

State of Vermont
Agency of Human Services

Global Commitment to Health
11-W-00194/1

Section 1115
Demonstration Year: 16
(1/1/2021 – 12/31/2021)

Quarterly Report for the period
April 1, 2021 – June 30, 2021

Submitted Via PMDA Portal on

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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, 2021 through June 30, 2021 (QE062021).***

II. Outreach/Innovative Activities

i. Member and Provider Services

Key updates from QE062021:

- Non-Emergency Medical Transportation (NEMT) Updates.
- Coordination of Benefit Activity
- Payer Initiated Eligibility (PIE)
- CMS Interoperability and Patient Access- Daily Transmission of MMA and Buy-in files

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 MountainCare (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.

Additionally, the unit works to coordinate benefit and collection practices with providers, members, and other insurance companies to ensure that Medicaid is the payer of last resort. The unit is also responsible for Medicare Part D casework including claims processing assistance, coverage verification, and issue resolution. The MPS Unit works diligently to recover funds from third parties where Medicaid should not have been solely responsible. Those efforts include estate recovery, absent parent medical support recovery, casualty recovery, patient liability recovery, Medicare recovery, Medicare prescription recovery, special needs recovery, and trust recovery.

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

NEMT Update

During the last quarter of FY21, DVHA's NEMT numbers and work volume continued the slow rebound from the drastic drop off at the beginning of the pandemic. All indicators (referrals, exemptions, incoming calls, and ride requests/provided) steadily increased over this period. Requests for out of state trips jumped markedly, reflecting the opening of more options for VT Medicaid members to care not available in the state.

	SFY21										
	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21
Due Date	09/15/20	10/15/20	11/15/20	12/15/20	01/15/21	02/15/21	03/15/21	04/15/21	05/15/21	06/15/21	07/15/21
# member rides	17,590	17,819	18,162	19,932	18,466	17,904	17,836	17,751	20,756	19,675	19,946
# member rides on time	17,456	17,710	18,068	19,509	18,312	17,748	17,654	17,673	20,546	19,482	19,751
% member rides on time	99.2%	99.4%	99.5%	97.9%	99.2%	99.1%	99.0%	99.6%	99.0%	99.0%	99.0%

Coordination of Benefit Activity

Coordination of Benefits (COB) refers to the activities involved in determining Medicaid benefits when an enrollee has coverage through an individual, entity, insurance, or program that is liable to pay for health care services. Individuals eligible for Medicaid assign their rights to third party payments to the State Medicaid Agency.

Medicaid beneficiaries may have one or more additional sources of coverage for health care services. Third Party Liability (TPL) refers to the legal obligation of third parties (for example, certain individuals, entities, insurers, or programs) to pay part or all the expenditures for medical assistance furnished under a Medicaid. By law, all other available third-party resources must meet their legal obligation to pay claims before the Medicaid program pays for the care of an individual eligible for Medicaid. DVHA is required to take all reasonable measures to ascertain the legal liability of third parties to pay for care and services that are available under the Medicaid state plan.

Coordination of Benefit Cost Avoidance Table:

Cost Avoidance "Q2"	
<u>Third Party Liability</u>	<u>\$11,857,697.14</u>
<u>Medicare</u>	<u>\$64,892,567.04</u>
<u>Total</u>	<u>\$76,750,264.18</u>

Coordination of Benefit Collection Table:

<u>Coordination Recovery Activities "Q2"</u>	
<u>Casualty</u>	<u>\$53,450.18</u>
<u>Estate</u>	<u>\$26,008.04</u>
<u>Third Party & Court Ordered Medical</u>	<u>\$37,810.95</u>
<u>Medicare Prescription Drug Premium/Claims</u>	<u>\$17,682.49</u>
<u>Over Resource/Hospice/Patient Share/Credit Balance</u>	<u>\$120,043.04</u>
<u>Annuity/Trust/Waiver</u>	<u>\$24,166.29</u>
<u>Medicare Claim Recoupment (Retro Billing)</u>	<u>\$109,330.43</u>
<u>Third Party Claim Recoupment (Retro Billing)</u>	<u>\$16,757.28</u>
<u>Total</u>	<u>\$405,248.70</u>

Payer Initiated Eligibility (PIE)

The Payer Initiated Eligibility (PIE) project restarted in 2021 after a hiatus due to COVID-19. PIE is data-matching with a health insurer to recover monies that Medicaid paid as the primary insurer in error. Medicaid currently receives files from United Health Care and BlueCross Blue Shield of Vermont. In the first quarter of 2021, connections and processes were established with Cigna, and Medicaid began receiving data in preparation to receive historical data files, as Medicaid can recover monies three years from the date of service. Historical files were received at the end of the first quarter into the beginning of the second quarter. Processing of the first historical file, including entry into ACCESS, has been completed. The expectation for the third quarter is to continue to work with Cigna to refine the file data, receive the files in PIE format, complete the processing and entry of the historical files, and to start receiving current year data.

The process of filtering and managing the data, including the matching algorithm, has been documented, requirements have been created, and these documents are ready to be provided to Gainwell Technologies for implementation. An RSO will be drafted and submitted to get this project in the queue for Gainwell to begin. The matching requirements, design of the ACCESS reports, and ACCESS screens for this project are complete and the ACCESS design is in process. Upon completion, review, and approval of the design documents for this project, ACCESS development will begin.

CMS Interoperability and Patient Access- Daily Transmission of MMA and Buy-in files

This project has reconvened after a hiatus due to Covid-19. A project schedule has been completed and approved. This project has been divided into three phases:

1. migration to the use of Globalscape to send and receive files to CMS,
2. requirements, system design and implementation of Buy-in file daily transmission, and lastly,
3. requirements, system design and implementation of MMA file daily transmission.

Phase one has begun through contact with CMS. Establishment of a Globalscape account for this purpose and necessary CMS paperwork has been completed and submitted to CMS, an account for the Globalscape transmissions to CMS has been created, with login id and password being received. Next steps will include Globalscape configuration and then testing with CMS. Simultaneously, the design for ACCESS is expected to begin in June.

III. Operational/Policy Developments/Issues

i. *Vermont Health Connect*

Enrollment

As of QE0621, more than 218,689 Vermonters were enrolled in Vermont Health Connect (VHC) health plans either through the marketplace or directly through an insurance carrier. This enrollment consisted of

Key updates from QE062021:

- The Customer Support Center received 58,650 calls in QE0621, down 11% from the previous year.
- As of July 2021, DVHA is currently supported by 114 Assistants (103 Certified Application Counselors, 7 Navigators, and 4 Brokers), with 8 Assistants in training, working in 52 organizations including hospitals, clinics, and community-based organizations.
- Increasing numbers of customers are using self-service functions. Self-serve applications comprised over half (63%) of all applications in QE0621. In addition, 69% of customers made recurring payments in QE0621. This is a 7% growth from the previous year.

147,440 in Medicaid for Children and Adults (MCA) and 71,249 in Qualified Health Plans (QHPs), with the latter divided between 24,162 enrolled with VHC, 6,596 direct-enrolled with their insurance carrier as individuals, and 40,491 enrolled with their small business employer.

Medicaid Renewals

For each month of the second quarter, 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 once the end date of the PHE is known. The passive renewal success rate for the quarter averaged 50%.

1095 Tax Forms

Tax year 2020 1095B corrections began mailing out to customers on February 8, 2021. As of June 30, 2021, 980 corrections have been sent.

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 58,650 calls in QE0621, down 11% from the previous year. Maximus answered 86% of calls within 24 seconds in April 2021, 88% in May 2021, and 82% in March 2021. With increased staffing and lower call volumes, Maximus met the target in QE0621.

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. 10% of QE0621 calls were transferred to DVHA-HAEEU staff, up from 8% in QE0620. Just as importantly, DVHA strived to answer all calls that were transferred; 98% of transferred calls were answered in five minutes in QE0621, compared to 93% in QE0620.

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 QE0620, more than 83% of the VHC requests were completed within the same ten-day time frame and 98% in QE0621.

System Performance

The system continued to operate as expected throughout QE0621, achieving 100% availability outside of scheduled maintenance in each of the three months. The average page load time for the quarter was 3 seconds – slightly over the two-second target.

In-Person Assistance

As of July 2021, DVHA is currently supported by 114 Assisters (103 Certified Application Counselors, 7 Navigators, and 4 Brokers), with 8 Assisters in training, working in 52 organizations including hospitals, clinics, and community-based organizations. Assister support is available in

Vermont's 14 counties to help Vermonters enroll in health coverage through Vermont's health insurance marketplace. The program continues to see increased Assister engagement in training participation. As expected, the total number of Assistors also climbed since last quarter.

Outreach

Vermont Health Connects website continued to be a key source of information for current and prospective customers alike, receiving more than 78,163 visits in the quarter – a 29% increase from last year's same quarter. The increase could be subject to the many communications alerting customers to our website for more information on ARPA.

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 12,902 sessions during the quarter.

Self-Service

During QE0621, 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 (63%) of all applications in QE0621. More than 7,600 customers made recurring payments per month in QE0621. Overall, 69% of total payments made per month are recurring payments.

ii. Choices for Care and Traumatic Brain Injury Programs

DAIL

Choices for Care

DAIL implemented the 3% rate increase for HCBS that was approved by the legislature for SFY 2022. The new rates became effective 7/1/2021

Adult Day Providers began to reopen in Q2. DAIL continues to support the providers with technical assistance in the reopening process. Nine out of 12 facilities planned to resume services by 5/31/2021.

DAIL continues to support Long Term Care providers during Q1 by updating and providing access to the [Guidance for Operations During COVID-19 Health Emergency](#). Resources for LTC providers can also be found here: <https://www.healthvermont.gov/covid-19/health-care-professionals/long-term-care-and-group-living-settings>

Money Follows the Person (MFP)

The MFP grant has been re-authorized through (CY) 2024. We have been awarded funds for CY2021 operations. This award is funded to help transition fifty-three (53) Choices for Care participants from a SNF to a home-based setting. As part of the grant re-authorization, CMS has always relaxed the eligibility rules for the MFP program. A math model that we created for CMS projects that Vermont should be able to serve 50% more participants. We are currently negotiating for additional funds to cover the additional transitions. We expect to receive funding authorization for CY2022 to CY2024 as part of the CY2022 budget process.

DAIL has completed the application process for a \$5M Supplemental Grant Award. The purpose of the grant is to build capacity and infrastructure for the LTSS system. The Application approval is in its final stage.

CY2021 transitions = 50 participants and there are currently 13 participants in the process of transitioning.

Brain Injury Program

Current enrollment = 82 individuals, 10 individuals are in the process of enrolling. 14 New Applicants pending clinical assessment.

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 550 people statewide. Because the eligibility criteria for Moderate Needs services is so broad, Vermont does not expect to eliminate the wait list. However, the state is piloting two separate acuity-based models for revising the wait list procedures from chronological to priority-based to serve applicants with the greatest needs first.
- There is currently no wait list for the Brain Injury program.

iii. Developmental Disabilities Services Division

Key updates from QE062021:

- DDS Director Selina Hickman has resigned and accepted a position in the private sector; her last day with the State of Vermont was June 22, 2021. We are actively recruiting for her replacement.
- Coronavirus 19 Response
- Payment Reform Activities
- HCBS Rules Implementation

Coronavirus 19 Response

The quarter ending 06/2021 continued to require response to the coronavirus pandemic. The Developmental Disabilities Services Division (DDSD) took continuing steps to protect the health and safety of developmental services recipients. New guidance in QE062021 included:

1. [In Person Services memo](#) for home and community-based services issued on 6/11/2021
2. Governor Scott [lifted the state of emergency](#) for Vermont on 6/15/2021
3. DDSD released an [updated COVID-19 Q&A document](#) on 6/15/2021

Please see prior report submissions for previous highlights.

Payment and Delivery System Reform

The Developmental Disabilities Services Division (DDSD) and DVHA have initiated a project to explore a new payment model for Developmental Disabilities home and community-based services (HCBS). This project was put on hold during the quarter ending 06/2020 due to the coronavirus pandemic.

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

DVHA previously engaged a Medicaid reimbursement consultant firm to assist the State in completing a provider rate study. The rate study collected detailed information from providers regarding actual costs to deliver the defined categories of service under HCBS. The rate study was completed and new rates for services were proposed. The information gathered will be utilized initially in developing the future payment model. It will later be decided whether these new rates can be adopted in the program. In addition to the provider rate study, the project has examined alternative assessment tools, resource allocation methods and options for more efficiently capturing encounter data for these services. A new methodology was established for providers to report encounter data regarding services being delivered to participants. Provider agencies are still adapting their electronic health records and business processes to prepare to report the data using the new method that will lead to increased transparency and accountability in the use of funds.

The State has resumed work on preparing providers to report encounter data in the first quarter of CY2021. Agencies began reporting encounter data to the MMIS on 3/1/21. The State developed an RFP for a contractor to conduct needs assessments using a standardized assessment tool, the Supports Intensity Scale. However, this RFP was interrupted due to the pandemic. The RFP was reposted in September and the State has selected Public Consulting Group (PCG) and finalized the contract in April. The State is working with PCG to prepare for the start of assessments,

scheduled for July, with a training period for assessors in May. Design of the new payment model will be continuing as the tempo of state response to the pandemic abates.

DDSD held three Encounter Data Workgroup Meetings during QE062021:
[DDSD Payment Reform-Encounter Data Meeting Schedule.pdf \(vermont.gov\)](#)

DDSD held five Standardized Assessment Meetings during QE062021: [DS Payment Reform-Standardized Assessment Meeting Schedule.pdf \(vermont.gov\)](#)

DDSD held a Town Hall for questions about the SIS-A assessments on May 25, 2021: [SIS-A Q&A Townhall 2021-05-25.pdf \(vermont.gov\)](#)

Ongoing work will be required, including seeking any needed CMS approval.

HCBS Rules Implementation

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

Summary of work to date- the Division completed site visits to validate survey information submitted by providers in September 2019. Providers are mostly in compliance with the setting requirements with minor changes being required. It is anticipated that all providers will be able to comply with the setting requirements and none will need to transition recipients to other settings. This information was included in the Vermont's State Transition Plan in February 2020. In addition, DDSD has been developing policy guidance for providers to ensure compliance with the rules. The DDSD Quality Management Unit has incorporated oversight of HCBS rule requirements into their overall quality review process to ensure ongoing compliance with the rules. With the completion of the site visits and information incorporated in the Vermont STP, the DDSD Quality Management Unit is preparing and sending reports to each provider agency requiring a plan of correction to address the areas of non-compliance by the 2022 deadline.

DDSD continued to participate in conversations with DVHA and other AHS departments about ways to improve safeguards and mitigation strategies that would reduce potential conflict. DDSD continues to work with the Department of Vermont Health Access and other AHS Departments on a plan for inclusion in the next Global Commitment to Health waiver renewal application.

A key component of Vermont's mitigation strategies includes reissuing the RFP for an independent developmental service needs assessor, also described in the section above regarding payment reform. As of the QE 0602021 the vendor, Public Consulting Group, has been selected and is beginning their needs assessment work.

iv. *Global Commitment Register*

Key updates from QE062021:

- 24 policies were posted to the GCR in Q2 2021.
- Since the Global Commitment Register (GCR) launched in November 2015, 247 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 Agency of Human Services' 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 389 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, and administrative rule change or a State Plan Amendment. The GCR also contains policy clarifications for when an issue is identified that is not clearly answered in current policy.

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

A public health emergency (PHE) was declared in March 2020 due to the COVID-19 pandemic. The PHE continues to impact the state budget and Medicaid operations, which is reflected in the number and type of policies being posted to the GCR. There were 16 proposed policies and one policy clarification posted in QE062021. A total of 7 final policies were posted in QE062021. Changes included updates to rates and/or rate methodologies, clinical coverage changes, and administrative rulemaking notices.

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

v. *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
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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	<i>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.</i>

Key updates for QE062021:

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

2. Executive Summary

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

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

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

ADAP's centralized intake and resource center, "VT Helplink: Alcohol and Drug Support Center" launched for public use in March 2020. Since launch VT Helplink has received over 1,900 calls and 22,700 website visits. Web visitors have searched for services online over 2,260 times. Major components include: 1) a call center staffed by certified Screening & Intake Specialists and licensed clinicians, 2) a website with information related to SUD and a self-screen tool, and 3) an appointment board to connect callers in need of treatment with appointments to ADAP's Preferred Provider Network. ADAP continues work to onboard SUD treatment providers into the provider portal and expand the database of SUD resources available to consumers.

The Substance Misuse Prevention Oversight and Advisory Council (SMPC) was established within the Vermont Department of Health and encompasses all substances of misuse including alcohol; cannabis; controlled substances such as opioids, cocaine, and methamphetamines; and tobacco products, tobacco substitutes and substances containing nicotine. The SMPC has met ten times between October 2019 to October 2020. The SMPC has three goals of the SMPC are the following:

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

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

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

- Prevention Services
- Policy
- Equity and Health Disparities

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

Assessment of Need and Qualification for SUD Services

Prompts	Demonstration Year (DY) and quarter first reported	Related metric (if any)	Summary
Metric Trends			

Discuss any relevant trends that the data shows related to assessment of need and qualification for SUD services. At a minimum, changes (+ or -) greater than two percent should be described.	DY2 Q2	3 Medicaid Beneficiaries with SUD Diagnosis (monthly) 4 Medicaid Beneficiaries with SUD Diagnosis (annually) 5 Medicaid Beneficiaries Treated in an IMD for SUD	Vermont experienced a decrease in the number of Medicaid beneficiaries identified with SUD diagnoses leading to decreases in people receiving SUD services other than medication assisted treatment for opioid use disorder. These changes in provision of treatment coincide with the COVID-19 pandemic which first peaked in Vermont in April and then again in November/December 2020. People were not seeking care across the healthcare system during the pandemic, which would account for the decrease and ongoing concerns about COVID and the variants have continued to impact people seeking healthcare services. ADAP has worked with VT Helplink and SUD treatment providers to market and educate Vermonters that treatment services are available, and it is safe to seek treatment.
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<i>[Add rows as needed]</i>			
The state has no metrics trends to report for this reporting topic.			
Implementation Update			
Compared to the demonstration design details outlined in the STCs and implementation plan, have there been any changes or does the state expect to make any changes to: A) the target population(s) of the demonstration? B) the clinical criteria (e.g., SUD diagnoses) that qualify a beneficiary for the demonstration?			There are no planned changes to the target population or clinical criteria.
Are there any other anticipated program changes that may impact metrics related to assessment of need and qualification for SUD services? If so, please describe these changes.			There are no anticipated program changes.
<input checked="" type="checkbox"/> The state has no implementation update to report for this reporting topic.			

Prompts	Demonstration Year (DY) and quarter first reported	Related metric (if any)	Summary
Milestone 1 Metric Trends			
Discuss any relevant trends that the data shows related to assessment of need and qualification for SUD services. At a minimum, changes (+ or -) greater than two percent should be described.	DY2 Q2	6 Any SUD Treatment	Vermont experienced a decrease in people receiving SUD treatment. People were not seeking care across the healthcare system during the pandemic, which would account for the decrease. ADAP has worked with VT Helplink and SUD treatment providers to market and educate Vermonters that treatment services are available, and it is safe to seek treatment. However, it is likely that ongoing concerns about the pandemic and the COVID variants continues to impact peoples' comfort in seeking out healthcare services.
		7 Early Intervention	Services coded as early intervention have been consistently low (averaging one beneficiary per month) as most intervention services in Vermont are provided through other funding mechanisms.
		8 Outpatient Services	Outpatient services decreased due to COVID and peoples' concerns about seeking healthcare services. Providers ramped up capacity to provide services through telemedicine while the stay-at-home order was in place and are currently able to provide services through telemedicine and in person, giving more options for those seeking services. Telemedicine services have been impacted by lack of access to adequate internet services in some rural areas as well as the cost/data limits.
		9 Intensive Outpatient and Partial Hospitalization Services	IOP services remain low due to the difficulty of providing group-based services during the pandemic. Some services are being provided via telemedicine.- Telemedicine services are impacted by the rural nature of the state, lack of adequate internet in some areas as well as the impact of limited data/usage for some individuals.
		10 Residential and Inpatient Services	One residential treatment provider experienced a COVID-19 outbreak among clients and were required to hold admissions while the provider and Health Department

			<p>staff worked to contain the outbreak through isolation and quarantine protocols. The provider was successful in containing the outbreak to a small number of clients and admissions were able to resume. Residential providers have continued to experience a reduction in available capacity due to COVID-19 safety precautions to reduce the potential for outbreaks in their facilities. Additionally, challenges with ensuring all clients are tested for COVID-19 immediately prior to admission has impacted pacing of admissions.</p>
		11 Withdrawal Management	This has been trending downward with some month-to-month variation
		12 Medication Assisted Treatment	The number of beneficiaries receiving MAT has continued to increase quarter by quarter.
		36 Average Length of Stay in IMDs	2020 data not yet available
[Add rows as needed]			
The state has no metrics trends to report for this reporting topic.			
Milestone 1: Access to Critical Levels of Care for OUD and other SUDs			
<i>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.</i>			
Milestone 1 Implementation Update			
<p>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:</p> <p>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?</p>			
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.
<input checked="" type="checkbox"/> 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				
<input checked="" type="checkbox"/> The state is not reporting any metrics related to this reporting topic.				
Milestone 2 Implementation Update				
<p>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:</p> <ul style="list-style-type: none">a. Planned activities to improve providers’ use of evidence-based, SUD-specific placement criteria?b. Implementation of a utilization management approach to ensure:<ul style="list-style-type: none">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?				
<p>Summary:</p> <p>The current version of the Substance Use Disorder Treatment Standards is being used. The Compliance Assessment Tool has been utilized with 32 substance use disorder treatment provider locations. The Substance Use Disorder Treatment Standards and corresponding compliance assessment tool were effective January 1, 2020. Due to the COVID pandemic, provider site reviews were put on hold. ADAP has completed one remote site visit utilizing the tool this quarter.</p>				
Milestone 2 - Table 1				
	Action	Revised Completion Date	Responsible	Status
	Finalize Substance Use Disorder Treatment Standards	August 1, 2018	Director of Quality Management and Compliance	Completed

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

Vermont suspended plans to develop a value-based payment model for residential programs to align with its All-Payer Model Agreement with CMS due to the impact of the COVID-19 pandemic. The rates for the episodic payments were adjusted effective January 1, 2020. ADAP has solicited feedback from the providers on the rate adjustment and opportunities for continued improvement of the model. ADAP has been collecting stakeholder feedback in anticipation of a Request for Information (RFI) related to the overall SUD treatment system. The value-based payment component of the residential payment model is in consideration for inclusion in the larger system reform.

Milestone 2 – Table 2

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

☐ 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			
<input checked="" type="checkbox"/> 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:

- Implementation of residential treatment provider qualifications that meet the ASAM Criteria or other nationally recognized, SUD-specific program standards?
- State review process for residential treatment providers' compliance with qualifications standards?
- Availability of medication assisted treatment at residential treatment facilities, either on-site or through facilitated access to services off site?

Summary:

The current version of the Substance Use Disorder Treatment Standards is being used. The Compliance Assessment Tool has been utilized with 32 substance use disorder treatment provider locations.

The Substance Use Disorder Treatment Standards and corresponding compliance assessment tool were effective January 1, 2020. Due to the COVID pandemic, provider site reviews were put on hold. ADAP has completed one remote site visit utilizing the tool this quarter.

