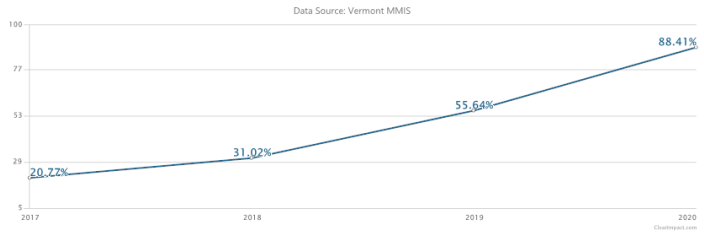
[Please note that final 2019 financial data is currently undergoing internal evaluation and is not publicly available at this time. It is Vermont's intent to report on this data when available.]

- The dotted red line above shows the ETCOC
- The solid blue line above shows the ATCOC

Story Behind the Curve

The ACO has agreed to a risk-based spending target for the full attributed population during the performance year. If the ACO exceeds its spending target for the Performance Year, it is liable for expenses up to 104% of the target; if the ACO spends less than its target, it may retain savings to 96% of the target. This arrangement provides an incentive to use resources efficiently. If the ETCOC and ATCOC are equal, then the ACO's actual spending is on consistent with its projected spending for the performance year, and a minimal amount of financial reconciliation will occur between the ACO and DVHA during the final financial reconciliation. If the ETCOC is greater than the ATCOC, the ACO's spending has been less than the financial target, and the ACO would be eligible to retain a portion of the dollars saved relative to the target. Conversely, if the ATCOC is higher than the ETCOC, the ACO's spending has exceeded its financial target, and the ACO would be liable for a portion of the dollars spent in excess of the target.

PM D Percent of Medicaid enrollees aligned with ACO



2020	88.41%			?	3
326% ? 2019	55.64%			?	2
					168% ?
2018	31.02%		?	1	49% ?
2017	20.77%		?	0	0% ?

Notes on Methodology

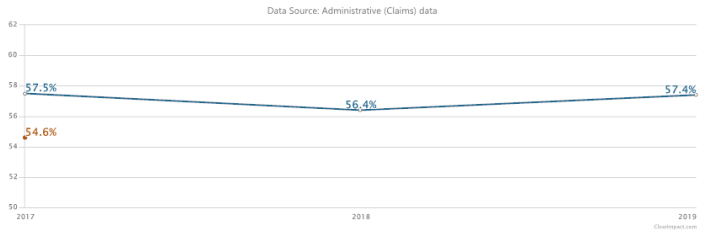
Attribution is prospective and set at the beginning of a performance year. Beginning in 2020, attribution is conducted in two steps. The first, or traditional methodology, is based on a member's relationship with a primary care provider in the ACO's network and qualifying utilization in a baseline period. The second, or expanded methodology, examines the remainder of the Medicaid population and attributes members based on their Medicaid eligibility at the beginning of the performance year, the absence of a primary care relationship with a non-ACO-participating provider, and a lack of other forms of insurance coverage (i.e., the member must be in an aid category that receives the full Medicaid benefit in order to be attribution-eligible).

Story Behind the Curve

This measure demonstrates the percentage of the attributable Medicaid population that has been assigned to the VMNG program on an annual basis. Attribution is prospective and set at the beginning of a performance year. Beginning in 2020, attribution is conducted in two steps. The first, or traditional methodology, is based on a member's relationship with a primary care provider in the ACO's network and qualifying utilization in a baseline period. The second, or expanded methodology, examines the remainder of the Medicaid population and attributes members based on their Medicaid eligibility at the beginning of the performance year, the absence of a primary care relationship with a non-ACO-participating provider, and a lack of other forms of insurance coverage (i.e., the member must be in an aid category that receives the full Medicaid benefit in order to be attribution-eligible).

The modified attribution methodology implemented for the 2020 performance year caused a significant increase in the number of eligible Medicaid members who were attributed to the ACO. This number may increase in future years if additional providers participate in the ACO, but that number will not increase significantly as the ACO has almost achieved scale statewide for participation in the VMNG program.

PM DVHA Adolescent Well Care Visits (HEDIS® AWC)



2019	57.4%			? 1	0% ?
2018	56.4%			? 1	-2% ?
2017	57.5%	54.6%		? 0	0% ?

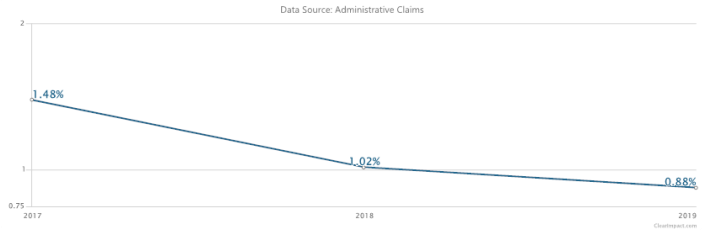
Notes on Methodology

The red dot above represents the CY 2017 50th percentile for National Medicaid All Lines of Business (ALOB). The solid blue trend line represents the ACO's actual annual performance rates.