Are there any other anticipated program changes that may impact metrics related to the use of nationally recognized SUD-specific program standards to set provider qualifications for residential treatment facilities (if the state is reporting such metrics)? If so, please describe these changes.			
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x 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.		13 SUD Provider Availability 14 SUD Provider Availability MAT	The number of providers who were enrolled in Medicaid and qualified to deliver SUD services, including those who meet the standards to provide buprenorphine/methadone as part of MAT, has increased.
[Add rows as needed]			
<input checked="" type="checkbox"/> The state has no metrics trends to report for this reporting topic.			
Milestone 4 Implementation Update			
<p>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?</p> <p>Summary: Vermont suspended plans to develop a value-based payment model for residential programs to align with its All Payer Model Agreement with CMS due to the COVID-19 pandemic. The episodic payments were adjusted effective January 1, 2020. Vermont solicited feedback from providers on the rate adjustment and opportunities to continue to refine the model to reflect the needs of the population served. Vermont anticipates resuming work on the model in spring/summer 2021.</p> <p>ADAP's centralized intake and resource center "VT Helplink: Alcohol and Drug Support Center" launched for public use March 2020. Since launch VT Helplink has received over 1,900 calls and 22,700 website visits. Major components include: 1) a call center staffed by certified Screening & Intake Specialists and licensed clinicians, 2) a website with information related to SUD and a self-screen tool, and 3) an appointment board to connect callers in need of treatment with appointments to ADAP's Preferred Provider Network. ADAP continues work onboard SUD treatment providers into the provider portal and expand the database of SUD resources available to consumers.</p>			
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.			
<input type="checkbox"/> 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.		<p>15 Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment</p> <p>18 Use of Opioids at High Dosage in Persons Without Cancer</p> <p>21 Concurrent Use of Opioids and Benzodiazepines</p> <p>22 Continuity of Pharmacotherapy for Opioid Use Disorder</p>	The percentage of adults in continuous pharmacotherapy for OUD has decreased which may be an unintended consequence of Vermont's robust access to MAT. Individuals who may be ambivalent about treatment may be less concerned about leaving treatment since they know there will be no wait to get back in; also, there are a number of cash only and other Spoke options available which may lead to more movement in and out of treatment..

<i>[Add rows as needed]</i>			
<input checked="" type="checkbox"/> The state has no metrics trends to report for this reporting topic.			
Milestone 5 Implementation Update			
<p>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:</p> <ol style="list-style-type: none"> Implementation of opioid prescribing guidelines and other interventions related to prevention of OUD? Expansion of coverage for and access to naloxone? 			
<p>Summary: There are no planned changes to the prescribing guidelines and other interventions.</p>			
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.			
<input checked="" type="checkbox"/> The state has no implementation update to report for this reporting topic.			

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

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

Prompts	Demonstration Year (DY) and quarter first reported	Related metric (if any)	Summary
Milestone 6 Metric Trends			
Discuss any relevant trends that the data shows related to assessment of need and qualification for SUD services. At a minimum, changes (+ or -) greater than two percent should be described.		17 Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence	Recovery Coaches are dispatched to 12 emergency departments to support individuals who present with a SUD at the ED including providing linkages to follow-up visits upon discharge.
<input checked="" type="checkbox"/> The state has no metrics trends to report for this reporting topic.			
Milestone 6 Implementation Update			

Prompts: Compared to the demonstration design and operational details outlined the implementation plan, have there been any changes or does the state expect to make any changes to implementation of policies supporting beneficiaries' transition from residential and inpatient facilities to community-based services and supports?

Summary:

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

Are there any other anticipated program changes that may impact metrics related to care coordination and transitions between levels of care? If so, please describe these changes.

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

SUD Health Information Technology (Health IT)

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

Prompts	Demonstration Year (DY) and quarter first reported	Related metric (if any)	Summary
Metric Trends			
Discuss any relevant trends that the data shows related to assessment of need and qualification for SUD services. At a minimum, changes (+ or -) greater than two percent should be described.		Q1 PDMP Users/Checks Q2 PDMP Linkages Q3 HIT/HIE Plan	
<i>[Add rows as needed]</i>			
<input checked="" type="checkbox"/> The state has no metrics trends to report for this reporting topic.			
Implementation Update			
<p>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:</p> <ol style="list-style-type: none"> How health IT is being used to slow down the rate of growth of individuals identified with SUD? How health IT is being used to treat effectively individuals identified with SUD? How health IT is being used to effectively monitor "recovery" supports and services for individuals identified with SUD? 			

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

Summary:

- Vermont has a requirement and funding in the current contract with Appriss to connect VPMS to RxCheck for interstate data sharing. RxCheck is developing functionality for direct integration with EHRs and other health systems. Appriss has provided a change order to connect to RxCheck. However, deployment of VPMS staff for COVID-19 response has delayed the start of this initiative.
- VPMS, Dr. First and Appriss are in the process of testing and verifying Appriss's Gateway integration tool to enable direct population of VPMS data into Dr. First's prescription ordering section, eliminating the need for providers to navigate between systems. However, deployment of VPMS staff for COVID-19 response has delayed the start of this initiative.
- VPMS staff are engaged with the NESCSO State HIT Learning Community. This group works to create a shared understanding of Federal legislation, the current state of PDMP activities, and identifies opportunities for multi-state alignment.
- Vermont continues to offer prescriber reports on a quarterly basis.
- Vermont has enabled permissions for the Veteran's Association to integrate with VPMS as required by the Mission Act. This project went live in November 2020. VPMS data is available for VA providers nationwide who are providing services to Vermonters.

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

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

Other SUD-Related Metrics

Prompts	Demonstration Year (DY) and quarter first reported	Related metric (if any)	Summary
9.2 Other SUD-Related Metrics			

9.2.1 Metric Trends			
Discuss any relevant trends that the data shows related to assessment of need and qualification for SUD services. At a minimum, changes (+		<p>23 Emergency Department Utilization for SUD per 1,000 Medicaid Beneficiaries</p> <p>24 Inpatient</p>	<p>Overdose deaths are variable. Vermont has seen a significant increase in fentanyl involvement in opioid overdose fatalities. Fentanyl is 50-100 times stronger than heroin and the amount in the drug supply often isn't known to users until it is used. Fentanyl is currently the most</p>

or -) greater than two percent should be described.		Stays for SUD per 1,000 Medicaid	prevalent substance involved in opioid-related deaths)
		Beneficiaries 25 Readmissions Among Beneficiaries with SUD 26 Overdose Deaths (count) 27 Overdose Deaths (rate) 32 Access to Preventive/ Ambulatory Health Services for Adult Medicaid Beneficiaries with SUD	<p>of opioid-related fatalities and has increased each year since 2011 (9%). Of note, deaths involving fentanyl can include prescription and/or illicit fentanyl and fentanyl analogues.</p> <p>Vermont has been working to decrease drug overdoses and in 2020, published a <u>social autopsy</u> showing places where individuals who died of a drug overdose interacted with a variety of Vermont programs.</p> <p>Fatal overdoses have increased in 2020 after a decrease in 2019. This is likely due to the stress, social isolation, and disruptions in services and drug supply associated with COVID-19. Community support systems such as recovery groups were moved to a remote format, a method not accessible or accepted by everyone accessing these services. COVID-related social isolation may have resulted in more people using alone and anecdotal information suggests that the stimulant payments allowed for larger drug purchases. Medication assisted treatment provision increased in 2020 but residential and intensive outpatient care were less available due to the group nature of these services, and outpatient care was provided remotely. Provision of harm reduction services, which includes information about safer use and referrals to treatment as well as distribution of naloxone and clean syringes were less able to be provided in-person. There was a 40% reduction in people visiting sites where naloxone is distributed and a 24% decrease in naloxone kits distributed in the first six months of 2020 compared to first six months of 2019.</p>

<i>[Add rows as needed]</i>			
<input checked="" type="checkbox"/> 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.			<p>As a result of COVID-19, the Vermont Department of Health Division of Alcohol and Drug Abuse (ADAP) is taking the following actions to address the increase in drug overdoses.</p> <ul style="list-style-type: none"> • Naloxone – The Department continues to provide naloxone and training through collaborations with community-based organizations, including getting naloxone to the motels where the state is housing people experiencing homelessness. • VT Helplink is a free and confidential referral service available to connect people to resources and treatment (802-565-LINK or VTHelplink.org) • Recovery Centers are conducting outreach to reduce relapse and prevent overdoses (e.g. Harm Reduction Pack distribution, peer support specialists, Recovery Coaching referrals, etc.) • Providers are increasing outreach to patients and are continually re-evaluating patients' stability to triage for in-person supports, decreased take-homes, etc. • ADAP has regular calls with Preferred Providers. <ul style="list-style-type: none"> ○ The clinical team at ADAP receives critical incidents for overdoses from the preferred providers for people currently in treatment. ○ Overdoses were reported by providers to include people in longer-term recovery and people who had left treatment prior to COVID. • The Department is working with partners to continue to disseminate key harm reduction messaging on the increased risks associated with overdose and using alone. • ADAP continues to collaborate with communities to enhance RapidAccess to Medication Assisted

			Treatment (RAM). The statewide expansion includes 13 hospital emergency departments with at least one waived practitioner in their Emergency Department (ED).
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. <i>Financial/Budget Neutrality Development/Issues</i> of this report.
<i>[Add rows as needed]</i>			
<input checked="" type="checkbox"/> 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.			
<i>[Add rows as needed]</i>			
<input checked="" type="checkbox"/> 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			
<p>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.</p> <p>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.</p>			
<i>[Add rows as needed]</i>			
<input checked="" type="checkbox"/> 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?			
<i>[Add rows as needed]</i>			
<input checked="" type="checkbox"/> 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. <i>Quality Improvement</i> and IX. <i>Demonstration Evaluation</i> 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.			
<i>[Add rows as needed]</i>			
<input checked="" type="checkbox"/> 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.			
<i>[Add rows as needed]</i>			
<input type="checkbox"/> 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			
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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: <ul style="list-style-type: none"> 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. <i>Compliance</i> of this report.
Has the state identified any real or anticipated issues submitting timely post-approval demonstration deliverables, including a plan for remediation?			
<i>[Add rows as needed]</i>			
<input checked="" type="checkbox"/> 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.			
<i>[Add rows as needed]</i>			
<input checked="" type="checkbox"/> 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.			
<i>[Add rows as needed]</i>			
<input checked="" type="checkbox"/> 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 QE062021:

- COVID-19 Response
- Working with AHS on improving transitions in care and implementing complex care model with population involved with Department of Corrections
- Resumption of in person visits with beneficiaries
- Alignment of VCCI with state health care reform and ACO

The VCCI provides holistic, intensive case management services to Vermonters enrolled in Medicaid, including dually eligible beneficiaries. The VCCI team is comprised of licensed, field-based case managers, including seven with certification in case management, who provide clinical case management services to beneficiaries with complex health and health related needs within the communities they serve. Primary mode of intervention is through in-person visits with beneficiaries, meeting them in their homes, at motels, shelters, at homeless camps and at co visits with providers. Two non- licensed professional staff complement the team, with their primary role as outreach to those beneficiaries new to the health plan. VCCI works with beneficiaries referred for complex case management by healthcare and human services providers, state colleagues and partners, as well as identified through our care management predictive modeling methodology. VCCI case managers and outreach coordinators are also welcoming those new to Medicaid (NTM), and completing screening, and identifying and prioritizing needs. Our screening tool asks questions about access to care (including medical and dental homes), the presence and status of health conditions, and about other needs that would assist them in maintaining +/-or improving their health by stabilizing social determinants such as housing, food and safety. The VCCI team works to facilitate direct connections with medical homes, community-based self-management programs, local care management teams and assist beneficiary in navigating the system of health and health related care.

This quarter, VCCI was invited to work with the Agency of Human Services and Justice Reinvestment work; a process to identify and address challenges in Vermont's criminal justice system. VCCI's role is to support the Department of Corrections (DOC) with learning and implementation of the complex care model with population with health conditions to include mental health and substance use, compounded by complex health and social needs. Toward the end of this quarter, VCCI began to develop a pilot with a site-specific probation and parole office, with DOC referring beneficiaries to VCCI for screening, stratification, and risk level-based intervention, including providing case management through the complex care model for those stratified at a high-risk level. In addition, VCCI continues to work with DOC and the health care vendor with goal of supporting successful transitions of care - from facility to community, with facility staff sending referrals to VCCI for community-based case management. Mutual goals are to support and facilitate beneficiaries' integration back into the community, and access to both health and health related services, for improved quality of life and decreasing chance of recidivism.

During QE 062021, VCCI continued to be a resource in the state's response to the public health crisis with both licensed and non-licensed staff remaining available for COVID-vaccination in roles of either

vaccinator or intake/exit worker. The demand of VCCI staff time at Vermont's vaccination clinics certainly waned this quarter, and staff continue to provide education, reinforce guidance, and inform of vaccine clinics to beneficiaries, as appropriate. With goal of increasing beneficiary access to telehealth services/providers, as well as to their VCCI case manager, VCCI procured technology through a federal grant. VCCI received 2 distributions of technology in late 2020 and the team continues to distribute both iPads and/or Wi-Fi extenders to beneficiaries with identified need and with the ability to navigate use of the technology to date, VCCI has been able to distribute technology to 60 unique beneficiaries and plans to continue to distribute supplies through 2021. This has afforded beneficiaries the opportunity to meet with health and health related service providers, through telehealth, including their VCCI case manager. Beginning in March 2020 and due to the pandemic, VCCI case managers pivoted from meeting with beneficiaries in person to carrying out interactions via phone and telehealth. Good to share that in June of this quarter, VCCI resumed in person visits and will continue to follow public health guidance.

VCCI continued efforts toward improved alignment with health care reform and the system of care; formalizing its shift from historically serving only those who were predicted to be high cost/high risk to needs based eligibility and outreach. VCCI is working with the ACO on two main areas for alignment: formal adoption of the complex care model with utilization of common tools and expanded attribution. In alignment with the ACO model, the VCCI implements the complex care model, utilizing patient engagement tools, pulling together care teams and helping the beneficiary in the identification of a long-term lead care coordinator. In addition to the beneficiary, potential care team members may include primary care providers, hospital case managers, community and designated mental health agency providers, AHS partners such as Economic Services Division and Employment Specialists. Lead Care Coordinators help to support the member in goal setting and in the development of the shared care plan. There remains varying community implementation of this service delivery: lead care coordinator may be identified but has not yet engaged with the beneficiary; an identified care team of one provider. Information is intended to be shared within OCV communication platform of Care Navigator, but this can be challenging. The system often feels like another health record to manage; not all partners on a beneficiary care team may have access to Care Navigator; the attribution information may not reflect current utilization; and 2021 attribution was not loaded into Care Navigator until late Spring. All VCCI field-based staff have been trained in using Care Navigator. There remains variance with community knowledge and scope of understanding of the expanded attribution and development of community workflows to help manage this population. VCCI has assessed how we could improve our role in supporting the ACO and communities; and have coordinated with colleagues at DVHA. VCCI and Blueprint for Health have just begun to meet with managers from OCV, with the objectives of ensuring consistent communication and messaging, ensuring communities have the knowledge and tools, and review of data.

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

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

Another area that VCCI is working on with our partners at VITL and the Blueprint is to have the data related to social determinants of health that VCCI collects on beneficiaries through both our initial screening and comprehensive surveys to be part of their record in the VHIE. This will assist the ACO with a more accurate way of predicting risk and being able to intervene on those beneficiaries with issues earlier, so they do not become part of that very high-risk group. VCCI expects to receive report analysis from the ACO in early Fall of 2021.

The clinical documentation system that VCCI utilizes through eQ Health is CMS certified and DVHA has exercised the option to extend the contract with the Vendor for one year with option to extend one additional year x 2. The system contains clinical information via an interface with Vermont’s HIE vendor, VITL to enhance case managers’ ability to formulate and put into motion a true patient centered, clinically focused plan of care.

VCCI is looking ahead to the next quarter with goals to include continued in-person, field-based beneficiary visits; assist with standardizing the tools of the complex care model delivery statewide; implementation of pilot with DOC probation and parole as part of AHS Justice Reinvestment; continued implementation of workstream with our colleagues at the Department of Corrections on transitions of care with beneficiaries released from/entering incarceration; and collaboration with our Agency of Human Services on broadening VCCI’s integration with other AHS Departments. The above goals are appropriate with consideration of the VCCI role in the All-Payer Model reboot and move to the AHS Secretary’s Office.

ii. Blueprint for Health

Patient-Centered Medical Home Program

The Blueprint uses national standards to drive improvements in primary care delivery and payment. The program helps primary care providers transform their practices into National Committee for Quality Assurance (NCQA)-certified Patient-Centered Medical Homes. The Patient-Centered Medical Home model supports care that is patient-centered, team-based, comprehensive, coordinated, accessible, and focused on quality and safety. The model also promotes care that is provided when and where the patient needs it, and in a way that the patient understands it. Patient-Centered Medical Homes in Vermont are supported by multi-disciplinary teams of dedicated health professionals in each of the state’s health service areas. These teams provide supplemental services that allow Blueprint- participating primary care practices to focus on promoting prevention, wellness, and coordinated care.

The Community Health Teams support primary care providers in identifying root causes of health problems, including mental health and screening for social determinants of health. They also connect patients with effective interventions, manage chronic conditions, or provide additional opportunities to support improved well-being. Patient Centered Medical Home Program Blueprint Program Managers,

who are local leaders in each community, are responsible for contacting all primary care practices within their health service area to encourage, engage, and support practice participation in the Blueprint for Health and learning health system activities. Annually, Program Managers report on the remaining primary care practices in each region that have not begun the process of transforming their practice into Patient-Centered Medical Homes and indicate the rationale provided by each practice contact. Importantly, Blueprint Program Managers report very few practices in each health service area remaining who are not currently engaged with the Blueprint for Health program. In addition to Program Managers, the Blueprint supports participating practices with a quality improvement coach, called a Quality Improvement Facilitator. Quality Improvement Facilitators use their own training and expertise in process improvement methodologies (such as Clinical Microsystems, Model for Improvement, and Lean process improvement) and data interpretation when they review the practice's data or data provided by the Blueprint for Health. Quality Improvement Facilitators initially help launch patient-centered practices and secure NCQA Patient-Centered Medical Home recognition. After recognition is achieved, the facilitators regularly return to help with quality improvement efforts related to panel management and outreach, care coordination, promotion of individual health and wellness, chronic condition management, and ongoing practice transformation in alignment with State-led health care reform priorities. These include:

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

Blueprint-participating Patient-Centered Medical Homes currently serve 306,061 insurer-attributed patients, of which 103,696 are Medicaid enrollees. Attribution to a practice is determined by the practice at which the patient has received the majority of their primary care within the 24 months prior to the date the attribution process is conducted. These practices and patients are supported by 165 full-time equivalents of Community Health Team staff.

Quarterly Highlights

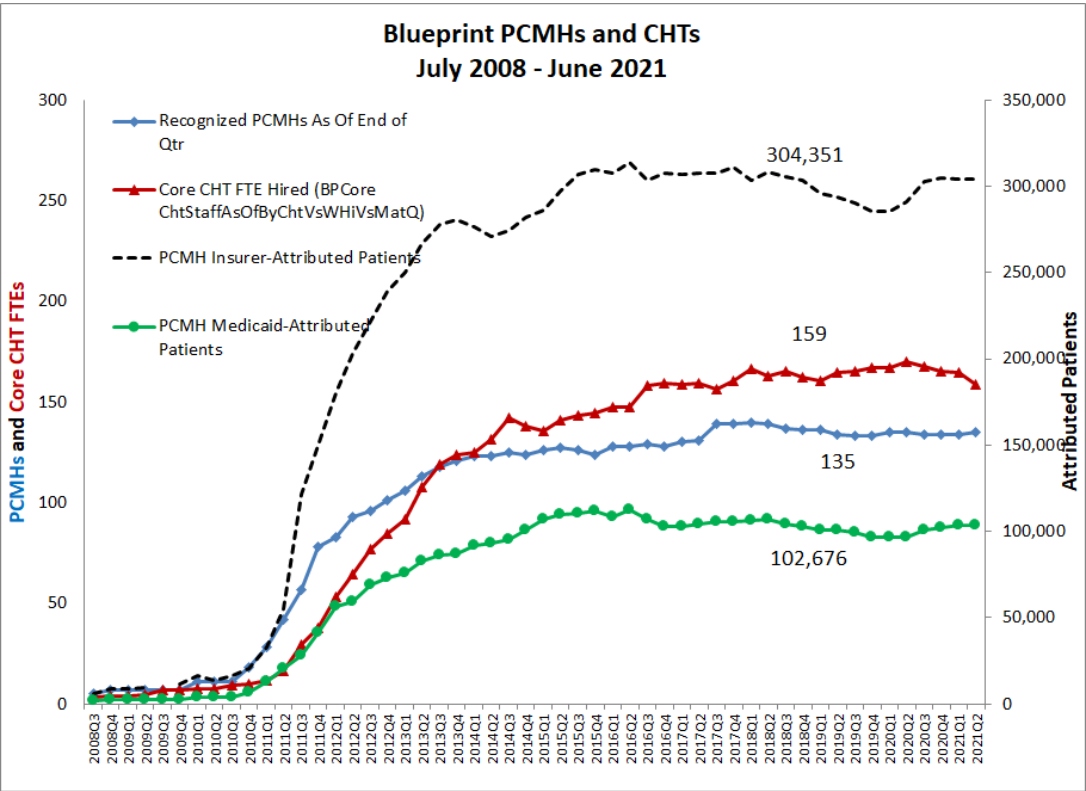
In Quarter 2 (April- June 2021), 135 Vermont practices were operating as Patient-Centered Medical Homes, thanks to the commitment of providers and staff, the support of Program Managers, and the technical assistance of Quality Improvement Facilitators. The number of practices participating in the Blueprint 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.

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

in-person visits have increased, telehealth continues to be an option for primary care appointments and screenings. The network continues to work diligently to ensure excellent patient care and care coordination for the best health outcomes. We are finding that behavioral health and dieticians are returning to the office and providing in person care with proper safety precautions in place.

As Vermont continues to have very high vaccination rates. The Blueprint team has been working closely on various committees and with VDH to understand the planning for transition of Covid 19 vaccine to the PCMH as large vaccination hubs are closing. We have asked our QI network to make this transition a priority in support to practice workflows.

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



Practice Health Profiles and Community Health Profiles

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

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

Profiles are posted at <http://blueprintforhealth.vermont.gov/community-health-profiles>. Most recently, the Blueprint for Health published its 2020 Annual Report. This report reviews more in depth how the Program Managers, Quality Improvement Facilitators, Patient-Centered Medical Homes, Community Health Teams interact to provide services, coordinate care across communities, and work with the state’s accountable care organization. The report is available at:

https://blueprintforhealth.vermont.gov/sites/bfh/files/doc_library/BlueprintforHealthAnnualReportCY2020.pdf.

Hub & Spoke Program

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

Many of these outcomes were supported by the recent evaluation of Vermont’s Hub & Spoke system. The State Plan Amendment for the Vermont Medicaid Program, approved by the Centers for Medicare and Medicaid Services, established a Health Home for Vermonters with opioid use disorder. As of July 1, 2013, Medicaid beneficiaries receiving

medication- assisted treatment for opioid use disorder in a Hub or Spoke setting were eligible to receive enhanced services, such as comprehensive care management, care coordination, comprehensive transitional care, health promotion, individual and family support, and referral to community and social support services. The Health Home functions to enhance Hub programming and embeds essential support staff (1 registered nurse and 1 licensed mental health clinician per every 100 Medicaid patients receiving medication-assisted treatment) into Spoke practices for a patient-centered, team- and evidenced- based approach to the treatment of opioid use disorder and the provision of Health Home services. Based upon the “significant impact” demonstrated by the Hub and Spoke system, Vermont is working towards gaining All Payer participation in the Opioid Use Disorder Health Home model.

The Blueprint, in partnership with the Division of Alcohol and Drug Abuse Programs (Department of Health), continues to offer learning sessions with expert-led, and peer-supported, training in best practices for providing team- and evidence-based medication-assisted treatment for opioid use disorder. For many physicians, nurse practitioners, and physician assistants, access to specialized staffing and ongoing training opportunities provide the support and confidence the providers need to accept the challenge of treating opioid use disorder in community-based medical practice settings (Spokes). For patients, the Spoke staff become a critical part of their care team, working together week-by-week and month- by-month towards long-term recovery and improved health and well-being. At the end of the 2nd quarter of 2021, capacity for receiving medication-assisted treatment in Spoke settings continued to increase, as evidenced by 3,928 Vermonters with Medicaid insurance receiving medication-assisted treatment for opioid use disorder from 285 prescribers and 70.56 full-time equivalent Spoke staff, working as teams, across more than 100¹ different Spoke settings (as of May 2021).

Quarterly Highlights

Vermont continues to demonstrate substantial access to medication-assisted treatment for Vermonters with opioid use disorder. As of May 2021, a monthly average of 3,928 Medicaid beneficiaries were served by Office-Based Opioid Treatment (OBOT/Spoke) programs. As of 2020-Q4, 3,259 Vermont residents aged 18-64 received treatment in a Hub (source: ADAP Hub and Spoke Quarterly Report for 2020-Q4).

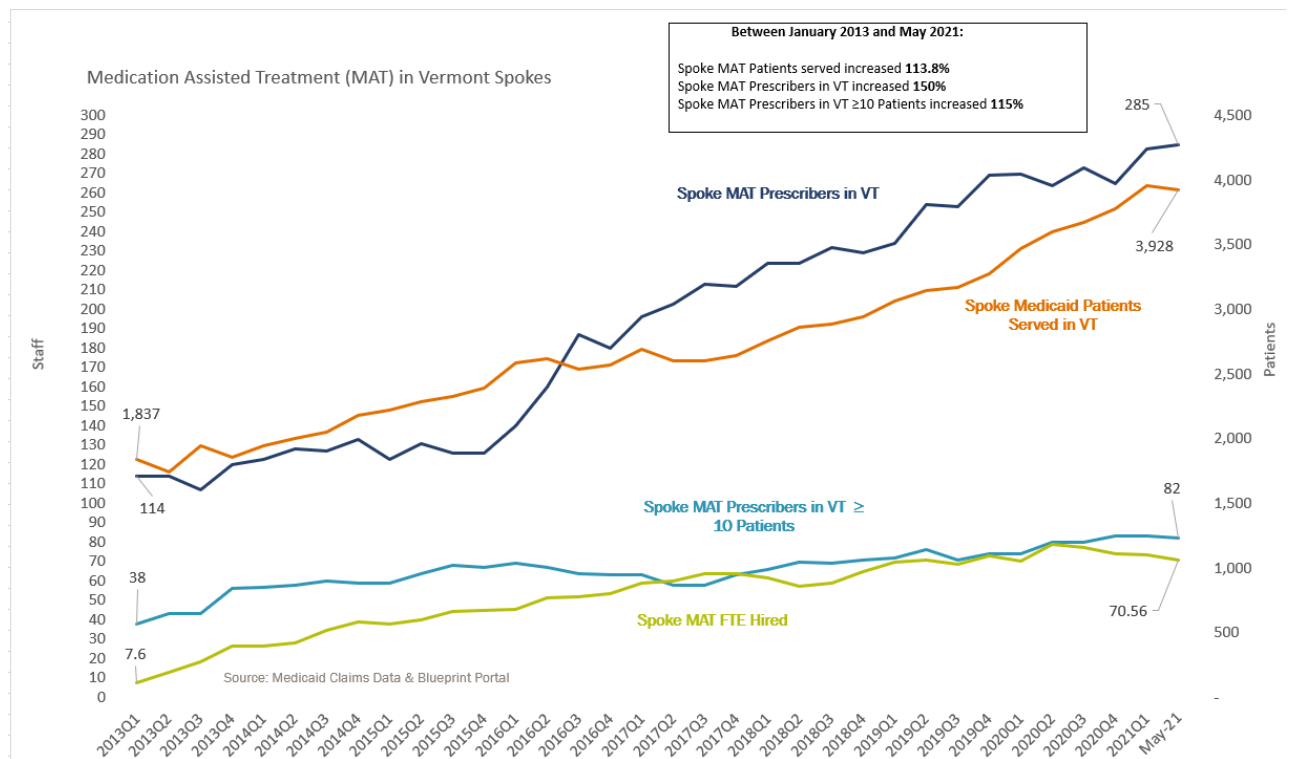
Medication-assisted treatment for opioid use disorder is being offered across the State of Vermont by more than 100 different Spoke settings and by 285 medical doctors, nurse practitioners and physician assistants who work with 70.56 FTE licensed, registered nurses and licensed, Master's-prepared, mental 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 May 2021).

At the end of Q1 2021, many Spoke nurses were providing care in both telehealth and in-person visits, and the Spoke counselors were continuing to deliver care remotely. Dependent on COVID-19 case rates throughout the state, in Q1 of 2021 Spoke nurses fluctuated their frequency of in-person care. For example, in areas of the state where case rates increased, spoke nurses reduced the amount of in-person visits they had based on patient risk stratification as evaluated by the provider and care team. Patients who were determined to be stable were more likely to have telehealth-only visits from both the Spoke nurse and the Spoke counselor at the end of Q1 2021. We are currently seeing increased staffing in office and in increase of in person visits.

The Blueprint has maintained a contract with Dartmouth College to Provide Organization, Coordination, Facilitation, and Delivery of the Blueprint-Sponsored Medication Assisted Treatment Program Learning Session since 2019. The Blueprint has continued to feel positive about collaboration and extended their contract through June 30, 2022. Some key themes for this set of learning sessions is, practice workflows, quality improvement, motivational engagement for harm reduction & promoting recovery and team behavioral management. We are currently finalizing the agenda and speakers for a two day Statewide Opioid Treatment Conference (virtual) in the Fall of 2021.

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

Figure 3. MAT-SPOKE Implementation Jan 2013 – May 2021



Women's Health Initiative

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

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

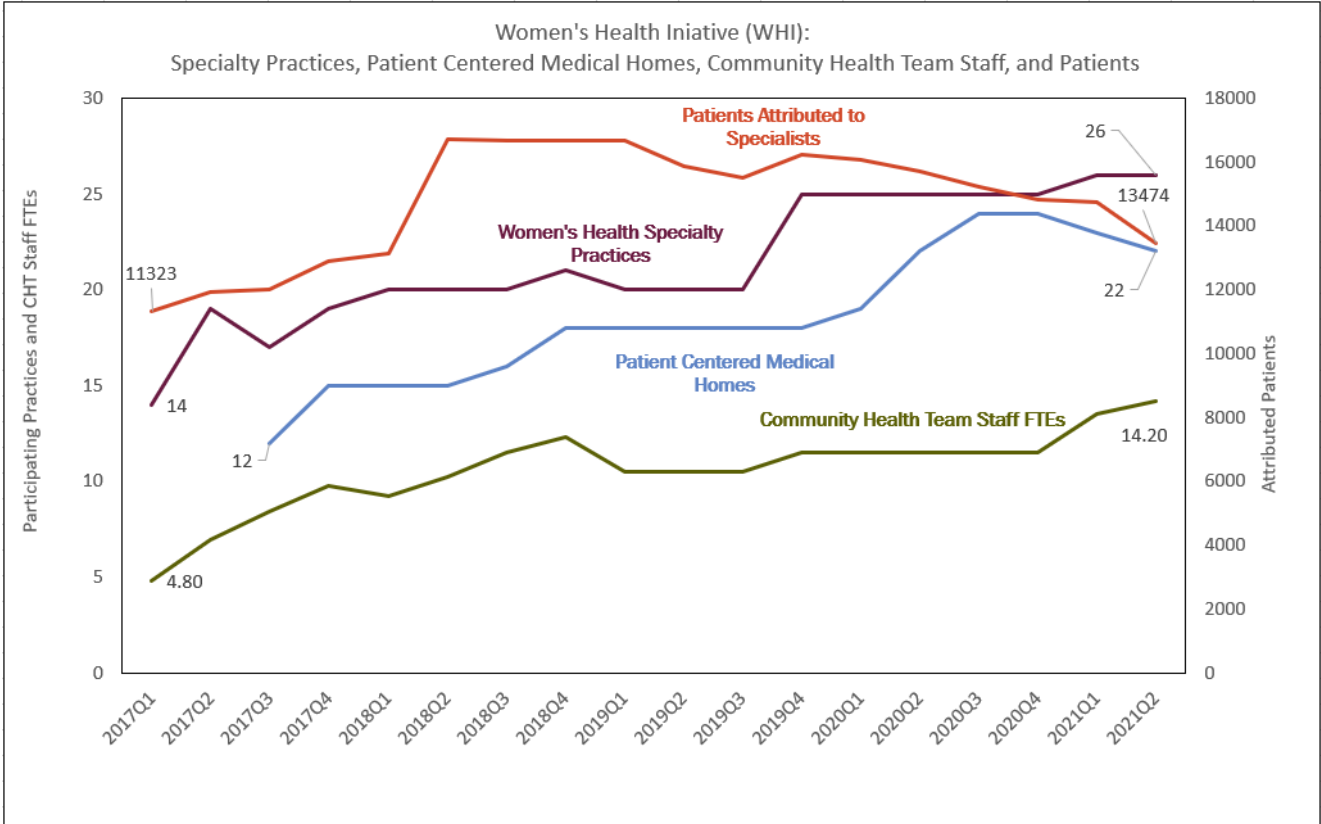
clinically indicated.

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

Quarterly Highlights

- Vermont continues to increase access to enhanced preventative health, psychosocial screening, and comprehensive family planning services, as evidenced by the commitment of 49 practices (26 women's health and 23 primary care) to participate in the Women's Health Initiative as of 4/1/2021.
- We have successfully engaged with a FQHC practice in the Windsor health service area. This is one area we have historically not had any practices show interest in joining. We hope they will join and become fully engaged in the next quarter.
- Practices are working hard to engage community partners in referral agreements. These agreements enhance relationships and pathways to care. Practices are updating policy/practices documents regarding SDOH and LARC insertion.
- We have been presenting the WHI data dashboard quarterly to the field in our monthly call. The field has shared that this has been extremely helpful in understanding LARC insertion and use of most and moderately effective contraception. Dr. Lauren MacAfee from the UVM network has presented to the field a lunch-and-learn on how to implement same day LARC and a virtual LARC insertion training. We and the field are very thankful to have this resource. We will be working with PPNNE to present 10 Best Practices of Contraceptive Counseling in the next quarter. We had a wonderful turnout for training and as always, the field is thankful for educational opportunities.
- The Community Quality Improvement Facilitator and Assistant Director meet with each Health Service Area practice leads and quality improvement facilitators to engage in continuous quality improvement projects related to the attestation elements. Program Managers reported that these were helpful to continue keeping a focus on this program.

Figure 4. Women’s Health Initiative: Practices, Patients, and Community



Health Team (CHT) Staffing Figure 5. Women's Health Implementation by Region

Health Service Area / Team	WHI Specialist Practices as of 7/1/2021	WHI PCMH Practices as of 7/1/2021	WHI CHT Staff FTE Hired as of 7/1/2021	WHI Specialist Quarterly Attributed** Medicaid Beneficiaries as of 7/1/2021	WHI PCMH Quarterly Attributed** Medicaid Beneficiaries as of 7/1/2021
Barre	1	1	1.5	604	359
Bennington	1	2	0.8	872	261
Brattleboro	1	0	.6	809	0
Burlington	3	8	2.0	2323	4752
Middlebury	2	0	0.75	587	0
Morrisville	1	4	0.50	356	1332
Newport	0	0	0.00	825	0
Randolph	2	0	0.50	532	0
Rutland	2	1	3.0	1601	0
Springfield	1	5	0.0	0	1661
St. Albans	1	0	1.0	929	0
St. Johnsbury	1	2	.75	803	784
Windsor*	0	0	0.0	0	0
Planned Parenthood (Statewide)	12	0	2.8	3714	0
Total	26	22	14.2	13474	9149

*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.

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

iii. *Behavioral Health*

Key updates from QE062021:

- Alternative payment model for Brattleboro Retreat
- Applied Behavior Analysis

The Behavioral Health Team is responsible for concurrent review and authorization of inpatient psychiatric and detoxification services for Medicaid primary members. The Behavioral Health team works 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 members already enrolled with VCCI admitted to inpatient or residential care facilities.

As of March 1, 2021, Vermont Medicaid modified reimbursement methodology for inpatient services delivered by the Brattleboro Retreat (the Retreat). Prior to implementation Department of Vermont Health Access & Department of Mental Health reimbursed the Retreat for services using different methodologies on a fee-for-service, per claim basis. The new model allows for a prospective payment informed by a number of factors:

- Historical utilization incurred by DMH and DVHA at the Retreat
- Projected utilization in the coming year
- Recent cost per day values incurred by the Retreat for direct care, fixed and administrative costs
- A negotiated allowance for changes in cost each year for direct care, fixed and administrative costs

DVHA, DMH and the Retreat have agreed upon performance measures and a monitoring platform for the model is being built by the Quality and Clinical Integrity team at DVHA.

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. All available data is reviewed to determine whether enrollees need to remain in the program. Standards for inclusion and removal have been operationalized by the team. A screening tool, manual, and inclusion procedure 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. In May a targeted mailing was sent to enrolled Primary Care providers. The mailing included a letter describing the program, copies of the Team Care brochure and the referral form, as well as links to the DVHA Team Care webpage. As a result of this mailing, there have been two referrals to the program from providers to date. Lack of referrals may demonstrate success of the Vermont Prescription Monitoring System (VPMS) and new opiate rules associated with VPMS.

Team members participate in the SFI Interagency Team and the Youth Service System Enhancement Council (a collaborative with ADAP, DMH, VCRIP, Vocation Rehabilitation, DCF, and more). Team members are active in ensuring that beneficiaries with multi- department involvement are getting appropriate services delivered in the most efficient manner. This is accomplished through participation in state interagency team meetings, the Mobile Crisis Response Initiative, by attending monthly CRC meetings, participating in weekly case review, and development of protocols for cross departmental service delivery. Our unit worked with other departments on developing a system to notify DVHA regarding all children with Medicaid that are awaiting placement in Emergency Departments 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 been receiving ABA services. There has been an increase in Vermont Medicaid enrollment of new agencies that provide ABA services. Although there have been positive outcomes with the implementation of the case rate methodology, multiple ABA providers have provided feedback regarding the difficulty of prospectively determining treatment hours for the next month. Provider concerns include end of year payment reconciliation. The ABA team includes the QICI, Payment Reform, Policy and Business units. The team explored alternatives and posted a Global Commitment Register (GCR) on May 5th which proposed a change in the timing of the payment to a post-delivery payment. Providers would not be required to prospectively set payment tiers. After posting the proposal for public comment and reviewing and considering responses, the team has decided that effective July 1, 2021, DVHA is changing the timing of ABA case rate tier submissions and payments from a prospective payment to a post-service delivery payment.

Prior to the COVID-19 pandemic, the DVHA ABA team was conducting site visits/audits with ABA providers. The purpose of these visits/audits was to ensure that members were receiving quality care, that providers are accurately reimbursed for provided services, to verify that required documentation is included in members charts, and that clinical documentation follows ABA Policy and Clinical Guideline standards.

Site visits/audits have resumed as of January 2021 and are completed in a virtual format due to social distancing restrictions. This includes a virtual tour of the providers Electronic Health Records system. Additionally, the provider electronically submits clinical documentation to be reviewed by the Autism Specialist or designee. Thirteen virtual site visits/audits have been successfully completed with the goal to visit every ABA provider by December 2021.

iv. Mental Health System of Care

Key updates from QE062021:

- Activities related to the COVID-19 pandemic.
- Integrating Family Services Activity
- Implementation of DMH 10-Year Plan

System Overview

The Department of Mental Health is responsible for mental health services provided under state funding to special-needs populations including children with serious emotional disturbances (SED) and adults with severe and persistent mental illnesses (SPMI). Funding is provided through the Vermont Agency of Human Services (AHS) Master Grants to ten Designated Agencies and two Specialized Service Agencies. These agencies are located across the state of Vermont for the provision of:

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

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

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

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

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, and 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 had a tremendous impact on the service delivery of mental health services throughout Vermont in all community-based settings and inpatient facilities. Recently, Vermont’s state of emergency officially ended by [executive order on June 15, 2021 due to Vermont’s high vaccination rate \(over 80% of eligible Vermonters\) and recovery efforts](#). However, the executive order also states interagency collaborations, food programs, and housing arrangements shall continue to be in place and arranged by the Agency of Human Services “to respond to the conditions created or caused by COVID-19 in order to alleviate hardship and suffering of citizens and communities”.

Enhancements of the Mental Health System of Care through
DMH:

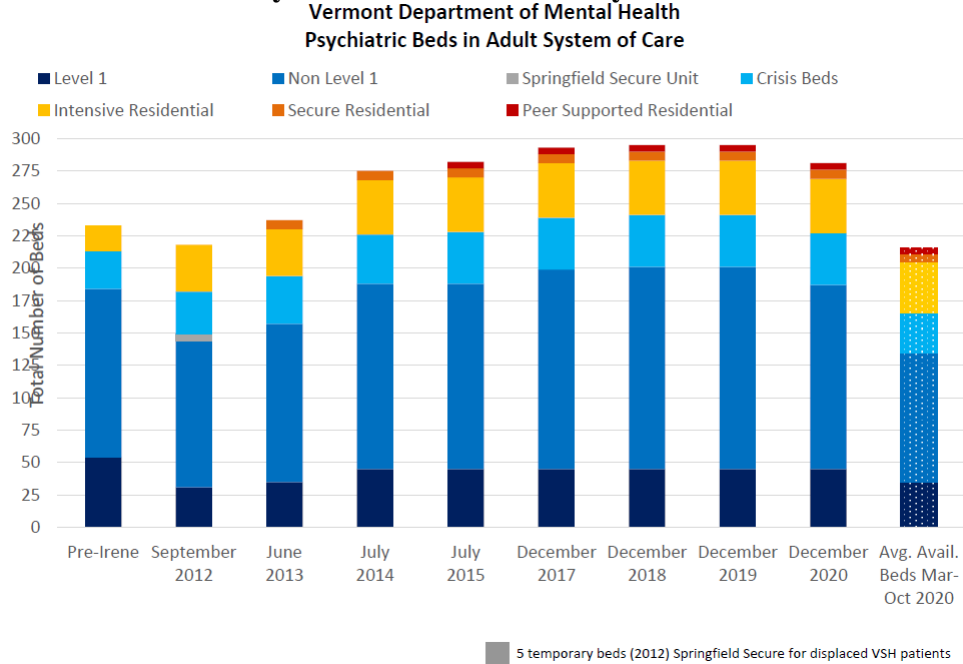
Hospital Services

There are 45 level 1 beds and a total of 159 adult psychiatric inpatient beds across the system of care. During the COVID-19 pandemic, a number of beds closed due to low staffing and a decrease in individuals presenting with a need for a higher level of care. The planned 12 inpatient Level I bed at the Brattleboro Retreat are complete, however they have not yet opened due to lack of staffing capacity. The Brattleboro Retreat is exploring all options to safely staff and have estimated these beds will be online by September 2021, which is expected to greatly improve our system capacity.

As of July 19, 2021, 59 inpatient beds are closed in the adult system. The primary reason for bed closures is lack of staffing, however there are still COVID-19 related bed closures in response to public health and environment safety guidelines, and some closures due to construction or acuity. This temporary bed loss is identified in the chart below.

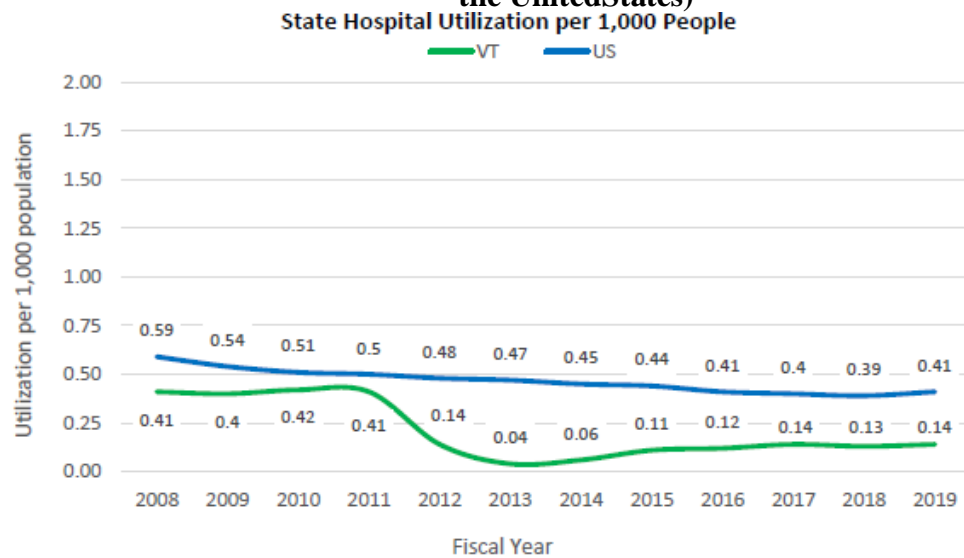
In addition to this temporary loss of adult beds, the COVID-19 pandemic had a ripple effect across the adult inpatient system of care during this same period. In the below table, a bar illustrating Average Available Beds March – October 2020 reflects a system-wide impact across inpatient and community-based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

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



DMH compares the utilization of its system of care to national benchmarks. The following two charts provide information on Vermont utilization as compared to national benchmarks. Data from these two charts are calculated by the Substance Abuse and Mental Health Services Administration's (SAMSHA) Uniform Reporting System (URS), which generates the National Outcomes Measures (NOMs). FY 2019 is the most recent data available.