Story Behind the Curve

This measure looks at whether adolescents receive regular check-ups. It reports the percentage of adolescents 12-21 years of age attributed to the ACO who had one or more well-care visits with a primary care provider or OB/GYN during the measurement year. Adolescents benefit from an annual preventive health care visit that addresses the physical, emotional and social aspects of their health.

PM DVH All Cause Unplanned Admissions for Patients with Multiple Chronic Conditions (NQF #2888)



2019	0.88%			2	-41%
2018	1.02%			1	-31%
2017	1.48%			0	0%

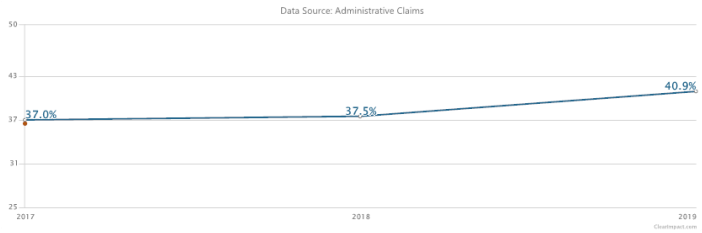
Notes on Methodology

The trend line above represents the ACO's actual annual performance rates. No corresponding benchmarks were available for this measure for this time period.

Story Behind the Curve

Rate of risk-standardized acute, unplanned hospital admissions among Medicaid members with multiple chronic conditions (MCCs) who are attributed to the ACO. Chronic conditions for this measure include acute myocardial infarction, Alzheimer's disease and related disorders or senile dementia, atrial fibrillation, chronic kidney disease, chronic obstructive pulmonary disease (COPD) and asthma, depression, heart failure, stroke and transient ischemic attack. For this measure, a lower rate is better.

PM DVH Follow Up After Hospitalization for Mental Illness - within 7 days (HEDIS® FUH)



2019	40.9%			2	11%
2018	37.5%			1	1%
2017	37.0%	36.5%		0	0%

Notes on Methodology

The red dot above represents the CY 2017 50th percentile for National Medicaid All Lines of Business (ALOB). The solid blue trend line represents the ACO's actual annual performance rates.

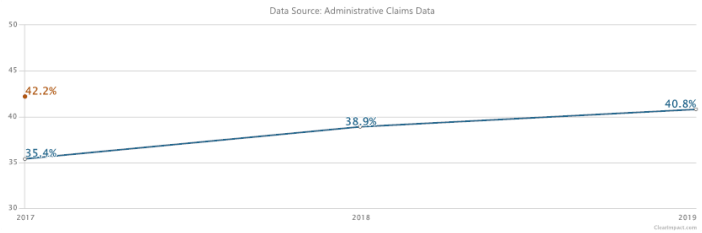
Story Behind the Curve

This measure looks at continuity of care for mental illness. It measures the percentage of Medicaid beneficiaries 6 years of age and older who are attributed to the ACO and who were hospitalized for selected mental disorders and then seen on an outpatient basis by a mental health provider **within 7 days** after their discharge from the hospital. The specifications for this measure are consistent with guidelines of the National Institute of Mental Health and the Centers for Mental Health Services.

It is important to provide regular follow-up treatment to patients after they have been hospitalized for mental illness. An outpatient visit with a mental health practitioner after discharge is recommended to make sure that the patient's transition to the home or work environment is supported and that gains made during hospitalization are not lost. It also helps health care providers detect early post-hospitalization reactions or medication problems and provide continuing care.

PM DVHA Initiation of Alcohol and Other Drug Abuse or Dependence Treatment (HEDIS® IET-Total)

2019	40.8%			2	15%



2018	38.9%		1	10%
2017	35.4%	42.2%	0	0%

Notes on Methodology

The red dot above represents the CY 2017 50th percentile for National Medicaid All Lines of Business (ALOB). The solid blue trend line represents the ACO's actual annual performance rates.

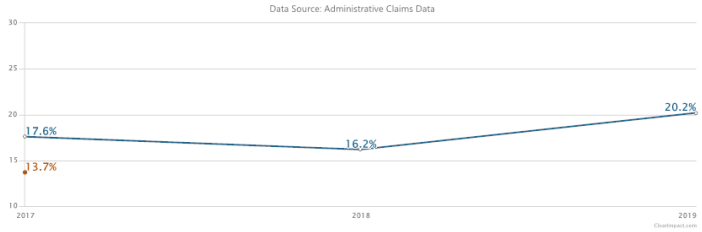
Story Behind the Curve

This measure assesses the percentage of ACO-attributed Medicaid beneficiaries 13 years of age and older who are diagnosed with alcohol and other drug dependence (AOD) and who start treatment through an inpatient AOD admission or an outpatient service for AOD within 14 days.