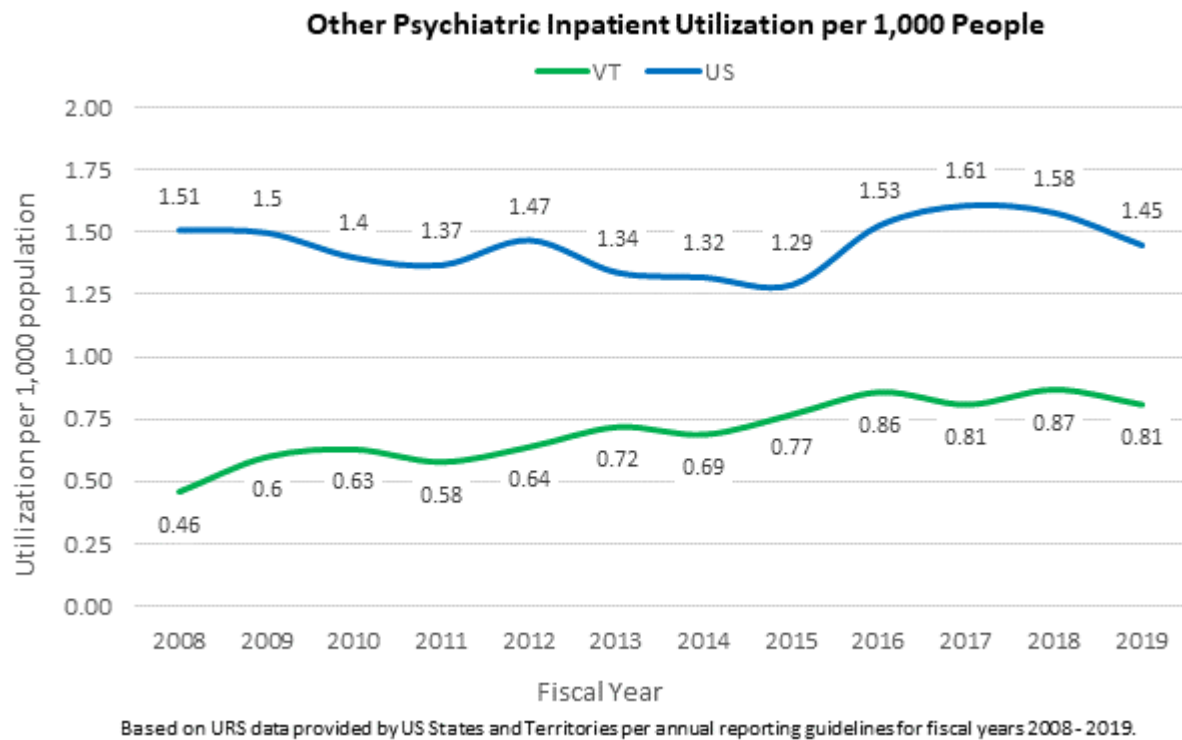
Figure 4. State Hospital Utilization per 1,000 people (in Vermont and the United States)



The national rate of state hospital utilization continues to decline year-over-year.

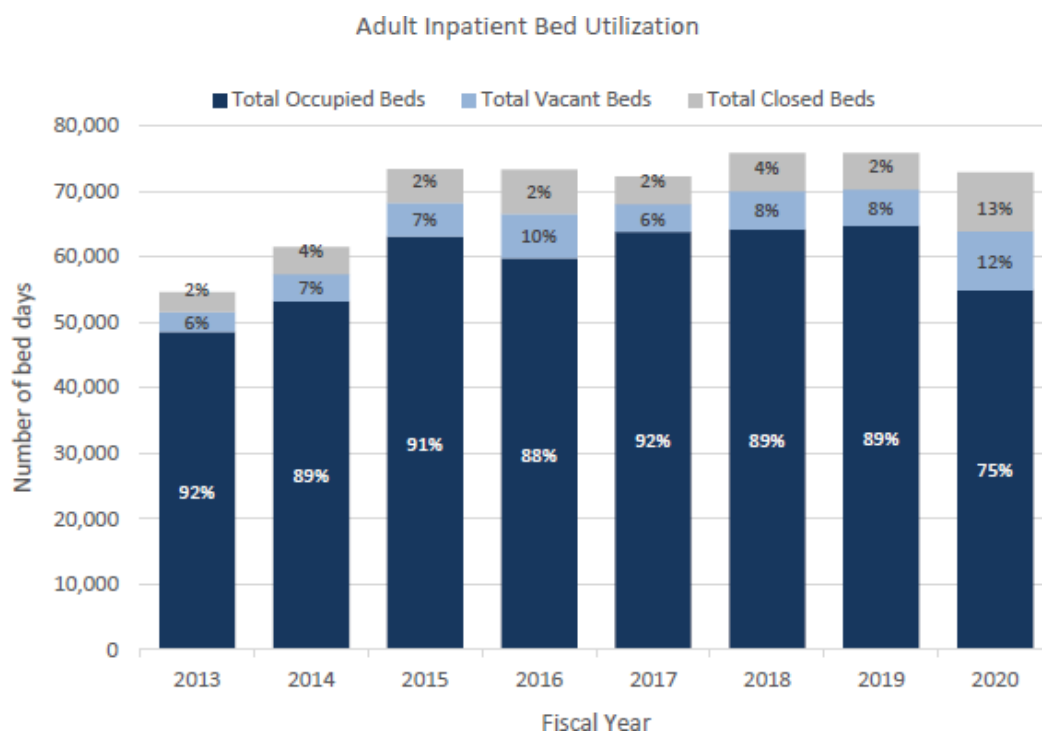
Vermont Psychiatric Care Hospital opened in FY 2015 with 25 beds and Vermont's rate of inpatient utilization continues to be lower than the national average in the United States. The significant decrease from FY 2011 to FY 2012 represents the closure of Vermont State Hospital due to flooding from Tropical 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. MH 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 the Other Psychiatric Hospital Utilization chart. The national rate of psychiatric hospital utilization since 2008 has generally declined year-over-year through 2016 while Vermont's rate of utilization has increased. However, in both 2017 and 2018 there have been substantial increases in national utilization of psychiatric hospital beds. Vermont experienced a slight decline in 2017. Inpatient utilization is still below the national averages while rates of community services utilization in Vermont continue to be markedly higher than national averages (Community Utilization per 1,000 Populations) (see Figure 8).

Figure 6. Adult Inpatient Utilization and Bed Closures



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

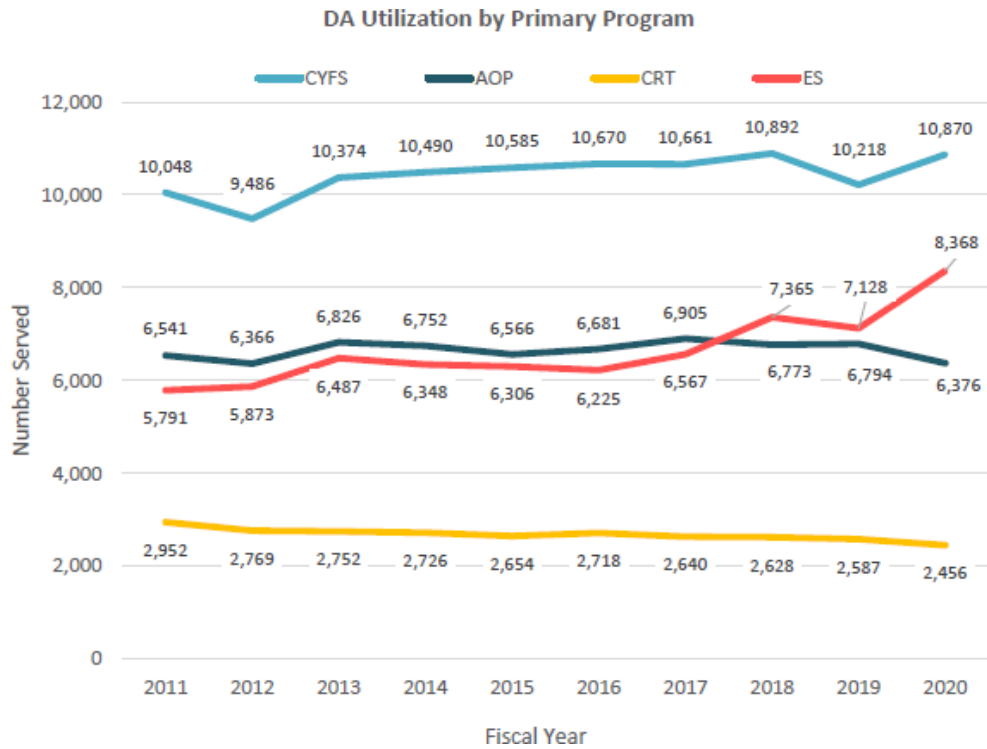
Community Services

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 integral 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.

Other Key Community Services Efforts Include:

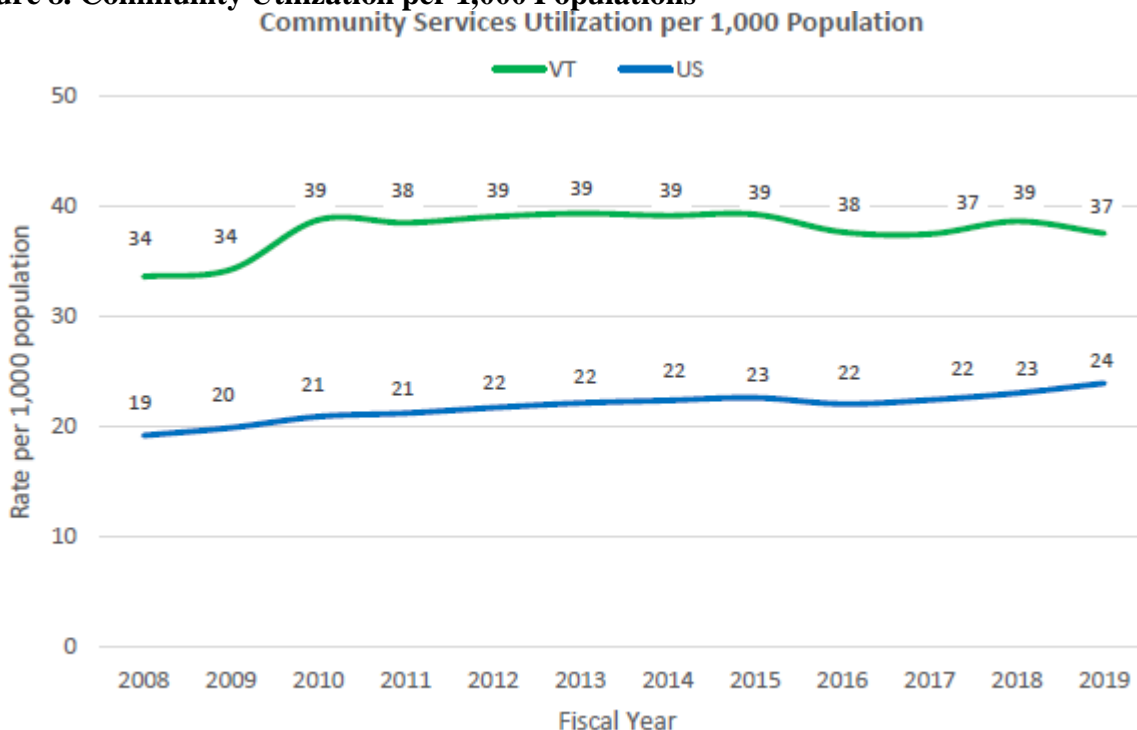
- Establish Community Outreach Team in Washington County (Collaboration with Public Safety)
- Increased capacity within Community Rehabilitation and Treatment and peer programs to provide community support, outreach, and crisis response continue to develop
- Broad utilization of non-categorical case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

Figure 7. Designated Agency Volume by Program



The highest number of persons served by programs offered by the Designated Agencies (DAs) continues to be in services for children, youth, and families. The 6% decrease noted in 2019 appears to have self-corrected and closely approximates utilization in 2018. Similarly, the Emergency Services programs also had an upward trend overall in 2020 which may reflect the increased support needs associated with the impacts of Covid-19. The Adult Outpatient programs saw a 6% decline in utilization while the Community Rehabilitation and Treatment (CRT) programs saw 4% decline. Both of these adult programs have seen flat or slow trend changes over the nine-year period reflected. Given that FY2020 utilization essentially reflects only one quarter of potential impact from the COVID-19 pandemic, FY 2021 will be more reflective of the virus' impact to system services and capacities.

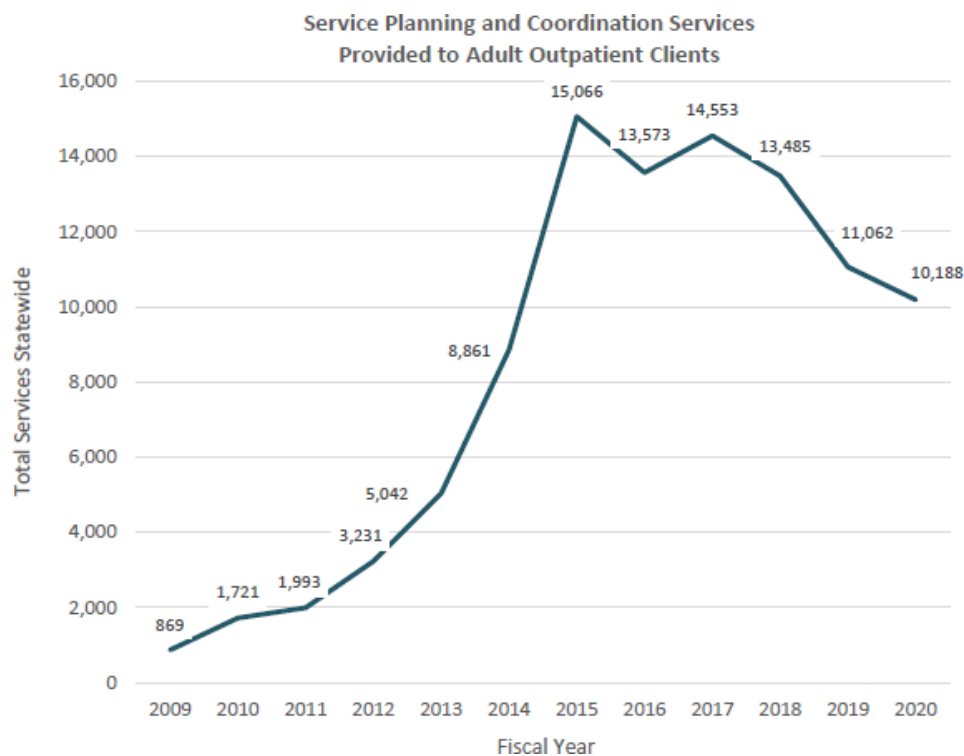
Figure 8. Community Utilization per 1,000 Populations



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

The Vermont community mental health system serves nearly 40 out of every 1,000 Vermonters, which is substantially higher than the national utilization rate. The most recent national data available through 2018 shows that Vermont has a strong and fairly consistent record of service delivery in community-based programs. The system of care is established on the principle that the intensity of services an individual requires will change over time. Individuals receive community-based treatment appropriate to their needs and move to higher or lower levels of care only as necessary to support them. For many who have a chronic illness this is more challenging, as they continuously require higher level of service needs within the system. For others, they enter and exit intermittently depending on their individual needs. The case rate payment reforms provide the ongoing flexibility to meet the needs of the individuals and provide the necessary services.

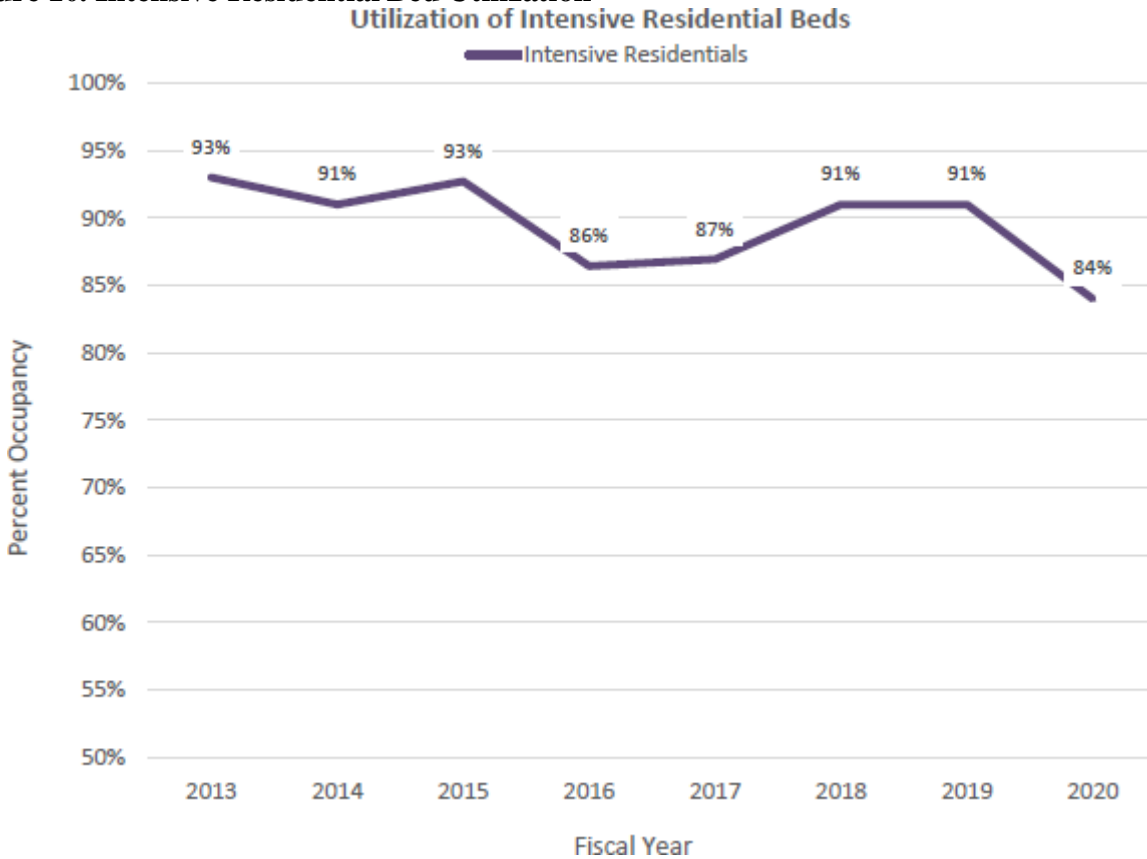
Figure 9. Service Delivery: Planning and Coordination



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

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

Figure 10. Intensive Residential Bed Utilization



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

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

Performance and Reporting

Along with AHS, DMH has adopted the Results-Based Accountability (RBA) framework for assessing performance of providers via grants and contracts. Recent additions to our RBA framework are:

- Implementation of value-based payment measures that allow agencies to earn an additional allocation based on performance on an agreed upon set of metrics
- Mental Health Payment Reform utilization scorecard, monitoring caseload and service utilization for all services within the mental health case rate to monitor the impact of the payment model.
- 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 year on:

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

Mental Health Payment Reform

DMH continues to work on payment reform, building off the Medicaid Pathways work and aligning necessary changes in the provider system with the All-Payer Model. The Department has created a case rate for children/youth mental health services, and a case rate for adult mental health services. The goal of this work is to move toward a simple, but accountable system that reduces the complexities of payment and shifts the focus of the providers and the department on outcomes and quality. DMH is committed to reforming the system to better serve Vermont’s population and continue to move towards full integration of mental health and physical health care.

Integrating Family Services (IFS)

The initial IFS implementation site in Addison County began on July 1, 2012, and the second pilot region in Franklin/Grand Isle counties began on April 1, 2014. These pilots included consolidation of over 30 state and federal funding streams into one unified whole through one AHS Master Grant

agreement. The State created an annual aggregate spending cap for two providers in Addison County (the Designated Agency and the Parent Child Center) and one in Franklin/Grand Isle (this provider is both the Designated Agency and Parent Child Center). This has created a seamless system of care to ensure no duplication of services for children and families.

On January 1, 2019, the IFS sites became aligned with larger payment reform efforts occurring across AHS including having value-based measures 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 that goes through 2022. 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.

In late June, the IFS grantee in Franklin/Grand Isle had their bi-annual integrated chart review which included all AHS departments reviewing charts for minimum standards across the various funding streams that create the integrated case rate. The results from the review are currently being collated and will be available for reporting during the next quarterly update.

Vision 2030

Through summer, fall, and early winter 2019, DMH engaged in a public planning and development process, soliciting stakeholder involvement and feedback as an integral part of planning. The Plan, “Vision 2030: A 10-Year Plan for An Integrated and Holistic System of Care,” was delivered to the Vermont State Legislature in January 2020.

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

Vision 2030 leverages the system’s current strengths to shape an integrated system of whole health—with holistic mental health promotion, prevention, recovery and care in all areas of healthcare—across every Vermont community. This requires improved coordination across sectors, between providers, community organizations and agencies. The workforce must use the best technologies, evidence-based tools and practices for making data-informed decisions, supporting systems-learning and producing measurable outcomes. Links to materials generated throughout this process are posted at this link: <https://mentalhealth.vermont.gov/about-us/departments-initiatives/10-year-planning-process-mental-health-think-tank>

Following the plan submission to the legislature in January 2020, DMH was anticipating convening a Mental Health Integration Council in the fall of 2020, to begin the work of implementation. The

demands of the COVID-19 pandemic on Vermont's health systems, however, delayed that work. The Mental Health Integration Council kicked off on July 13th, 2021 and the council will meet every two months with sub groups convening on specific topics in between meetings.

v. Pharmacy Program

Key updates from QE062021

- Operational Activities
 - Prior Authorization (PA) Data
 - Paid Claims and Drug Spend
 - Provider Communications
- Clinical Activities
 - Pharmacist enrollment
 - Drug Utilization Review Board (DURB)/Preferred Drug List
 - Pharmacy Cost Management (PCM) Program
- Pharmacy Changes related to Federal/State Legislation
 - Tobacco Cessation
 - Morphine Milligram Equivalents (MME)

Pharmacy Benefit Management Program

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

Pharmacy Operations

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

Needs (CSHN) to assist in the drug and rebate management of the programs.

- Clinical Activities include managing drug utilization and cost.
 - Federal, State, Supplemental rebate programs
 - Preferred Drug list management
 - Prior authorization and utilization management programs
 - Drug Utilization Review Board activities-therapeutic class reviews, new drug reviews, prior authorization criteria review and step-therapy protocols.
 - Specialty pharmacy management
 - Physician-administered drug management
- Manages exception requests, EPSDT requests, appeals and fair hearings with Policy Unit.
- Works with Program Integrity Unit on drug utilization issues related to fraud, waste, and abuse.

Operational Activity Reports

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

	No PA	Automated Edits						
Period	Claims Paid w/o PA	Claims Paid w/Auto PA	Claims Paid with Auto Edit	Claims Paid w/Online Override	Claims Paid w/Emergency PA	Claims Paid due to Grandfathering	Claims Paid w/Clinical PA	Total Claim Count
Quarter 2	471,000	108	42,925	388	110	8,529	19,152	545,312
	86%	<1%	8%	<1%	<1%	2%	4%	100%
Quarter 1	438,915	92	46,264	249	104	9,093	19,441	514,158
	85%	<1%	9%	<1%	<1%	2%	4%	100%

- Total claim count does not include compounded drugs.