Action Plan

Quality Improvement staff from the ACO are participating in a DVHA-led performance improvement project focused on SUD treatment initiation.

PM DVH Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (HEDIS® IET-TOTAL)



2019	20.2%		1	15%
2018	16.2%		1	-8%
2017	17.6%	13.7%	0	0%

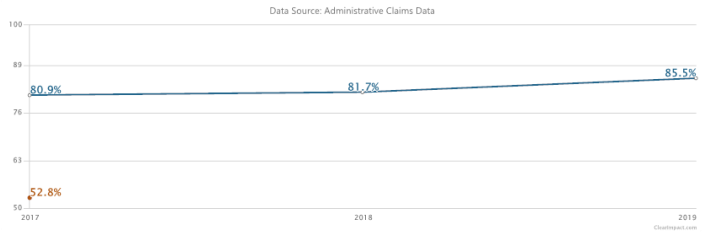
Notes on Methodology

The red dot above represents the CY 2017 50th percentile for National Medicaid All Lines of Business (ALOB). The solid blue trend line represents the ACO's actual annual performance rates.

Story Behind the Curve

This measure assesses the percentage of ACO-attributed Medicaid beneficiaries 10 years of age and older who are diagnosed with alcohol and other drug dependence (AOD) and who initiated AOD treatment within 14 days of diagnosis and then received two (2) additional AOD services within 34 days after the start of AOD treatment.

PM DVHA Follow Up After ED Visit for Mental Illness - within 30 days (HEDIS® FUM)



2019	85.5%		2	6%
2018	81.7%		1	1%
2017	80.9%	52.8%	0	0%

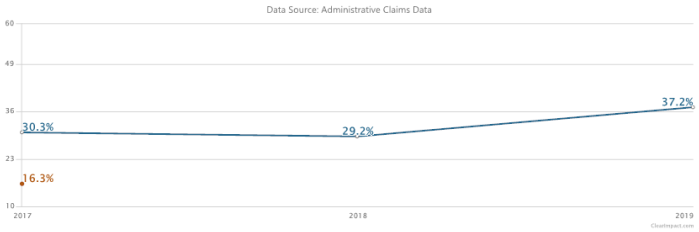
Notes on Methodology

The red dot above represents the CY 2017 50th percentile for National Medicaid All Lines of Business (ALOB). The solid blue trend line represents the ACO's actual annual performance rates.

Story Behind the Curve

This measure looks at the percentage of ACO-attributed Medicaid beneficiaries 18 years of age and older with emergency department visits with a principal diagnosis of mental illness, who had a follow up visit for mental health treatment within 30 days.

PM DVH Follow Up After ED Visit for Alcohol or Other Drug Dependence - within 30 days (HEDIS® FUA)



2019	37.2%			1	23%
2018	29.2%			1	-4%
2017	30.3%	16.3%		0	0%

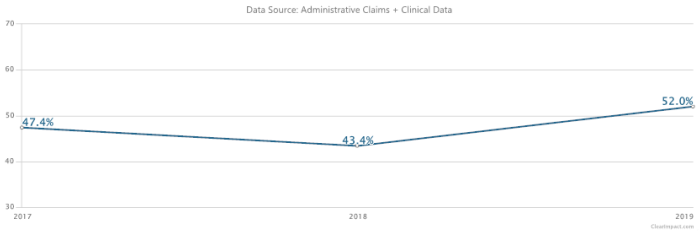
Notes on Methodology

The red dot above represents the CY 2017 50th percentile for National Medicaid All Lines of Business (ALOB). The solid blue trend line represents the ACO's actual annual performance rates.

Story Behind the Curve

This measure looks at the percentage of ACO-attributed Medicaid beneficiaries 18 years of age and older with emergency department visits with a principal diagnosis of alcohol or other drug dependence, who had a follow up visit for alcohol or other drug dependence treatment within 30 days.

PM DVH Screening for Clinical Depression and Follow-Up Plan (HEDIS® DSF)



2019	52.0%			1	10%
2018	43.4%			1	-8%
2017	47.4%			0	0%

Notes on Methodology

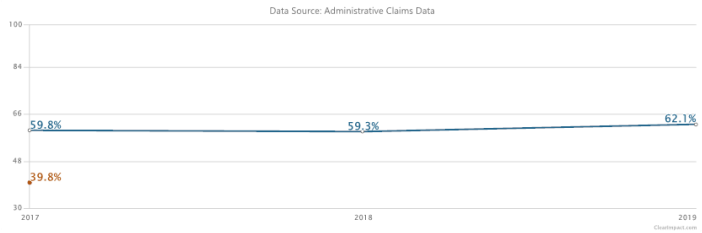
The blue trend line above represents the ACO's actual annual performance rates. No corresponding benchmarks were available for this measure.