Paid Claims and Drug Spend

MEDICAID

<u>Period</u>	<u># Claims</u>	<u># of Members</u>	<u>State Paid Amounts</u>
2Q2021	476,838	81,436	\$62,231,651.39
1Q2021	444,632	74,351	\$58,370,599.25

VPHARM

<u>Period</u>	<u># Claims</u>	<u># of Members</u>	<u>State Paid Amounts</u>
2Q2021	70,811	7,339	\$1,337,018.07
1Q2021	72,027	7,834	\$1,873,161.14

Provider Communications Issued

Cumulative MME Limits	In 2017, The Department of Vermont Health Access implemented prescription limits on initial short-acting opiate prescriptions. Patients 18 years and older are limited to 50 MME per day and a maximum of 7 days' supply. Patients 17 years of age and younger are limited to 24 MME per day and a maximum of 3 days' supply. These limits remain unchanged. Effective May 1, 2021, additional edits apply that include any combination of short and long-acting opioids and members on chronic therapy for non-cancer pain. Members new to opioid therapy (no opioid in claims history after February 1, 2021) with a daily MME > 90 per day will require the new completion of an opioid safety checklist as a prior authorization. Members with existing claims history in the past 90 days for opioids will require a safety checklist if the daily MME > 120 per day.
New Coverage of Omnipod® DASH Insulin Pump	Effective 4/1/21, the Department of Vermont Health Access (DVHA) added coverage of Omnipod® DASH products to the pharmacy benefit. The manufacturer is only making it available through the retail pharmacy channel, and not through DME. This allows claims to adjudicate in "real" time through the Pharmacy Point of Sale (POS) System which will allow for faster and easier access for patients. Vermont Medicaid members will now be able to receive their Omnipod®Dash supplies through the pharmacy where they receive their insulin, diabetes supplies, and other medications. Omnipod®Dash will not require a Prior Authorization. Omnipod®Eros will continue to be available from DME providers until the manufacturer phase out.
Pharmacy Benefit Provider Satisfaction Survey for Prescribers and Pharmacies	On May 10, 2021, a Pharmacy Benefit Provider Satisfaction Survey was distributed to Vermont Medicaid enrolled Prescribers and Pharmacies. The Department of Vermont Health Access (DVHA) contracts with Change Healthcare to support Vermont's publicly funded pharmacy benefit programs. The Change Healthcare Help Desk supports all pharmacies and prescribers enrolled in Vermont's pharmacy benefit programs such as Medicaid and Dr. Dynasaur and is the first point of contact for pharmacy and medical providers for drug prior authorization requests, drug claims processing issues, and other drug-related questions, concerns, and complaints. This survey is required annually by DVHA to assure that enrolled providers are receiving the highest quality of service possible from its contracted vendors.
Pharmacy Newsletter	A pharmacy newsletter went out in May 2021 giving updates on the Pharmacy Benefit Provider Satisfactory Survey for Prescribers and Pharmacies, Information on Cumulative MME Edits, New Coverage of Omnipod® DASH Insulin Pump, Specialty Pharmacy List, and DURB meeting April 6, and May 11, 2021.
Hepatitis C Direct Acting Antivirals (DDAs)	To further improve access to Direct Acting Antivirals (DAA) therapies, effective 07/09/2021, DVHA will no longer require dispensing by an accredited specialty pharmacy. Prescriptions for Epclusa®, Harvoni®, Ledipasvir/Sofosbuvir, Mavyret®, Sofosbuvir/Velpatasvir, Solvaldi®, Viekira PAK®, Vosevi®, and

	Zepatier® can filled at any VT Medicaid enrolled pharmacy. Additionally, the Hepatitis C Treatment Prior Authorization (PA) form has been updated.
Point of Sale (POS) Blackout Period	The Department of Vermont Health Access Point of Sale (POS) system will be unavailable for approximately 8 hours starting at 8:00PM on Wednesday June 23,2021 for a system maintenance. Pharmacy claims will not be adjudicated during this time
Reminder: Vermont Medicaid Billing with Closed Primary Commercial Insurance	Federal Statute requires pharmacies to bill a member's primary commercial insurance before billing Vermont Medicaid as the secondary payer. Pharmacy claims are rejected by a member's primary insurer if the member has been terminated from the policy or the policy has been terminated. Occasionally, the TPL information has not been updated and the member's primary insurance policy is still active in the Medicaid system. If a pharmacy determines (e.g., Either through the receipt of an "Other Payer Reject Code" or by validating the policy closure with the member) the primary insurance is no longer active, the pharmacy can submit the claim to Medicaid as the primary payer.

Clinical Activities

Pharmacist Enrollment

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

During Q2 CY2021, we enrolled 122 pharmacists for an overall total of 314 enrolled pharmacist at the end of the quarter.

Drug Utilization Review Board (DURB)

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

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

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

The DURB was designated as the entity to provide clinical guidance on the development of a Preferred

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

Drug Utilization Review Board (DURB) Meetings

Drug Utilization Review Board meetings occur seven times per year and always have a robust agenda. During Q2 CY2021, DVHA held 3 DURB meetings.

The chart below lists CYQ1 2021 activities of the Drug Utilization Review Board.

Review Topic	CYQ2 2021 Total
Therapeutic Drug Classes: Periodic Review	26
Full New Drug Reviews	22
FDA Safety Alerts	0
New/Updated Clinical Guidelines	3
RetroDUR/ProDUR reviews	2
New Managed Therapeutic Drug Classes	0
BioSimilar Drug Reviews	1

Information on the DURB and its activities in 2021 is available at this link:
<https://dvha.vermont.gov/advisory-boards/drug-utilization-review-board>

The agenda typically follows this sample format.



-
- | | |
|--|--------------------|
| ▪ Executive Session | 6:00 - 6:30 |
| ▪ Introductions and Approval of DUR Board Minutes
(Public Comment Prior to Board Action) | 6:30 - 6:35 |
| ▪ DVHA Pharmacy Administration Updates | 6:40 - 6:45 |
| ▪ Medical Director Update | 6:45 - 6:50 |
| ▪ Follow-up Items from Previous Meetings | 6:50 - 6:50 |
| ▪ RetroDUR/ProDUR | 6:50- 7:10 |
| ▪ Introduce: | |
| ▪ Data presentation: | |
| ▪ Clinical Update: Drug Reviews
(Public comment prior to Board action) | 7:10-7:45 |

Biosimilar Drug Reviews

- **Full New Drug Reviews**
(Any new drug reviews that also fall within the Therapeutic Class Review (TCR) will be discussed during the Therapeutic Class Review)
- **New Managed Therapeutic Drug Classes** **7:45 -7:45**
(Public comment prior to Board action)
- **Therapeutic Drug Classes – Periodic Review** **7:45 - 8:30**
(Public comment prior to Board action)
- **Review of Newly Developed/Revised Criteria** **8:30 - 8:30**
(Public comment prior to Board action)
- **General Announcements** **8:30 – 8:30**
- **Adjourn** **8:30**

Pharmacy Cost Management (PCM) Program

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

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

Vermont PCM Progress Report– 06/30/2021

Program-to-Date (through 06/30/2021):

Total Members Enrolled: **2323**

Total Medications covered: **146**

Fiscal Year 2021, Quarter 4:

Current Active Enrollments: **434¹**

Newly Enrolled: **145**

Initial claim/Prior Authorization reviews: **145**

Follow-up reviews: **342**

Patient Contact

- Phone call attempts²: **261**
 - Answered/Member Counseled: **112**
- Phone calls received from member: **0**

Provider Contact

- Phone calls: **11**

Chart notes

- Requested: **142**
- Received: **68**

Interventions with Direct Cost Avoidance: **4**



Direct Cost Avoidance

Current Quarter (04/01/2021 – 06/30/2021):

\$283,904.28

Fiscal Year 2021:

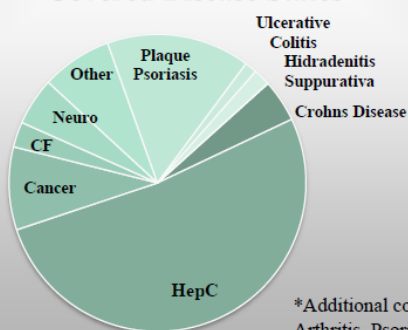
\$757,023.86

Total (Program Initiation – 06/30/2021):

\$3,307,824.08

*State/Federal Dollars - extrapolated to end of program year (06/30/21)

Covered Disease States



*Additional covered disease states with few members: Rheumatoid Arthritis, Psoriatic Arthritis, HIV, Ankylosing Spondylitis, Hemophilia

Quick Summary

✓ Enbrel

Provider was looking to double the dose, as medication was not effective

- Worked with provider to discuss lack of adherence to refills, suggesting that as a reason for lack of efficacy instead
- **\$69,780.96** (difference from increased frequency back to standard dosing, extrapolated)

✓ Cosentyx

Pharmacy billing for two 150mg unit pens instead of using the 300mg-dose unit

- Worked with pharmacy to change the NDC for proper billing
- **\$66,540.84** (difference extrapolated)

Change Healthcare (April 1, 2021 through June 30, 2021). Change Healthcare Pharmacy Management Reporting Suite by a collection of reports recording the process and progress of PCM.

The program is actively monitoring 434 enrollees. A total of 261 outgoing telephone calls were placed to members, 112 of which resulted in member counseling. During this quarter of the Vermont PCM program, four interventions led to direct and measurable cost avoidance. Furthermore, interventions that do not bring about direct cost avoidance are in place to encourage adherence and thus improve member outcomes and avoid unnecessary medical costs. In CYQ2 2021, the Vermont Medicaid Pharmacy Cost Management (PCM) program enrolled 145 new members, and continued management of an additional 342 patients, resulting in improved pharmaceutical care and a savings of nearly \$283,904 and lifetime savings attributable to the PCM program total more than \$3.3 million.

Pharmacy Changes related to Federal/State Legislation:

Tobacco Cessation

Per Act 178 of the 2020 legislative session pharmacists may prescribe both prescription and over-the-counter tobacco cessation products. Provision of this service must be done in accordance with a protocol approved by the Commissioner of Health after consultation with the Director of Professional Regulation and the Board of Pharmacy. The Vermont Medicaid program will reimburse pharmacists for providing tobacco cessation counseling. Pharmacists will be paid according to the Resource-Based Relative Value Scale (RBRVS) fee schedule. Coverage will continue to be limited to 16 visits per year for Medicaid

members, which can be exceeded with prior authorization. This expansion to cover tobacco cessation services provided by pharmacists is expected to increase utilization of this benefit and improve the quit rate among Vermont Medicaid members. This change was implemented on July 1, 2021.

Morphine Milligram Equivalent (MME)

Pursuant to the Medicaid Drug Utilization (DUR) provisions that were included in Section 1004 of the “Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment of Patients and Communities Act”, also referred to as the SUPPORT Act, the Department of Vermont Health Access (DVHA) implemented prescription limits for opioids used in treating chronic pain. These standards are focused on preventing harm by minimizing opportunities for misuse, abuse, and diversion, and to optimize prevention of addition and overdose. The amount of daily morphine milligram equivalents (MMEs) is frequently used as a risk factor to evaluate potential opioid related harms. DVHA uses the MME conversion factors provided by the Centers for Disease Control (CDC). More detailed information can be found on their website at <https://www.cdc.gov/drugoverdose/prescribing/guideline.html>. Effective May 1, 2021, additional edits apply that include any combination of short and long-acting opioids and members on chronic therapy for non-cancer pain. Members new to opioid therapy with a daily MME greater than 90 per day will require the completion of an opioid safety checklist as a prior authorization. Members with existing claims history in the past 90 days for opioids (not new to therapy) will require a safety checklist if the daily MME exceeds 120 per day.

vi. All Payer Model: Vermont Medicaid Next Generation Program

Key updates from QE062021:

- Continued conducting financial reconciliation activities for the 2020 performance year, in order to determine financial and quality performance. Results will be available in late Q3 2021.
- Selected an Apparently Successful Bidder through the RFP process for ACO services in the VMNG program for the 2022 contract start date.
- 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 Medical Center, Central Vermont Medical Center, Northwestern

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

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

DVHA continued conducting financial reconciliation activities for its 2020 performance year in Q2 2021. Reconciliation activities will determine the ACO's spend as compared to their financial target and quality performance for the 2020 performance year. Reconciliation activities will continue through Q2 2021, and final results will be available by the end of Q3 2021.

DVHA issued a Request for Proposals (RFP) for ACO services through the Vermont Medicaid Next Generation ACO Program for a contract start date of January 1, 2022 and received one bid. In Q2, DVHA selected and entered into contract negotiations with an apparently successful bidder, OneCare Vermont. DVHA anticipates the elements of its VMNG model will remain similar to its current iteration.

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 2021 quarter (April through June 2021). 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 QE0621 on July 30, 2021, as is normal.

Vermont received partial approval for the temporary 10% fmap increase for qualifying HCBS services under the American Rescue Plan (ARP). The MBES system was not updated to reflect this FMAP opportunity as of the QE0621 CMS-64 filing. Vermont will be entering a Prior Quarter Adjustment (PQA) in the next CMS-64 submission to account for this. Vermont may also need to engage CMS for technical assistance of how the HCBS will affect Budget Neutrality once the reinvestment spending begins.

Overall, the budget neutrality exercise indicates that for June 2021 quarter, the State's total "With Waiver" expenditures were \$73,890,874 (19%) lower than the total "Without Waiver" amount (caseloads multiplied by the Budget Neutrality PMPMs), indicating a quarterly surplus. This compares to a surplus of \$103,526,841 for QE0321, and a total CY2021 surplus to date of \$177,417,416.

For the supplemental budget neutrality tests, the New Adult test is showing a surplus of \$24,116,802 for QE0621. This compares to a surplus of \$32,054,230 for QE0321 and a total CY2021 surplus to date of \$56,171,032.

For QE0621, the SMI IMD test is showing a deficit of \$4,138,460, compared to a deficit of \$1,468,888 for QE0321. CY2021 to date, the deficit for SMI IMD is \$5,607,348.

The SUD IMD test is showing a surplus of \$801,174, compared to a deficit of \$125,509 for QE0321. CY2021 to date, the surplus \$675,565.

Deficits in SMI IMD and SUD IMD are applied to the overall budget neutrality test. Currently, there is ample room in the overall budget neutrality test to accommodate SUD IMD and SMI IMD deficits.

Please note, the above-mentioned budget neutrality calculations are based on Vermont's interpretation of how Budget Neutrality should be calculated. Vermont uploaded the PMDA Budget Neutrality template for DY15 which has different calculations. Vermont is not in agreement with those calculations and looks forward to finding resolution with CMS on these discrepancies.

AHS continues to actively monitor Investment spending. The total Investment spending for QE0621 was \$24,613,970 (compared with \$22,886,232 for QE0321). The total CY2021 investment expenditures for both quarters total \$47,278,202. The total CY2021 Budget Neutrality Investment Limit is \$136,500,000.

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 QE0621 of CY2021 and includes the unduplicated count of member months for SUD IMD and SMI IMD stays. CY2020 and CY 2019 member months are also reported in the tables below.

Table 1. Member Month Reporting – Calendar Year 2021 (QE0321 through QE0621), *subject to revision*, with CY2020 and CY2019.

Demonstration Population	Medicaid Eligibility Group	Total CY 2021 (Jan-June)	Total CY 2020	Total CY 2019
1, 4*, 5*	ABD - Non-Medicare - Adult	40,039	79,874	81,293
	SUD - IMD - ABD	44	106	149
	SMI - IMD - ABD	18	68	
1	ABD - Non-Medicare - Child	9,607	20,046	23,855
1, 4*, 5*	ABD - Dual	131,847	260,484	257,866
	SUD - IMD - ABD Dual	70	136	158
	SMI - IMD - ABD Dual	8	8	N/A
2	Non ABD - Non-Medicare - Adult	71,593	112,612	104,150
	SUD - IMD - Non ABD	86	161	222
	SMI - IMD - Non ABD	8	24	N/A
2	Non ABD - Non-Medicare - Child	370,755	714,031	703,957
	Medicaid Expansion			
7	Global RX	39,083	78,067	77,498
8	Global RX	20,441	41,565	44,169
6	Moderate Needs	888	1,967	2,208
	New Adults			
3	New Adult without Child	263,643	453,610	423,150
	SUD - IMD New Adult w/o Child	550	1,157	1,352
	SMI - IMD New Adult w/o Child	75	210	N/A
3	New Adult with Child	152,381	267,040	233,294
	SUD - IMD New Adult with Child	117	209	259
	SMI - IMD New Adult with Child	13	43	N/A
	Total	1,101,266	2,031,418	1,953,580

Table 2. GC Budget Neutrality PMPM Rates, CY 2021 (January 1, 2021 – December 31, 2021)

STC PMPM Budget Neutrality	
Medicaid Eligibility Group	DY 16 PMPM CY2021
ABD - Non-Medicare - Adult	\$1,745.83
SUD - IMD ABD	\$ 3,798.97
SMI - IMD ABD	\$ 16,054.00
ABD - Non-Medicare - Child	\$3,419.74
ABD - Dual	\$3,006.28
SUD - IMD ABD Dual	\$ 2,901.13
SMI - IMD ABD Dual	\$ 19,633.00
Non ABD - Non-Medicare - Adult	\$780.03
SUD - IMD Non ABD	\$ 2,852.36
SMI - IMD Non ABD	\$ 10,448.00
Non ABD - Non-Medicare - Child	\$643.26
New Adult Group	\$ 610.97
SUD - IMD - New Adult	\$ 3,042.23
SMI - IMD - New Adult	\$ 12,182.00

Table 3. Actuarially Certified PMPM Rates, CY 2021 (January 1, 2021 – December 31, 2021)

Effective 1/1/21 - 12/31/21	CY 2021
ABD Adult	\$2,245.83
ABD Child	2,937.38
ABD Dual	2,364.58
Global Rx	107.97
Moderate Needs	669.53
New Adult	436.24
Non-ABD Adult	584.09
Non-ABD Child	494.25

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 Assurance and Performance Improvement Activities

Key updates from QE062021:

- Intervention planning continued for DVHA's new formal PIP topic, management of hypertension. 3 focused sub-groups are working on activities related to: policy/reimbursement, provider and patient education and community resources.
- DHVA's Quality Team submitted and scored 100% on our formal PIP topic's annual summary report.
- DVHA's Quality Team applied for and was accepted into the CMS/Mathematica sponsored Foster Care Learning Collaborative.

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 QE0621 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 healthcare. During this time period, the committee followed our work plan and reviewed the the QAPI standard elements of quality and appropriateness of care. We discussed the process for special health care needs populations' assessment by appropriate health care professionals. The committee also received a report out on DVHA's progress on our formal PIP topic – management of hypertension.

Formal CMS Performance Improvement Project (PIP)

During QE0920, DVHA followed our standard operating procedure (SOP) for selection of a new formal CMS PIP topic. Through that process, managing hypertension was chosen as our recommended study topic. The project team was assembled during QE1220 and performed a root cause analysis exercise. During QE0321, barriers were reviewed and prioritized by the project team. Intervention activities were chosen and 3 focused sub-groups were created to work on activities related to: policy/reimbursement, provider and patient education and

community resources. Sub-group intervention planning continued during QE0621. Additionally, DVHA submitted our annual PIP Summary Report during this reporting period and received a score of 100% from our EQRO.

Other Collaborative Quality Improvement Projects

DVHA's Clinical Services Team strives to realize efficiencies, align priorities and reduce redundancies. With these overarching goals in mind, the Quality team continued to work with the following groups on collaborative QI projects during QE0621:

- DVHA's Long Term Care unit in relation to a data collection process improvement that will allow that unit to present sought-after metrics on the effects of COVID-19 on our long-term care application processing.
- DVHA's Clinical Operations unit to address a legislative directive. DVHA is exploring prior authorization requirements with a lens toward recommending modifications to current practice.
- The Department of Mental Health on an Agency-wide alternative payment model (APM) for inpatient services delivered by a regional psychiatric and detoxification facility. The purpose of the APM is to add administrative simplicity in claims processing and a predictable cash flow for inpatient stays that are primarily the responsibility of Vermont Medicaid. The Clinical Services Team lead the work group that established quality of care measures to ensure that cost and quality incentives are aligned in the APM.

Additionally, during QE0621, DVHA's Quality team applied for and was accepted into the CMS/Mathematica sponsored learning collaborative focused on youth in foster care. We are partnering with colleagues from the Department of Children and Families (DCF), the Vermont Department of Health (VDH) and the Vermont Child Health Improvement Program (VCHIP) on this effort which will begin in QE0921.

Quality Measure Reporting

- Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey - the DVHA Quality Unit's Director of Quality Management coordinated the 2020 Consumer Assessment of Healthcare Providers and Systems (CAHPS) Children's and Adults Medicaid 5.0H survey. The contracted vendor, DataStat, Inc., distributed and collated the surveys according to AHRQ and NCQA protocols in the fall of 2020. The results of the surveys were delivered to DVHA during this reporting period and were presented by the Director of Quality Management to the PIHP Quality Committee and to DVHA's Management Team in March 2021. DVHA's vendor uploaded our 2020 results to the AHRQ database during QE0621.
- HEDIS measure production –In addition to producing administrative (claims based) measures, the Clinical Services Team produced four (4) HEDIS hybrid measures in 2021. DVHA's Quality Assurance Manager prepared abstraction training, tools and materials during QE0321. Record abstraction was performed during QE0621. Hybrid measure rates will be validated by our EQRO during QE0921.
- Quality Unit staff originally spearheaded conversations with staff from Vermont Information Technology Leaders (VITL) in 2019 to explore using the data stored in the Vermont Health Information Exchange (VHIE) for hybrid measure production in the future. Initial system testing was performed in CY 2020 and indicated a need for further analysis. This work was slowed due to the COVID-19 pandemic but will resume in the next quarter when we discuss with VITL the best approach to the data comparisons we need to make.

Results Based Accountability (RBA)/Process Improvement

Results Based Accountability (RBA) scorecards are developed at DVHA for both internal and external performance management purposes. The use of this performance management framework and corresponding presentation tool has been spearheaded by the Agency's Central Office QI staff. The DVHA Quality Unit staff use this tool to create a *Global Commitment to Health* Core Measure scorecard, Experience of Care, and other performance budgeting scorecards. DVHA's largest scorecard, named the Performance Accountability Scorecard includes key performance measures for each unit within the Department for use by the Management Team to evaluate programs and services. Scorecards that were newly developed or actively maintained during QE0621 include the following initiatives: DVHA Dental Program, Payment Reform Models and the Global Commitment Core Performance Measure Set.

The Quality Improvement Team also maintained their "Green Belt" status during QE0621 by participating in quality improvement activities. 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. As an internal evaluation tool, the dashboard is updated weekly and made available to all DVHA staff via our intranet. DVHA's Management Team highlights certain metrics within the dashboard at its regular meetings. This work was maintained throughout 2020 and continues into 2021. Additional measures are added to the dashboard as appropriate.

Vermont Next Generation Medicaid ACO

During QE0621, 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 typically meet quarterly with a focus on quality measurement and ongoing QI efforts. Although temporarily paused during CY 2020 due primarily to the pandemic, these quarterly meetings have been re-established and were carried forward starting in QE0621. A representative from the VMNG ACO is also a standing member on DVHA's new formal PIP, the topic of which is managing hypertension.

AHS Performance Accountability Committee

COVID-19 response has delayed the restart of the Performance Accountability Committee. A re-visioning session has been re-scheduled for next quarter. Agenda items include but are not limited to the following: performance accountability system building/sustaining, Medicaid program quality assessment and performance improvement requirements, and alignment with health care reform efforts.

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)

During this quarter, the state STP Implementation Team reviewed the CMS comments received in the previous quarter. The group did not identify any points requiring additional clarification. After their review, draft responses were assembled and circulated for final review. Before finalizing edits to VT's STP and resubmitting – the state wanted to make sure that the responses and proposed changes suggested by the team address the outstanding issues. The state submitted their responses and proposed changes to CMS and asked if they were fully responsive to the remaining issues – and put the state on the path for final approval. 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.

During this quarter, the state received CMS feedback on their SUD monitoring reports. To assist the state with any revisions of metrics data, CMS included a customized workbook, breaking out each quarter's metrics in a separate tab. In this workbook, they also corrected the measurement period for metrics #3 and 4 and incorporated the deviations from CMS specifications as indicated in the monitoring protocol.

After reviewing the changes for accuracy, the state drafted a response to the feedback and agreed that future reports would use the most recent technical specifications and monitoring metrics and that the metric workbooks would only contain a single tab of data reflecting that quarter's submission. To

allow additional time to ensure incorporation of the changes and updates, SUD metric reporting will resume with the 8/29/21 Operational Report.

SUD Mid-Point Assessment

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

SMI 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.

During this quarter, the state received formal approval of their SMI Monitoring Protocol. After reviewing the reporting schedule in the SMI monitoring protocol, it was agreed that SMI annual metric reporting would begin with the 11/29/21 Operational Report, to ensure adequate time to build these into the state's reporting schedule. In addition, CMS expects to release updated technical specifications later in the summer for use in reporting the CY2020 established quality measures, so 11/29 is likely to be better all around.

SMI/SED Mid-Point Assessment

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

IX. Demonstration Evaluation Activities (*including SUD and SMI/SED*)

GC Final Evaluation Design

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

Specifically, the design identifies the state's hypotheses, evaluation questions, associated measures, and analytic methods.

The GC Final Evaluation Design is the state's plan for how it will accomplish the evaluation of their 1115 waiver. Specifically, the design identifies the state's hypotheses, evaluation questions, associated measures, and analytic methods.

During last quarter, the state submitted a final version of the GC Evaluation Design to CMS for review/approval. This version incorporated the CMS feedback that was received on October 20, 2020. During a subsequent phone conversation, CMS indicated that the state's design was "for all intent and purposes" approved – but due to the administration transition – a formal approval letter would be delayed.

PHE Evaluation Design

During last quarter, the state submitted an evaluation design for the COVID-19 section 1115 demonstration. The design provided a background description of the policies and objectives of the state's demonstration, a general overview of the research questions the state will examine in the final report, an outline of data sources the state feels may be useful to both contextualize and respond to these questions, and any anticipated limitations to these monitoring and evaluation plans. During last quarter, the state's PHE Evaluation Design received formal CMS approval.

GC Interim Evaluation Report

During this quarter, the state responded to CMS Interim Evaluation Report feedback via email. The response included 1) the state's revised interim evaluation report (final) and 2) a file that contains specific state responses to the CMS Feedback. The updated version of the report incorporates CMS feedback to strengthen the report. Specifically, the report updates language to avoid causal interpretation of the results, refines the presentation of summary findings, clarifies the state's qualitative analysis plans, and describes planned changes for the summative evaluation report. Both files were also posted to the PMDA via the CMS Portal. As per STC #77, the Final Interim Evaluation Report was also posted on the [state's website](#). Toward the end of the quarter, the amended Interim Evaluation Report received CMS final approval.

X. Compliance

Key updates from QE062021:

- 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 this 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 were sent to DVHA during this quarter. Due to the ongoing COVID-19 pandemic, both on-site reviews (i.e., review of compliance with standards & performance measure validation) will be conducted remotely.

Monitoring Compliance with Standards

During next quarter, The External Quality Review Organization (EQRO) will conduct the annual compliance review. This year's audit cycle will include the following standards:

- Practice Guidelines
- Quality Assessment and Performance Improvement Program
- Health Information Systems

Compliance Committee

During this quarter, the committee completed its annual workplan and agreed to focus on five key areas:

- Care Coordination
- Authorization of Services
- Program Integrity
- Current year EQRO Prep
- Completing prior-year EQRO corrective actions

The first three topics are being reviewed from a risk-assessment perspective with the goal of identifying any strengths, gaps or areas for improved collaboration.

The committee also began work to improve the process we use for updating intra-governmental agreements between the departments responsible for delivering Medicaid services.

Program Integrity Reporting

Q2 2021

- The number of provider investigations conducted by the PIHP: 17
- The number of suspected fraud referrals provided to the state Medicaid agency by the PIHP: 1

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:

- a. Reduce the rate of uninsured and/or underinsured in Vermont.
- b. Increase the access of quality health care to uninsured, underinsured, and Medicaid beneficiaries.
- c. 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
- d. 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 QE062021.

XII. Enclosures/Attachments

Attachment 1: Budget Neutrality Workbook

Attachment 2: Enrollment and Expenditures Report

Attachment 3: Complaints Received by Health Access Members Services

Attachment 4: Medicaid Grievance and Appeal Reports

Attachment 5: Office of the Health Care Advocate Report

Attachment 6: QE062021 Investments

Attachment 7: Investment Scorecards

Attachment 8: Payment Model Scorecard

XIII. State Contact(s)

Fiscal	Sarah Clark, CFO VT Agency of Human Services 280 State Drive Waterbury, VT 05671-1000	802-505-0285 (P) 802-241-0450 (F) Sarah.Clark@vermont.gov
Policy/Program	Ashley Berliner, Director of Health Care Policy & Planning VT Agency of Human Services 280 State Drive Waterbury, VT 05671-1000	802-578-9305 (P) 802-241-0958 (F) Ashley.Berliner@vermont.gov
Managed Care Entity	Adaline Strumolo, Acting Commissioner of Department of Health VT Agency of Human Services 280 State Drive Waterbury, VT 05671-1000	802-241-0147 (P) 802-879-5962 (F) Adaline.Strumolo@vermont.gov

Date Submitted to CMS: August 30, 2021

ATTACHMENTS

Attachment 1: Budget Neutrality Workbook

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

ELIGIBILITY GROUP	DY 12	DY 13	DY 14	DY 15	DY 16	Total
	JAN - DEC 2017	JAN - DEC 2018	JAN - DEC 2019	JAN - DEC 2020	JAN - June 2021	
Without Waiver (Caseload x pmpms)						
ABD - Non-Medicare - Adult	\$ 142,860,455	\$ 130,050,973	\$ 131,976,747	\$ 134,471,074	\$ 69,901,287	\$ 609,260,536
ABD - Non-Medicare - Child	\$ 85,359,001	\$ 78,434,428	\$ 75,860,331	\$ 66,106,095	\$ 32,853,442	\$ 338,613,298
ABD - Dual	\$ 664,153,383	\$ 693,539,886	\$ 720,885,032	\$ 755,148,326	\$ 396,368,999	\$ 3,230,095,626
Non ABD - Non-Medicare - Adult	\$ 101,757,250	\$ 96,887,008	\$ 73,827,769	\$ 83,738,283	\$ 55,844,688	\$ 412,054,997
Non ABD - Non-Medicare - Child	\$ 392,665,288	\$ 406,444,058	\$ 413,877,439	\$ 439,107,644	\$ 238,491,861	\$ 1,890,586,291
Total Expenditures Without Waiver	\$ 1,386,795,376	\$ 1,405,356,354	\$ 1,416,427,318	\$ 1,478,571,422	\$ 793,460,278	\$ 6,480,610,748
With Waiver						
ABD Non Medicare Adult	\$ 162,602,152	\$ 162,728,372	\$ 168,382,861	\$ 177,858,509	\$ 87,005,535	\$ 758,577,429
ABD - Non-Medicare - Child	\$ 66,593,208	\$ 60,077,015	\$ 58,176,676	\$ 55,369,700	\$ 23,801,602	\$ 264,018,200
ABD - Dual	\$ 445,847,909	\$ 461,739,496	\$ 484,543,363	\$ 476,164,427	\$ 228,336,800	\$ 2,096,631,994
Non ABD - Non-Medicare - Adult	\$ 84,040,229	\$ 84,275,155	\$ 67,221,781	\$ 69,967,054	\$ 41,367,826	\$ 346,872,044
Non ABD - Non-Medicare - Child	\$ 305,543,574	\$ 335,706,591	\$ 350,805,773	\$ 334,351,461	\$ 180,353,130	\$ 1,506,760,530
Premium Offsets	\$ (655,991)	\$ (772,935)	\$ (774,152)	\$ (413,790)	\$ (59,488)	\$ (2,676,355)
Moderate Needs Group	\$ 1,488,408	\$ 1,378,915	\$ 1,429,868	\$ 703,701	\$ 207,470	\$ 5,208,362
Marketplace Subsidy	\$ 6,355,286	\$ 6,242,717	\$ 5,915,336	\$ 5,862,966	\$ 2,881,221	\$ 27,257,527
VT Global Rx	\$ 13,824,167	\$ 15,300,919	\$ 10,692,124	\$ 3,494,233	\$ 2,618,790	\$ 45,930,233
VT Global Expansion VHAP	\$ 414,825	\$ (0)	\$ 0	\$ -	\$ -	\$ 414,825
CRT DSHP	\$ 10,331,787	\$ 9,240,772	\$ 6,787,058	\$ 5,604,875	\$ 2,192,287	\$ 34,156,779
Investments	\$ 142,332,671	\$ 148,500,000	\$ 119,133,231	\$ 114,806,088	\$ 47,278,201	\$ 572,050,192
Total Expenditures With Waiver	\$ 1,239,374,215	\$ 1,285,189,954	\$ 1,273,088,069	\$ 1,244,183,015	\$ 616,042,862	\$ 5,657,878,115
Hypothetical Test 1: New Adult						
Limit New Adult PMPM*Mem-Mon	\$ 370,689,611	\$ 375,735,593	\$ 369,387,603	\$ 422,545,921	\$ 254,178,183	\$ 1,792,536,912
With Waiver New Adult Total Expenditures	\$ 295,620,338	\$ 312,104,578	\$ 315,240,526	\$ 368,166,529	\$ 198,007,151	\$ 1,489,139,121
Surplus (Deficit)	\$ 75,069,273	\$ 63,631,015	\$ 54,147,078	\$ 54,379,392	\$ 56,171,032	\$ 303,397,790
Hypothetical Test 2: SUD IMD						
SUD - IMD ABD - Non-Medicare - Adult		\$ 268,039	\$ 529,433	\$ 389,449	\$ 167,155	\$ 1,354,076
SUD - IMD ABD - Dual		\$ 214,495	\$ 442,312	\$ 387,577	\$ 203,079	\$ 1,247,463
SUD - IMD Non ABD - Non-Medicare - Adult		\$ 533,391	\$ 633,224	\$ 459,230	\$ 245,303	\$ 1,871,148
SUD - IMD New Adult		\$ 2,704,249	\$ 4,842,747	\$ 4,130,907	\$ 2,029,167	\$ 13,707,070
Limit SUD IMD Without Waiver PMPM*Mem-Mon	\$ -	\$ 3,720,174	\$ 6,447,715	\$ 5,367,163	\$ 2,644,704	\$ 18,179,756
SUD - IMD ABD Non Medicare Adult		\$ 249,820	\$ 646,440	\$ 411,251	\$ 105,020	\$ 1,412,532
SUD - IMD ABD - Dual		\$ 199,224	\$ 545,837	\$ 342,450	\$ 35,335	\$ 1,122,846
SUD - IMD Non ABD - Non-Medicare - Adult		\$ 540,841	\$ 803,762	\$ 516,507	\$ 189,602	\$ 2,050,713
SUD - IMD New Adult		\$ 2,826,119	\$ 5,869,169	\$ 4,250,210	\$ 1,639,182	\$ 14,584,680
Limit SUD IMD With Waiver (Total Expenditures)	\$ -	\$ 3,816,005	\$ 7,865,208	\$ 5,520,418	\$ 1,969,139	\$ 19,170,770
Surplus (Deficit)	\$ -	\$ (95,830)	\$ (1,417,494)	\$ (153,255)	\$ 675,565	\$ (991,014)
Hypothetical Test 3: SMI IMD						
SMI - IMD ABD - Non-Medicare - Adult				\$ 1,059,916	\$ 288,972	\$ 1,348,888
SMI - IMD ABD - Dual				\$ 151,168	\$ 157,064	\$ 308,232
SMI - IMD Non ABD - Non-Medicare - Adult				\$ 241,344	\$ 83,584	\$ 324,928
SMI - IMD New Adult				\$ 2,952,257	\$ 1,072,016	\$ 4,024,273
Limit SMI IMD Without Waiver PMPM*Mem-Mon	\$ -	\$ -	\$ -	\$ 4,404,685	\$ 1,601,636	\$ 6,006,321
SMI - IMD ABD Non Medicare Adult				\$ 1,726,684	\$ 1,283,679	\$ 3,010,363
SMI - IMD ABD - Dual				\$ 188,470	\$ 470,144	\$ 658,614
SMI - IMD Non ABD - Non-Medicare - Adult				\$ 727,204	\$ 388,242	\$ 1,115,446
SMI - IMD New Adult				\$ 5,348,474	\$ 5,066,919	\$ 10,415,393
Limit SMI IMD With Waiver (Total Expenditures)	\$ -	\$ -	\$ -	\$ 7,990,832	\$ 7,208,984	\$ 15,199,816
Surplus (Deficit)		\$ -	\$ -	\$ (3,586,147)	\$ (5,607,348)	\$ (9,193,495)
Waiver Savings Summary						
Annual Savings	\$ 147,421,162	\$ 120,166,400	\$ 143,339,249	\$ 234,388,407	\$ 177,417,416	\$ 822,732,633
Shared Savings Percentage	30%	25%	25%	25%	25%	
Shared Annual Savings	\$ 44,226,348	\$ 30,041,600	\$ 35,834,812	\$ 58,597,102	\$ 44,354,354	\$ 213,054,216
Hypothetical Test 2 & 3 adjustment	\$ -	\$ (95,830)	\$ (1,417,494)	\$ (3,739,402)	\$ (5,607,348)	\$ (10,860,074)
Total Cumulative Savings		\$ 74,172,118	\$ 108,589,437	\$ 163,447,137	\$ 202,194,143	\$ 202,194,143

New Adult Waiver Savings Not Included in Waiver Savings Summary
See Budget Neutrality New Adult tab (STC#64)
See CY2021 Investments tab
See EG MM CY 2021 Tab for Member Month Reporting

Budget Neutrality New Adult
New Adult (w/ and w/o Child) Medical Costs Only

	DY 14 – PMPM				DY 15 – PMPM				DY 16 – PMPM			
	QE 0319	QE 0619	QE 0919	QE 1219	QE 0320	QE 0620	QE 0920	QE 1220	QE 0321	QE 0621	QE 0921	QE 1221
(A) New Adult Group PMPM Projection	\$562.71	\$562.71	\$562.71	\$562.71	\$586.34	\$586.34	\$586.34	\$586.34	\$610.97	\$610.97		
(B-1) eligible member months w/ Child	57,969	58,516	58,610	58,199	60,037	65,214	66,459	67,867	75,413	76,985		
(B-2) eligible member months w/o Child	110,736	106,927	103,710	101,777	102,648	110,982	116,879	118,703	129,659	133,962		
(C-1 = (A x B-1) Supplemental Cap 1 w/ Child	\$ 32,619,735.99	\$ 32,927,538.36	\$ 32,980,433.10	\$ 32,749,159.29	\$ 35,202,094.58	\$ 38,237,576.76	\$ 38,967,570.06	\$ 39,793,136.78	\$ 46,075,080.61	\$ 47,035,525.45		
(C-2 = (A x B-2) Supplemental Cap 1 w/o Child	\$ 62,312,254.56	\$ 60,168,892.17	\$ 58,358,654.10	\$ 57,270,935.67	\$ 60,186,628.32	\$ 65,073,185.88	\$ 68,530,832.86	\$ 69,600,317.02	\$ 79,217,759.23	\$ 81,846,763.14		
(D-1) New Adult FMAP w/ Child	53.89%	53.89%	53.89%	53.86%	60.06%	60.06%	60.06%	60.77%	60.77%	60.77%		
(D-2) New Adult FMAP w/o Child	93.00%	93.00%	93.00%	93.00%	90%	90%	90%	90%	90%	90%		
(E-1 = C-1 x D-1) Federal Share of Supplemental Cap 1 w/ Child	\$ 17,578,775.73	\$ 17,744,650.42	\$ 17,773,155.40	\$ 17,638,697.19	\$ 21,142,378.00	\$ 22,965,488.60	\$ 23,403,922.58	\$ 24,182,289.22	\$ 27,999,826.49	\$ 28,583,488.82		
(E-2 = C2 x D-2) Federal Share of Supplemental Cap 1 w/o Child	\$ 57,950,396.74	\$ 55,957,069.72	\$ 54,273,548.31	\$ 53,261,970.17	\$ 54,167,965.49	\$ 58,565,867.29	\$ 61,677,749.57	\$ 62,640,285.32	\$ 71,295,983.31	\$ 73,662,086.83		
Subtotal Federal Share Supplemental Cap 1	\$ 75,529,172.47	\$ 73,701,720.14	\$ 72,046,703.71	\$ 70,900,667.37	\$ 75,310,343.49	\$ 81,531,355.89	\$ 85,081,672.15	\$ 86,822,574.54	\$ 99,295,809.79	\$ 102,245,575.64		
Total FFP reported for New Adult Group	\$ 67,854,834.87	\$ 68,588,592.26	\$ 63,276,555.83	\$ 54,245,264.74	\$ 82,218,290.81	\$ 68,092,015.38	\$ 69,686,466.57	\$ 73,806,046.32	\$ 74,243,005.17	\$ 83,700,518.33		
Supplemental Budget Neutrality Test 1 over/(under) - report any negative # under main GC budget neutrality	\$ 7,674,337.60	\$ 5,113,127.88	\$ 8,770,147.88	\$ 16,655,402.63	\$ (6,907,947.32)	\$ 13,439,340.51	\$ 15,395,205.59	\$ 13,016,528.22	\$ 25,052,804.62	\$ 18,545,057.31		

**Report to
The Vermont Legislature**

Medicaid Program Enrollment and Expenditures Quarterly Report

In Accordance with 33 V.S.A. § 1901f

Submitted to: The General Assembly

Submitted by: Mike Smith, Secretary
Agency of Human Services

Prepared by: Sarah Clark, Chief Financial Officer
Agency of Human Services

Report Date: June 3, 2021

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BACKGROUND

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

KEY TERMS

Caseload: Average monthly member enrollment

PMPM: Per Member Per Month

MEG: Medicaid Eligibility Group

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MEDICAID PROGRAM ENROLLMENT AND EXPENDITURES

Agency of Human Services Caseload and Expenditure Report

DVHA Only YTD SFY'21

Medicaid Eligibility Group	SFY'21 BAA			SFY'21 Actuals Thru March 31, 2021			% of Expenses to Budget Line Item	Ending Enrollment as of March 2021
	Caseload	Budget	PMPM	Caseload	Expenses	PMPM		
ABD Adult	6,475	\$ 59,467,740	\$ 765.35	6,253	\$ 40,027,754	\$ 711.28	67.31%	6,240
ABD Dual	17,678	\$ 48,359,639	\$ 227.97	17,835	\$ 33,503,875	\$ 208.72	69.28%	17,966
General Adult	10,043	\$ 60,812,047	\$ 504.60	10,667	\$ 41,284,741	\$ 430.02	67.89%	11,609
New Adult Childless	37,550	\$ 204,362,854	\$ 453.53	41,114	\$ 156,671,025	\$ 423.41	76.66%	43,347
New Adult w/Child	22,473	\$ 102,062,482	\$ 378.46	24,161	\$ 82,322,558	\$ 378.59	80.66%	25,236
BD Child	1,634	\$ 21,562,729	\$ 1,099.69	1,630	\$ 16,313,358	\$ 1,112.10	75.66%	1,585
General Child	59,540	\$ 146,388,328	\$ 204.89	60,358	\$ 110,629,882	\$ 203.66	75.57%	60,877
Underinsured Child	549	\$ 527,572	\$ 80.08	564	\$ 316,615	\$ 62.35	60.01%	557
CHIP	4,450	\$ 8,852,317	\$ 165.77	4,355	\$ 6,696,388	\$ 170.84	75.65%	4,338
Vermont Premium Assistance	15,935	\$ 5,625,792	\$ 29.42	15,359	\$ 4,242,273	\$ 30.69	75.41%	14,917
Vermont Cost Sharing	3,235	\$ 1,076,393	\$ 27.73	3,093	\$ 935,080	\$ 33.59	86.87%	2,918
Pharmacy Only	9,889	\$ 5,630,360	\$ 47.45	10,028	\$ 3,346,974	\$ 37.08	59.45%	10,032
Choices for Care - Traditional	-	\$ -	\$ -	-	\$ -	\$ -	0.00%	-
Choices for Care - Acute	4,477	\$ 46,175,225	\$ 859.49	4,438	\$ 31,230,573	\$ 781.88	67.63%	4,270
Total Medicaid	190,693	\$ 710,903,477	\$ 310.67	196,763	\$ 527,521,096	\$ 297.89	74.20%	200,974

All AHS YTD SFY'21

Medicaid Eligibility Group	SFY'21 BAA			SFY'21 Actuals Thru March 31, 2021			% of Expenses to Budget Line Item	Ending Enrollment as of March 2021
	Caseload	Budget	PMPM	Caseload	Expenses	PMPM		
ABD Adult	6,475	\$ 149,134,880	\$ 1,919.37	6,253	\$ 104,030,408	\$ 1,848.58	69.76%	6,240
ABD Dual	17,678	\$ 227,898,074	\$ 1,074.30	17,835	\$ 159,002,501	\$ 990.55	69.77%	17,966
General Adult	10,043	\$ 74,194,121	\$ 615.64	10,667	\$ 51,903,424	\$ 540.62	69.96%	11,609
New Adult Childless	37,550	\$ 239,454,004	\$ 531.41	41,114	\$ 184,144,972	\$ 497.66	76.90%	43,347
New Adult w/Child	22,473	\$ 115,165,886	\$ 427.05	24,161	\$ 93,760,265	\$ 431.19	81.41%	25,236
BD Child	1,634	\$ 43,998,441	\$ 2,243.90	1,630	\$ 30,256,154	\$ 2,062.59	68.77%	1,585
General Child	59,540	\$ 297,289,260	\$ 416.09	60,358	\$ 208,858,639	\$ 384.48	70.25%	60,877
Underinsured Child	549	\$ 989,028	\$ 150.13	564	\$ 698,683	\$ 137.59	70.64%	557
CHIP	4,450	\$ 11,789,545	\$ 220.78	4,355	\$ 8,367,935	\$ 213.49	70.98%	4,338
Vermont Premium Assistance	15,935	\$ 5,625,792	\$ 29.42	15,359	\$ 4,242,273	\$ 30.69	75.41%	14,917
Vermont Cost Sharing	3,235	\$ 1,076,393	\$ 27.73	3,093	\$ 935,080	\$ 33.59	86.87%	2,918
Pharmacy Only	9,889	\$ 5,630,360	\$ 47.45	10,028	\$ 3,346,974	\$ 37.08	59.45%	10,032
Choices for Care - Traditional	4,605	\$ 233,587,557	\$ 4,227.06	4,589	\$ 152,359,576	\$ 3,689.09	65.23%	4,417
Choices for Care - Acute	4,477	\$ 51,163,140	\$ 952.33	4,438	\$ 34,652,515	\$ 867.55	67.73%	4,270
Total Medicaid	190,821	\$ 1,456,996,483	\$ 636.28	196,914	\$ 1,036,559,398	\$ 584.89	71.14%	201,121

All AHS and AOE YTD SFY'21

Medicaid Eligibility Group	SFY'21 BAA			SFY'21 Actuals Thru March 31, 2021			% of Expenses to Budget Line Item	Ending Enrollment as of March 2021
	Caseload	Budget	PMPM	Caseload	Expenses	PMPM		
ABD Adult	6,475	\$ 150,357,616	\$ 1,935.10	6,253	\$ 104,546,250	\$ 1,857.74	69.53%	6,240
ABD Dual	17,678	\$ 228,042,405	\$ 1,074.98	17,835	\$ 159,035,552	\$ 990.76	69.74%	17,966
General Adult	10,043	\$ 74,408,446	\$ 617.42	10,667	\$ 52,006,470	\$ 541.69	69.89%	11,609
New Adult Childless	37,550	\$ 239,555,805	\$ 531.64	41,114	\$ 184,175,076	\$ 497.74	76.88%	43,347
New Adult w/Child	22,473	\$ 115,169,170	\$ 427.06	24,161	\$ 93,768,196	\$ 431.23	81.42%	25,236
BD Child	1,634	\$ 56,756,374	\$ 2,894.55	1,630	\$ 34,644,480	\$ 2,361.75	61.04%	1,585
General Child	59,540	\$ 333,315,028	\$ 466.51	60,358	\$ 225,857,714	\$ 415.78	67.76%	60,877
Underinsured Child	549	\$ 1,248,108	\$ 189.45	564	\$ 819,965	\$ 161.47	65.70%	557
CHIP	4,450	\$ 13,318,106	\$ 249.40	4,355	\$ 9,125,899	\$ 232.83	68.52%	4,338
Vermont Premium Assistance	15,935	\$ 5,625,792	\$ 29.42	15,359	\$ 4,242,273	\$ 30.69	75.41%	14,917
<i>Vermont Cost Sharing</i>	3,235	\$ 1,076,393	\$ 27.73	3,093	\$ 935,080	\$ 33.59	86.87%	2,918
Pharmacy Only	9,889	\$ 5,630,360	\$ 47.45	10,028	\$ 3,346,974	\$ 37.08	59.45%	10,032
Choices for Care - Traditional	4,605	\$ 233,587,557	\$ 4,227.06	4,589	\$ 152,359,576	\$ 3,689.09	65.23%	4,417
<i>Choices for Care - Acute</i>	4,477	\$ 51,193,885	\$ 952.91	4,438	\$ 34,656,990	\$ 867.66	67.70%	4,270
Total Medicaid	190,821	\$ 1,509,285,044	\$ 659.12	196,914	\$ 1,059,520,493	\$ 597.85	70.20%	201,121

The Vermont Cost Sharing Reduction (VCSR) population are also eligible for Vermont Premium Assistance (VPA) and the caseload counts are included in the VPA caseload counts and are not duplicatively reflected in the total. The budget and expenses are specific to each program.