Story Behind the Curve

This measure looks at the percentage of ACO-attributed Medicaid members age 18 and older screened for clinical depression on the date of the encounter using an age-appropriate standardized depression screening tool, and if positive, a follow-up plan is documented on the date of the positive screen.

PM DVHA Developmental Screening in the First 3 Years of Life (NQF #1448)

2019	62.1%			1	4%



2018	59.3%		1	-1%
2017	59.8%	39.8%	0	0%

Notes on Methodology

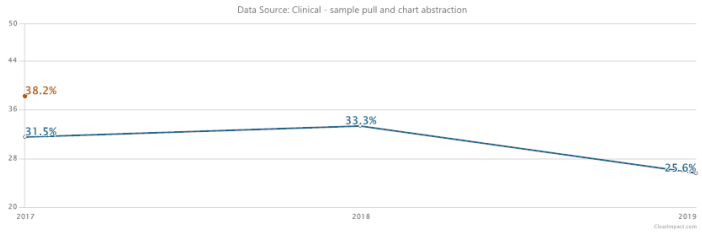
The red dot above represents the CY 2017 50th percentile for National Medicaid All Lines of Business (ALOB). The solid blue trend line represents the ACO's actual annual performance rates.

Story Behind the Curve

This measure shows the percentage of ACO-attributed children screened for risk of developmental, behavioral and social delays using a standardized screening tool in the 12 months preceding or on their first, second, or third birthday. This is a composite measure of screening in the first three years of life that includes three, age-specific indicators assessing whether children are screened in the 12 months preceding or on their first, second or third birthday.

PM DVI

Diabetes Mellitus: Hemoglobin A1c Poor Control (greater than 9%) (NQF #0059)



2019	25.6%		1	-19%
2018	33.3%		1	6%
2017	31.5%	38.2%	0	0%

Notes on Methodology

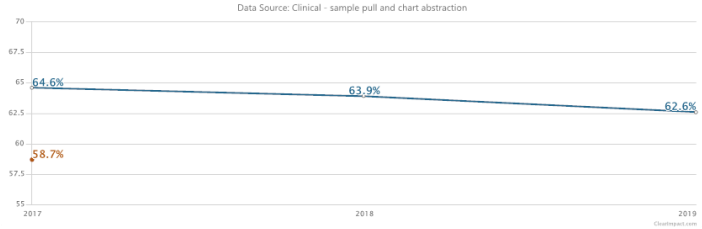
The red dot above represents the CY 2017 50th percentile for National Medicaid All Lines of Business (ALOB). The solid blue trend line represents the ACO's actual annual performance rates.

Story Behind the Curve

This measure looks at the percentage of ACO-attributed Medicaid members ages 18-75 with diabetes who had hemoglobin A1c > 9.0% (poor control) during the measurement period. For this measure, a lower rate is better.

P DVI

Hypertension: Controlling High Blood Pressure (HEDIS® CBP)



2019	62.6%		2	
-3% 2018	63.9%		1	-1%
2017	64.6%	58.7%	0	0%

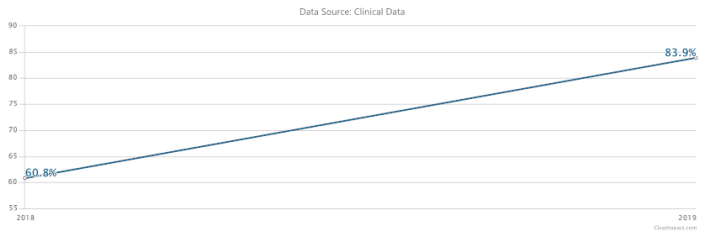
Notes on Methodology

The red target data point above represents the CY 2017 50th percentile for National Medicaid All Lines of Business (ALOB). The blue trend line represents the ACO's actual annual performance rates.

Story Behind the Curve

This intermediate-outcome measure looks at whether blood pressure was controlled among ACO-attributed adults 18-85 years of age who were diagnosed with hypertension.

PM DVHA Tobacco Use Assessment and Tobacco Cessation Intervention



2019	83.9%			1	38%
2018	60.8%			0	0%

Notes on Methodology

There is currently no benchmark for this measure. The solid blue line above represents the ACO's actual annual performance rates.

Story Behind the Curve

This measure looks at ACO-attributed Medicaid beneficiaries 18 years and older who were screened for tobacco use one or more times within 24 months and who received cessation counseling when screening was positive.

Actions

Name	Assigned To	Status	Due Date	Progress