The Choices for Care Acute caseload counts are included within the Choices for Care Traditional caseload counts. The Choices for Care Traditional caseload also includes the Waiver Moderate only population. The Waiver Moderate only population are categorically ineligible for Acute Medicaid services.



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

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

Questions, Complaints and Concerns Received by Health Access Member Services
April 1, 2021 – June 30, 2021

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 2021:

- Caller is reporting concerns for Medicaid rides/ transportation. Caller feels as though they are not being treated fairly. Caller has a hard time getting rides and has been going back and forth for quite a while with SSTA for paperwork to be submitted. Caller feels as though SSTA has made several excuses for Medicaid transportation. Caller has been experiencing this concern for an entire year. CSR apologized for the inconvenience, documented their feedback and referred him to VPTA for further discussion and review.
- Caller does not believe that it is fair that Medicaid does not cover pre-surgery eyedrops for the cataract surgery that they will be going in for soon. Caller states they do not know what these eyedrops are or what the product is called, but that these medications should all be covered fully for people on Medicaid. CSR apologized for the inconvenience and documented their feedback

May 2021:

- Caller wished to submit feedback regarding North Country Hospital. Caller states they not being treated fairly. They went to the clinic for sinus related issues and they could not figure out what is wrong and now they state that they require expensive surgery. Caller states that the doctors at North Country Hospital are hostile with them and everyone at the



hospital knows their medical history. Caller states they do not feel safe at the hospital. CSR apologized for the inconvenience and documented the caller's feedback. DVHA MPS Unit worked with the caller to better understand their concerns and offered to assist in finding other providers if necessary.

June 2021:

- Caller requested to file negative feedback as they believe that there should be more culturally diverse options when choosing and searching for a provider, as well as more resources for cultural diversity. CSR apologized for the inconvenience, documented their feedback and assisted with finding a provider.
- Caller was unhappy with the fact that as a customer, they are unable to call Medicaid to determine if a specific test is covered or not. Also, that they are unable to expedite the process and instead have to have their PCP call in order to determine if the test is covered/what is required. CSR apologized for the inconvenience, documented their feedback and discussed the information listed on the Medicaid & Dr. Dynasaur Covered Services Chart.

**Grievance and Appeal Quarterly Report
Medicaid Managed Care Model
All Departments Combined Data
April 1, 2021 – July 31, 2021**

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 from the centralized database that were filed from April 1, 2021 through July 31, 2021.

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 25 grievances filed; eleven 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, 64% were filed by the beneficiary, 28% were filed by a representative, and 8% were filed by other. DMH had 60%, DAIL had 16%, DVHA had 12%, and VDH had 12% of the grievances filed. There were no grievances filed for DCF during this quarter.

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

There were no Grievance Reviews filed this quarter.

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

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

During this quarter, there were 31 appeals filed. Of these 31 appeals, 16 were resolved (52%).

Of the 31 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 22 days. Acknowledgement letters of the receipt of an appeal must be sent within five days; the average was two days.

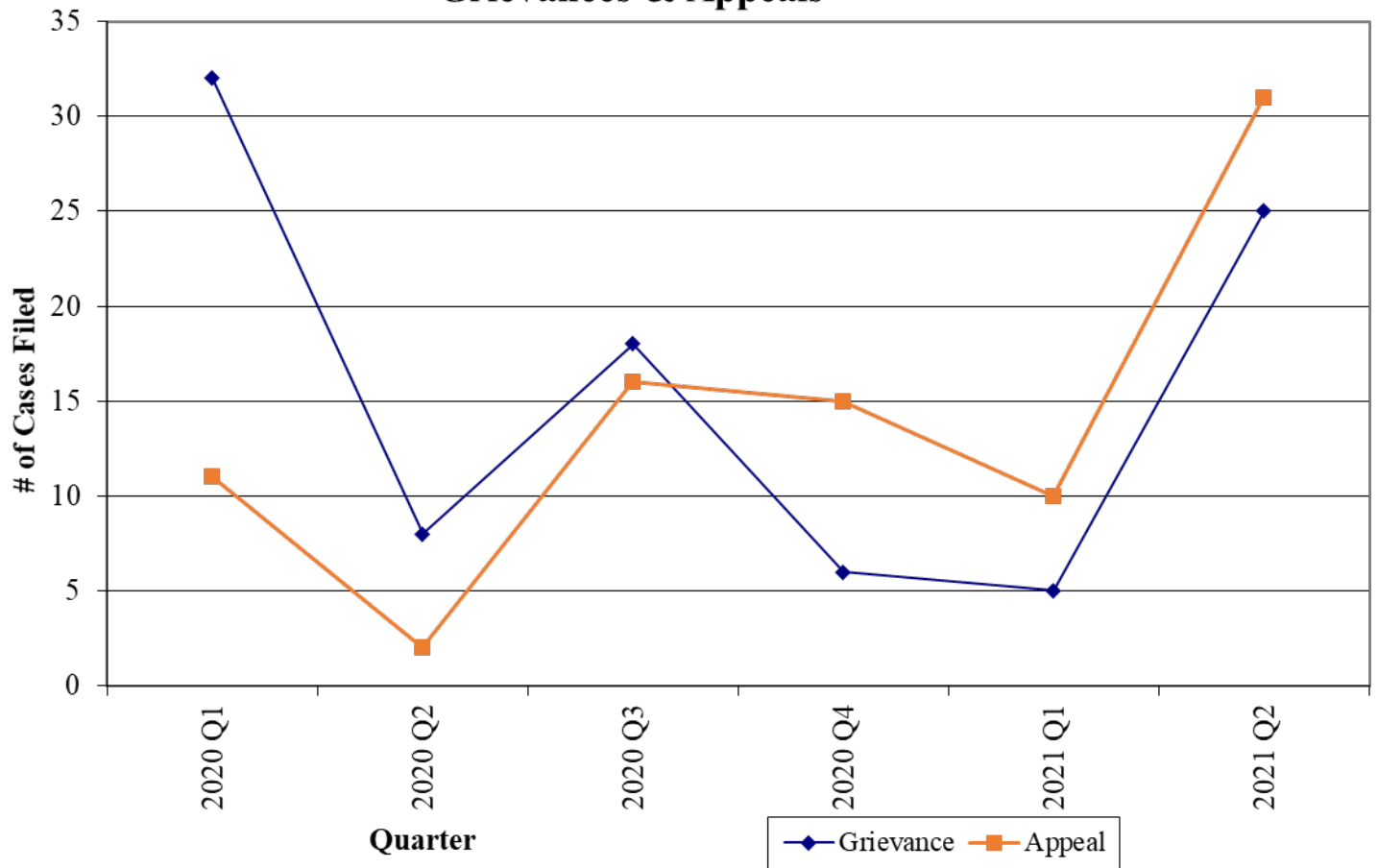
Of the 31 appeals filed, DVHA had 23 appeals filed (74%) and DAIL had 8 (26%).

The appeals filed were for service categories chiropractic services, community/social supports, supplies, surgical services, transportation, prescriptions, and Long-Term Care.

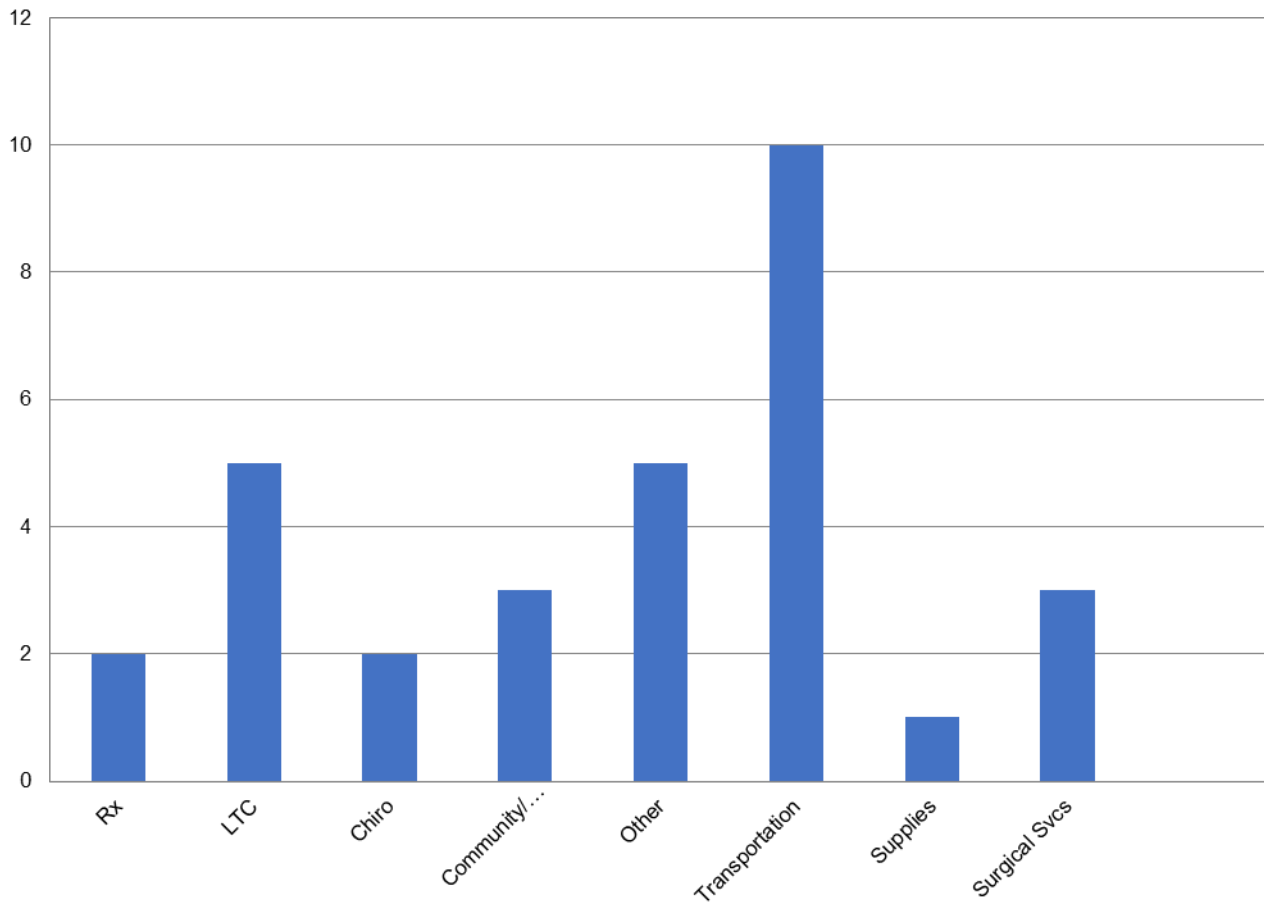
Beneficiaries must exhaust the internal appeal process before they can file a fair hearing if their appeal is not decided in their favor. There were two fair hearing filed this quarter.

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

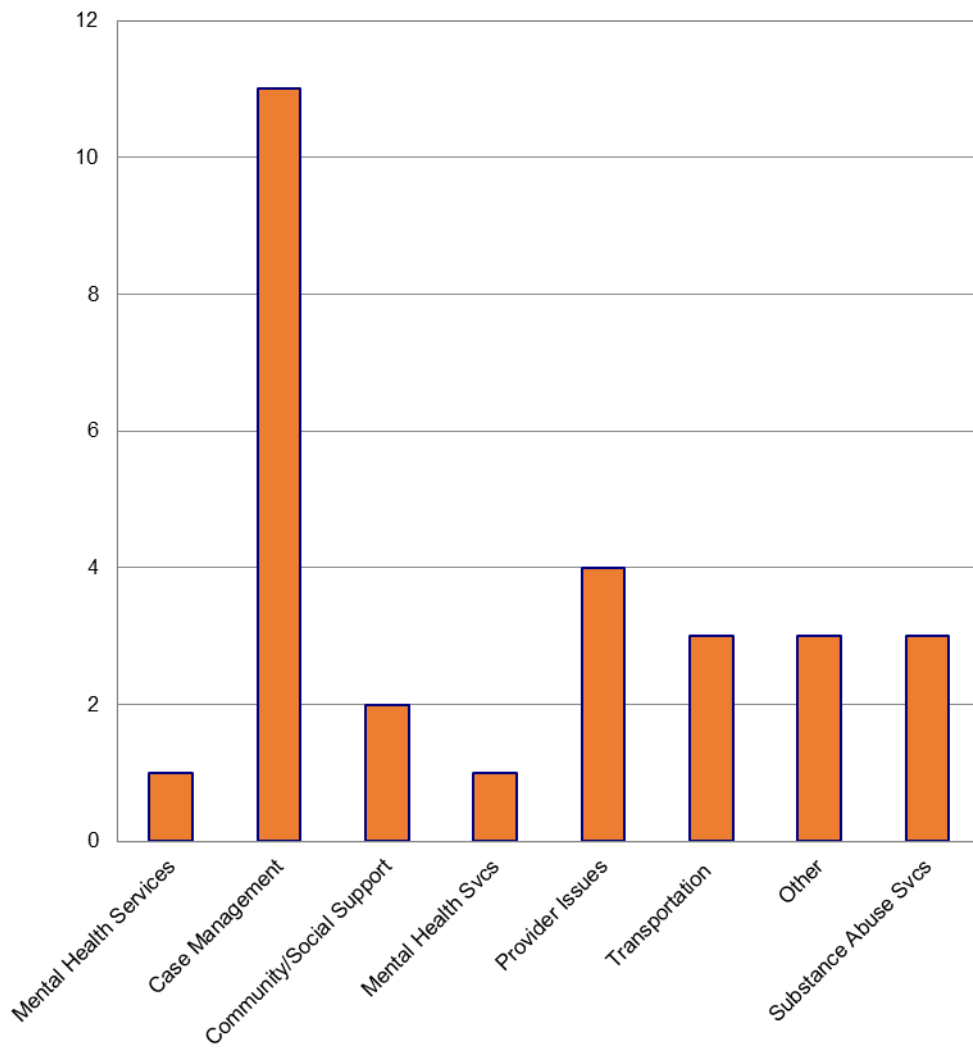
Grievances & Appeals



Appeals by Service Category



Grievance by Service Catagory



Attachment 5: Office of the Health Care Advocate Report

Vermont Legal Aid
Office of the Health Care Advocate

Quarterly Report
April 1, 2021 - June 30, 2021
to the
Agency of Administration
submitted by
Michael Fisher, Chief Health Care Advocate
Office of the Health Care Advocate

July 21, 2021



Summary and Update

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

Since Governor Scott's "stay at home" order on March 24, 2020, the HCA has been operating remotely and it anticipates operating remotely through the early fall of 2021. The HCA Helpline now has seven advocates working to resolve issues.

During this quarter, we saw a high number of cases related to the American Rescue Plan Act (ARPA). ARPA increases the amount of Advance Premium Tax Credit (APTC) most Vermont households are eligible for, which makes Vermont Health Connect (VHC) plans more affordable. It also removes the income eligibility cut-off for APTC, which makes some households newly eligible for APTC. Additionally, it will pay for COBRA subsidies for eligible employees, from April to September 2021. The HCA gave consumer education about ARPA to 43 households. It spoke to another 32 households about their eligibility under ARPA. On our website, we had 189 page views of our page about ARPA. We spoke to 7 households about COBRA eligibility. The HCA has also been collaborating with VHC on ARPA outreach and notices. We provided feedback on three ARPA Notices that VHC was sending out to enrollees and have been meeting on a regular basis. The HCA will continue to do significant outreach, including town halls and consumer education on ARPA in the next quarter.

The HCA helpline had 739 calls this quarter. Medicaid eligibility remains the top issues. We had 204 calls about all types of Medicaid eligibility. We had 2,443 pageview on our website on Medicaid eligibility. We also had significant calls about Special Enrollment Periods to enroll on VHC (46), and had 128 page views of our webpage on the VHC's COVID SEP. Advocates also helped Vermonters with 8 cases involving a VHC eligibility error.

The HCA had worked on the passage of H.430-Act-48, which will allow children and pregnant Vermonters to be eligible for Dr. Dynasaur coverage without regard to their immigration status. The HCA is now working with DVHA to implement the program and increase access to health care for these Vermonters. The HCA also brought the question of whether ARPA subsidies gave the state a new opportunity that was sufficient to warrant dividing the Small and Individual groups for rating purposes for the 2022 plan year. The Legislature took fast action and did provide for this division in S.88 (Sec.34) – Act 25. The HCA is now actively involved in the resulting rate cases with this newly-divided market.

Lena's Story

Lena called the HCA because she was uninsured. She applied for Medicaid for Children and Adults (MCA). However, she was told she was not eligible for MCA, and did not understand why. The HCA advocate discovered that although Lena was income-eligible for MCA, she was not eligible due her immigration status. She had gotten her green card in 2020 which meant she is a legal permanent resident. But even with the green card, she is subject to what is called the five-year bar and could not enroll in Medicaid for five years after getting the green card, even though she met the income requirements. But she was eligible for a VHC plan with APTC. Normally, unless you have a qualifying event, you need to wait until open enrollment to enroll on a VHC plan. But VHC still has a COVID SEP for uninsured Vermonters. Lena enrolled in a plan, and her premium was less than \$5 per month.

The HCA helpline continues collaborating with other parts of Vermont Legal Aid to make sure the community understands the impact on health care programs of both new unemployment programs, hazard pay, and the stimulus checks created by the CARES ACT and the American Rescue Plan Act. We are continually working on updating our website so consumers can access the latest information on how these programs will impact their Medicaid and other public benefits.

The HCA advocated for the use of one-time Federal funds to improve access to dental care and dentures for lower income Vermonters, and plan to continue to advocate for increased dental access in the coming year. We continue to participate on the Vaccine Implementation Advisory Committee convened by the Vermont Department of Health as well as various other boards and work groups.

As the state of Vermont re-opens this summer and fall, we know that Vermonters will be confronting the economic and health impacts of the pandemic. The HCA will continue to work to make health care more accessible for all Vermonters, and to make the system more equitable, responsive, and affordable.

Suni's Story:

Suni called the HCA because her doctor had prescribed a new medication, and she could not afford it. The HCA advocate learned that she had just lost her job. Suni had just applied for unemployment, but she had not been found eligible yet, and she did not have any other income. First, the HCA advocate told Suni that she would be eligible for Medicaid for Children and Adults (MCA) and helped Suni submit her application. The advocate also explained that Vermont Health Connect (VHC) was not closing Medicaid during the COVID public health emergency (PHE). This meant that Suni could stay on Medicaid until the PHE ends. The advocate also did some research on the prescription and found that it required a prior authorization to be covered by Medicaid. For the immediate prescription, the advocate helped Suni find a coupon that would provide a discount. She was able to pick up the prescription with the coupon. The advocate then explained the prior authorization process for that medication to Suni, so her provider could submit the request once Suni was approved for Medicaid.

Leslie's Story:

Leslie's partner had lost his job which meant they both had lost their employer-sponsored insurance. She called because she wanted to know if they should enroll on COBRA or get a plan on VHC. COBRA coverage allows some employees to continue on their employer coverage after they leave the job. However, typically, COBRA is very expensive. But the American Rescue Plan Act (ARPA) that was passed in 2021 had a provision that said the federal government would pay for COBRA premiums from April to September 2021 for eligible employees. After September, the couple would have a special enrollment period to enroll on a VHC plan. Because they had lost their insurance, the couple also was eligible for a special enrollment period to enroll on a VHC plan right away, and they would be eligible for increased subsidies in 2021, because ARPA also increased the subsidies most households could get. This meant Leslie and her partner had the option of getting COBRA with the premiums paid for six months and then enrolling on VHC, or enrolling on VHC, with increased APTC. The advocate discussed both options and reviewed the subsidies that they would be eligible for on a VHC plan. Ultimately, the couple decided to enroll in COBRA, with the intention of enrolling on a VHC plan when the COBRA subsidies ended in the fall.

Arnold's Story:

Arnold was turning 65 in a couple of months, and he was unsure if he could afford Medicare. He was on Medicaid for Children and Adults (MCA). Eligibility for MCA ends when you turn 65. The type of Medicaid that works with Medicare is called Medicaid for Aged, Blind and Disabled (MABD). MABD has lower income limits than MCA, and it also has resource limits. The advocate spoke to Arnold and discovered that he was going to be eligible for MABD and a Medicare Savings Program (MSP). The MSP would pay for his Part B premium, and his Medicare cost-sharing. Medicare normally covers 80% of the costs for covered services, and the patient is responsible for the remainder. The advocate advised Arnold to apply for MABD and MSP. Being approved for the MSP would also mean that Arnold would be deemed eligible for a Low Income Subsidy (LIS). LIS helps pay Medicare Part D prescription drug plan premiums and reduces the copayments. This meant Arnold would have help with his Part D premiums, Part B premiums, and Medicare cost-sharing when he turned 65 and became Medicare eligible.

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 739 calls¹ 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:

- **27.06%** about **Access to Care**
- **13.67%** about **Billing/Coverage**
- **2.17%** about **Buying Insurance**
- **14.07%** about **Complaints**
- **9.20%** about **Consumer Education**
- **21.65%** about **Eligibility** for state and federal programs
- **9.61%** were categorized as **Other**, which includes communication problems with 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 160 of our cases had eligibility for state and federal healthcare programs listed as the primary issue, an additional 383 cases had eligibility listed as a secondary concern.

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

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

The full quarterly report for April - June 2021 includes:

- This narrative
- Seven data reports, including three based on the caller's insurance status:
 - **All Calls/All Coverages: 739**
 - **Department of Vermont Health Access (DVHA) beneficiaries: 229**

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

- **Commercial Plan Beneficiaries:** 129
- **Uninsured Vermonters:** 46
- **Vermont Health Connect (VHC):** 124

The Top Issues Generating Calls

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

All Calls 739 (vs. 778 last quarter)

1. MAGI Medicaid Eligibility 98 (78)
2. Complaints about Providers 87 (109)
3. Information/Applying for DVHA programs 64 (64)
4. Premium Tax Credit Eligibility 56 (50)
5. Medicare Consumer Education 52 (52)
6. Complaints about Hospitals 50 (46)
7. Medicaid eligibility (non-MAGI) 48 (41)
8. Termination of Insurance 47 (34)
9. ARPA (American Rescue Plan Act) Consumer Education 43
10. Access to Nursing Home & Home Health 43 (35)
11. Buy-in programs/Medicare Savings Programs 42 (37)
12. Access to Prescription Drugs/Pharmacy 39 (43)
13. Special Enrollment Period 37 (27)
14. Buying QHPs through VHC 36 (47)
15. Long term care Medicaid & Choices for Care 36 (26)
16. Hospital Financial Assistance 34 (42)

Vermont Health Connect Calls 124 (151)

1. Premium Tax Credit eligibility 53 (47)
2. MAGI Medicaid Eligibility 51 (46)
3. ARPA (American Rescue Plan Act) Consumer Education 40
4. Buying QHPs through VHC 33 (43)
5. ARPA Eligibility 30
6. IRS Reconciliation Education 27 (31)
7. Information about DVHA 25 (22)
8. Termination of Insurance 24 (20)
9. Information about ACA 23 (21)
10. ACA Tax issues 22 (28)
11. Eligibility for Special Enrollment Periods 22 (27)

DVHA Beneficiary Calls 229 (vs. 255 last quarter)

1. MAGI Medicaid Eligibility 48 (48)
2. Information about DVHA 28 (32)
3. Medicaid Eligibility (non-MAGI) 26 (19)
4. Eligibility for MSPs/Buy-In Programs 19 (15)
5. Balance Billing 18 (15)
6. Prior Authorization Criteria for Healthcare Access 17 (14)
7. Access to Prescription Drugs/Pharmacy 16 (17)
8. Access to Dental Care 15 (19)
9. Access to Transportation 15 (13)
10. Specialty Care 15 (12)

Commercial Plan Beneficiary Calls 129 (vs. 149 last quarter)

1. Premium Tax Credit Eligibility 32 (32)
2. ARPA Consumer Education 32
3. ARPA Eligibility (24)
4. Termination of Insurance 23 (18)
5. Special Enrollment Period Eligibility 22 (24)
6. Buying QHPs through VHC 21 (29)
7. IRS Reconciliation Education 20 (24)
8. Coverage & Contract Questions 18 (16)
9. Eligibility for MAGI Medicaid 17 (9)
10. Premiums Billing 16 (18)

The HCA received **739** total calls this quarter. Callers had the following insurance status:

- **DVHA program beneficiaries** (Medicaid, Medicare Savings Program also called Buy-In program, VPharm, or both Medicaid and Medicare also known as “dual eligible”): 31% (229 calls)
- **Medicare² beneficiaries** (Medicare only, Medicare Advantage Plans, Medicare and a Medicare Supplemental Plan aka Medigap, Medicare and Medicaid also known as “dual eligible,” Medicare and Medicare Savings Program also called Buy-In program, Medicare and Part D, or Medicare and VPharm): 20.7% (153 calls)
- **Commercial plan beneficiaries** (employer-sponsored insurance, small group plans, or individual plans) 17.4% (129 calls)
- **Uninsured:** 6.2 % (46 calls)

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

Dispositions of Closed Cases

All Calls: We closed 757 cases this quarter. Overall, 302 were resolved by brief analysis and advice. Another 246 were resolved by brief analysis and referral. There were 81 complex interventions involving complex analysis and more than two hours of an advocate's time, and 57 cases that involved at least one direct intervention on behalf of a consumer. The HCA provided consumer education in 451 cases. We also estimated eligibility for insurance coverage and helped enroll people onto coverage in 65 cases. We saved consumers \$44,672.35 this quarter.

Consumer Protection Activities

Health Insurance Rate Review

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

The Board decided four premium price change requests during the quarter from April 1, 2021, through June 30, 2021. Additionally, there are four premium price change requests pending as of the end of this quarter.

MVP submitted one premium price change request decided by the Board this quarter: the MVP Large Group HMO 2021 POS Riders filing. MVP requested an overall manual rate impact of - 3.4% for its large group members with coverage dates between 7/1/2021 - 12/31/2021. On May 7, 2021, the Board approved MVP's premium price change request as filed. The HCA appeared on behalf of Vermonters in this matter.

The Vermont Health Plan (TVHP) submitted one premium price change request decided by the Board this quarter: the TVHP Large Group filing. On February 10, 2021, TVHP submitted a premium price change request to take effect in the third quarter of 2021 for four quarters. The overall premium price change requested was -0.6%. This premium price change request was consolidated with the Blue Cross Blue Shield of Vermont (BCBSVT) Large Group premium price change request. On May 7, 2021, the Board approved an average premium change of -1.7%. The HCA appeared on behalf of Vermonters in this matter.

BCBSVT submitted two premium price change requests decided by the Board this quarter: the BCBSVT Association Health Plan filing and the BCBSVT Large Group filing. In the first premium price change request, the BCBSVT Association Health Plan filing, BCBSVT requested a premium price decrease of - 1.3% to take effect January 1, 2022. On June 1, 2021, the Board approved the premium price change request. The second premium price change request, the BCBSVT Large Group filing, was consolidated with the TVHP Large Group filing. As detailed above, BCBSVT submitted a premium price change request that to take effect in the third quarter of 2021 for four quarters. The overall premium price change requested was -0.6%. On May 7, 2021, the Board approved an average premium change of -1.7%. The HCA appeared on behalf of Vermonters in these matters.

There are four premium price change requests pending at the end of this quarter: the 2022 BCBSVT Small Group Vermont Health Connect (VHC) filing (BCBSVT Small Group); the 2022 BSBCVT Individual Group VHC filing (BCBSVT Individual); the 2022 MVP Small Group VHC filing (MVP Small Group); and the 2022 MVP Individual Group filing (MVP Individual). Collectively, these four filings are the 2022 VHC Filings. There are four filings, as opposed to two, because, for 2022, the legislature unmerged the individual and small group markets.

The BCBSVT Small Group filing impacts roughly 18,750 Vermonters. BCBSVT is requesting an average premium price decrease of -7.8%. The BCBSVT Individual filing impacts roughly 15,800 Vermonters. BCBSVT is requesting an average premium price increase of 7.9%. The MVP Small Group filing impacts roughly 21,850 Vermonters. MVP is requesting an average premium price increase of 5%. The MVP Individual filing impacts roughly 15,350 Vermonters. MVP is requesting an average premium price increase of 17%. The HCA has appeared on behalf of Vermonters in all four of these matters. Further, we will file all appropriate memoranda and other documents, in addition to appearing at hearings, to represent the interests of Vermonters in these matters.

Certificate of Need Review Process (SP)

In the last quarter, the HCA entered an appearance in four Certificate of Need matters to monitor them for potential consumer protection issues. The first application was submitted by an out-of-state entity proposing to purchase and operate a Vermont ambulance company. The GMCB approved the application with reporting requirements. The second application was submitted by the Vermont Department of Mental Health and proposes to develop a secure residential mental health treatment program in Essex, Vermont. This application is still pending at the time of this report. The third application is a proposal to build a 40-bed residential substance abuse disorder treatment facility in Ludlow. The fourth application is to implement a QC Kinetics franchise for pain management. Both applications are pending Board review.

Oversight of Accountable Care Organizations (SP)

The HCA participates in the Board's annual ACO budget review process. This quarter, the HCA reviewed the Board's proposed changes to its rule governing the ACO certification and budget review processes. We provided written feedback on the draft rule and met with the Board staff to discuss our comments and recommendations. Our concerns focused on transparency, improving and developing metrics for ACO performance evaluation, consumer representation, and advocating for considering policy "lessons learned" from the COVID-19 pandemic. The HCA also submitted a public comment recommending that the GMCB reject a request from a Medicare-only ACO to waive the requirements of GMCB Rule 5.400 (Board review and approval of an ACO's annual budget) and GMCB Rule 5.500 (Board's monitoring and enforcement of ACOs) for Clover Health. Clover Health is participating as a Direct Contracting Entity in CMS' Direct Contracting Model. This waiver request was denied by the Board, and the HCA agreed to the Board's request to work together with its staff to develop oversight and budgetary guidance for Medicare-only ACOs in Vermont.

Other Green Mountain Care Board and other agency workgroups

Over the last quarter, the HCA attended the Board's weekly board meetings, monthly Data Governance meetings, weekly Prescription Drug Technical Advisory subgroup meetings, and the Board's General

Advisory Committee meeting. In addition, we met with Board staff to review the status of their legislatively-mandated hospital sustainability planning.

Vaccine Implementation Advisory Committee

The COVID-19 Vaccine Implementation Advisory Committee serves in an advisory role to the Commissioner of Health. It was given the charge of assisting with four primary activities including to identify and reach critical populations, promote COVID-19 vaccination, develop crisis and risk communication messaging, and to carry out the vaccine implementation plan. During this quarter, the Advisory committee met less frequently than in the previous quarter. The HCA is supportive of the Administration's move to offer COVID Vaccines to Vermont's BIPOC communities who are at increased risk due to a long history of systemic racism that has resulted in unequal access to our health care system and other social determinants that increase their risks. We also joined with other members of the committee in recognizing substantial successes in getting a high percentage of Vermonters vaccinated.

The Medicaid and Exchange Advisory Committee

The HCA participated in three meetings this quarter. The content of this quarter's meetings was primarily focused on the impacts of the American Rescue Plan Act on Vermont's Medicaid and Exchange programs. In addition to this focus on the programmatic changes, the Advisory committee also focused on the question of how best to communicate these changes to Vermonters. The Advisory committee also spent time understanding the planned changes to premium processing and considered how best to help Vermonters understand this change.

Legislative Advocacy

The HCA continued to advocate for Vermonters in the new landscape of a fully-remote Legislative session. In addition to weighing in on policy matters, the HCA continued our supportive role, helping legislators in their role of assisting Vermonters who are having a hard time managing the complexity of our health care systems of care and health finance systems.

During this quarter, the HCA continued our legislative advocacy on the proposal to expand Dr Dynasaur-like coverage for children and pregnant individuals who are not eligible for coverage due to their immigration status. We continued to play a supportive role as the bill worked its way through the Senate and the Governor's signature. This included the ongoing communications and organizing of a stakeholder group that continued to grow as the bill moved through the legislative process.

Through the end of the session the HCA also continued our work on the initiative to divide the individual and small group QHP marketplace for the 2022 plan year. As the session moved toward a close, the coalition of supporters of this effort grew to include both carriers in the QHP marketplace as well as the Scott Administration and the business community. The initiative finally landed as section 34 of S.88, and upon the Governor's signature became Act 25.

Collaboration with Other Organizations

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

- American Civil Liberties Union of Vermont
- Bi-State Primary Care
- Blue Cross Blue Shield of Vermont
- Department of Financial Regulation
- Economic Equity Fund Group/Vermont Community Foundation
- Families USA
- Georgetown University Health Policy Institute
- IRS Taxpayer Advocate Service
- Migrant Justice
- MVP Health Care
- National Academy for State Health Policy
- NHeLP, National Health Law Program
- New American Clinic/Family Room
- OneCare Vermont
- Open Door Clinic
- Planned Parenthood of Northern New England
- RISPnet Group
- Rural Vermont
- South Royalton Legal Clinic
- Spectrum Youth and Family Services
- SHIP, State Health Insurance Assistance Program
- United States of Care
- University of Vermont Medical Center
- University of Vermont Migrant Health, Bridges to Health Vermont Association of Hospitals and Health Systems
- Vermont Department of Health
- Vermont Department of Taxes
- Vermont Health Connect
- Vermont Medical Society
- Vermont Workers' Center
- You First

Increasing Reach and Education Through the Website

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

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

Popular Web Pages

* means the page moved into the top 20 this quarter

The top-20 health pages on our website this quarter:

1. *Income Limits - Medicaid* – 2,443 pageviews
2. *Health* - section home page – 1,480
3. *Dental Services* – 710
4. *Services Covered – Medicaid* – 513
5. *Long-Term Care* – 439
6. *Medicaid* – 419
7. *News: Coronavirus and Long-Term Care* – 364
8. *Resource Limits - Medicaid* – 337
9. *HCA Help Request Form* – 302 pageviews and 102 online help requests
10. *Medicaid, Dr. Dynasaur & Vermont Health Connect* – 286
11. *Medicare Savings Programs* – 282
12. *Vermont Health Connect* – 269
13. *Choices for Care* – 240
14. *Dr. Dynasaur* – 213
15. *Federally Qualified Health Centers* – 210
16. *Advance Directive forms* – 207
17. *Choices for Care Income Limits* – 205
18. *Transportation for Health Care* – 205 *
19. *Medical Decisions: Advance Directives* – 196
20. *Vermont Long-Term Care Ombudsman Project* – 154

This quarter we had these additional news items:

- *News: You May Be Eligible for New Financial Help for Health Insurance* – 189
- *News: Coronavirus SEP for Vermont Health Connect* – 128

Outreach and Education

The Office of the Health Care Advocates' (HCA) ability to conduct in-person outreach activities was limited this quarter because of the COVID-19 pandemic. To better meet the needs of Vermonters during this time, our office used virtual platforms to connect community members, with accurate and accessible information about health insurance eligibility and health care policy.

Many of the HCA's outreach activities this quarter focused on informing and educating Vermonters about the increased financial help that is available through Vermont Health Connect (VHC), as a result of the American Rescue Plan Act (ARPA).

We partnered with **14 organizations and participated in 10 outreach presentations** to provide Vermonters and direct service providers with accurate and accessible information on insurance eligibility health care policy.

The HCA partnered with a variety of stakeholders to distribute outreach material and host legal education events.

We co-hosted two education events with **Let's Grow Kids** and the **Vermont Association for the Education of Young Children**. The first webinar on **May 18th** provided 15 attendees with consumer education on the free services that are available through the HCA. The second webinar in this series took place on **June 9th**. During this hour-long event, attendees learned about Dr. Dynasaur eligibility and the increased financial help that is available through Vermont Health Connect because of ARPA. Participants had the opportunity to ask questions live, and in total, 28 individuals attended this presentation.

On **May 19th** the HCA's Helpline Director and the Communications Coordinator gave a virtual presentation to 33 members of the **Department of Vermont Health Access's Assistor team**. This educational event focused on providing this group with information about the advocacy services that are available through the HCA and how individuals and assistors could access our services.

From **May 15th - June 23rd** the HCA also collaborated with the **New American Pediatric Clinic, Planned Parenthood of Northern New England, the Open Door Clinic, UVM's Clinical Social Work Team, and Bridges to Health**, to host education events and stakeholder meetings to build a stronger referral relationship and provide consumer education on health insurance eligibility in Vermont. This collaboration has helped our office connect with an array of Vermonters who often have urgent access to care questions.

On **June 3rd**, Mike Fisher, the Chief Health Care Advocate, attended **Emily Kornheiser's zoom/cable access television show**. We discussed new opportunities for Vermonters to get health insurance with increased subsidies given the American Rescue Plan Act. Also discussed was the HCA's Helpline and its availability to all Vermonters, as well as the major regulatory activities taking place this summer.

The HCA developed and distributed outreach material targeted at restaurant staff to connect this population with information about the increased financial assistance that is available through Vermont Health Connect for those who received unemployment in 2021. The HCA also used social media to communicate with Vermonters about recent changes to health insurance eligibility criteria and increased financial help. We used targeted ads through Facebook to connect over 1,000 Vermonters with information about Act. 48. In addition, the HCA used Front Porch Forum to reach 515 Vermonters and spread the word about the educational videos our office developed regarding VHC and ARPA.

Promoting Plain Language in Health Communications

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

- **IFC second draft**
- **ARPA Missing Data Notice**
- **ARPA NOD for Existing QHP enrollees**
- **ARPA Notice for Non-Financial Assistance**
- **VHC Open Enrollment Stuffer**

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: QE062021 Investments						
CY 2021 Investment Expenditures						
Final Receiver		Investment Description	QE 0321	QE 0621	QE 0921	QE 1221
Department	Suffix					
AHSCO	9091	Investments (STC-79) - 2-1-1 Grant (41)	113,250	10,235		
AHSCO	9090	Investments (STC-79) - Designated Agency Underinsured Services (54)	1,575,984	1,575,984		
AOE	n/a	Non-state plan Related Education Fund Investments				
DCF	9402	Investments (STC-79) - Medical Services (55)	41,263	14,021		
DCF	9403	Investments (STC-79) - Residential Care for Youth/Substitute Care (1)				
DCF	9405	Investments (STC-79) - Aid to the Aged, Blind and Disabled CCL Level III (56)	1,010,750	1,021,040		
DCF	9406	Investments (STC-79) - Aid to the Aged, Blind and Disabled Res Care Level III (57)	26,243	26,431		
DCF	9407	Investments (STC-79) - Aid to the Aged, Blind and Disabled Res Care Level IV (58)	61,115	58,539		
DCF	9408	Investments (STC-79) - Essential Person Program (59)	191,025	184,639		
DCF	9409	Investments (STC-79) - GA Medical Expenses (60)	42,555	20,511		
DCF	9411	Investments (STC-79) - Therapeutic Child Care (61)	287,305	279,190		
DCF	9412	Investments (STC-79) - Lund Home (2)	693,053	720,143		
DCF	9413	Investments (STC-79) - Prevent Child Abuse Vermont: Shaken Baby (33)				
DCF	9414	Investments (STC-79) - Prevent Child Abuse Vermont: Nurturing Parent (34)	32,315	18,270		
DCF	9415	Investments (STC-79) - Challenges for Change: DCF (9)	36,083	23,333		
DCF	9416	Investments (STC-79) - Strengthening Families (26)	198,336	304,099		
DCF	9417	Investments (STC-79) - Lamoille Valley Community Justice Project (62)	54,594	58,253		
DCF	9418	Investments (STC-79) - Building Bright Futures (35)	129,876	112,290		
DDAIL	9602	Investments (STC-79) - Mobility Training/Other Svcs.-Elderly Visually Impaired (63)	148,054	90,774		
DDAIL	9603	Investments (STC-79) - DS Special Payments for Medical Services (64)	1,119,839	374,476		
DDAIL	9604	Investments (STC-79) - Flexible Family/Respite Funding (27)	289,286	267,578		
DDAIL	9605	Investments (STC-79) - Quality Review of Home Health Agencies (42)				
DDAIL	9606	Investments (STC-79) - Support and Services at Home (SASH) (43)	245,870	245,124		
DDAIL	9607	Investments (STC-79) - HomeSharing (77)	69,670	69,459		
DDAIL	9608	Investments (STC-79) - Self-Neglect Initiative (78)	130,202			
DDAIL	9609	Investments (STC-79) - Seriously Functionally Impaired: DAIL (65)		29,990		
DMH	9501	Investments (STC-79) - Special Payments for Treatment Plan Services (28)	23,353	39,545		
DMH	9502	Investments (STC-79) - MH Outpatient Services for Adults (66)	827,220	774,685		
DMH	9504	Investments (STC-79) - Mental Health Consumer Support Programs (79)	98,319	113,715		
DMH	9505	Investments (STC-79) - Mental Health CRT Community Support Services (16)	(697,469)	1,436,960		
DMH	9506	Investments (STC-79) - Mental Health Children's Community Services (12)	597,557	559,399		
DMH	9507	Investments (STC-79) - Emergency Mental Health for Children and Adults (29)	2,332,038	2,304,917		
DMH	9508	Investments (STC-79) - Respite Services for Youth with SED and their Families (67)	311,549	267,100		
DMH	9510	Investments (STC-79) - Emergency Support Fund (22)	131,863	105,167		
DMH	9511	Investments (STC-79) - Institution for Mental Disease Services: DMH (3) - VPCH	3,154,313	3,069,979		
DMH	9512	Investments (STC-79) - Institution for Mental Disease Services: DMH (3) - BR	2,607,983	2,161,055		
DMH	9514	Investments (STC-79) - Seriously Functionally Impaired: DMH (68)	28,956	27,630		
DMH	9516	Investments (STC-79) - Acute Psychiatric Inpatient Services (13)	156,906	194,642		
DOC	n/a	Return House	74,551	187,218		
DOC	n/a	Northern Lights	79,633	152,252		
DOC	n/a	Pathways to Housing - Transitional Housing	176,666	159,478		
DOC	n/a	St. Albans and United Counseling Service Transitional Housing (Challenges for Change)	68,677	125,682		
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	800,210	1,371,534		
DOC	n/a	Intensive Sexual Abuse Program				
DOC	n/a	Vermont Achievement Center				
DVHA	9101	Investments (STC-79) - Vermont Information Technology Leaders/HIT/HIE/HCR (8)				
DVHA	9102	Investments (STC-79) - Vermont Blueprint for Health (51)	702,782	659,434		
DVHA	9103	Investments (STC-79) - Buy-In (52)	15,276	10,701		
DVHA	9104	Investments (STC-79) - HIV Drug Coverage (53)	1,438			
DVHA	9106	Investments (STC-79) - Patient Safety Net Services (18)				
DVHA	9107	Investments (STC-79) - Institution for Mental Disease Services: DVHA (7)	426,792	1,591,171		
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 (82)				
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	108,212			
VAAF	n/a	Agriculture Public Health Initiatives				
VDH	9201	Investments (STC-79) - Emergency Medical Services (19)	84,423	143,874		
VDH	9203	Investments (STC-79) - TB Medical Services (74)	487	309		
VDH	9204	Investments (STC-79) - Epidemiology (40)	27,503	27,340		
VDH	9205	Investments (STC-79) - Health Research and Statistics (39)	140,741	207,756		
VDH	9206	Investments (STC-79) - Health Laboratory (31)	454,147	584,377		
VDH	9207	Investments (STC-79) - Tobacco Cessation: Community Coalitions (50)	582,170	588,892		
VDH	9208	Investments (STC-79) - Statewide Tobacco Cessation (76)				
VDH	9209	Investments (STC-79) - Family Planning (75)	296,039	274,108		
VDH	9210	Investments (STC-79) - Physician/Dentist Loan Repayment Program (25)	144,000	455,000		
VDH	9211	Investments (STC-79) - Renal Disease (73)				
VDH	9213	Investments (STC-79) - WIC Coverage (37)		1,983		
VDH	9214	Investments (STC-79) - Area Health Education Centers (AHEC) (21)	166,717			
VDH	9217	Investments (STC-79) - Patient Safety - Adverse Events (47)	8,582	10,082		
VDH	9219	Investments (STC-79) - Substance Use Disorder Treatment (30)	1,009,910	623,086		
VDH	9220	Investments (STC-79) - Recovery Centers (17)	478,134	313,439		
VDH	9221	Investments (STC-79) - Enhanced Immunization (46)	17,426	22,648		
VDH	9222	Investments (STC-79) - Poison Control (48)	37,010	31,765		
VDH	9223	Investments (STC-79) - Public Inebriate Services, C for C (23)	561,415	421,582		
VDH	9224	Investments (STC-79) - Fluoride Treatment (38)	6,196	5,179		
VDH	9225	Investments (STC-79) - Medicaid Vaccines (24)				
VDH	9226	Investments (STC-79) - Healthy Homes and Lead Poisoning Prevention Program (49)	15,804	19,072		
VDH	9228	Investments (STC-79) - VT Blueprint for Health (44)	110,032	66,834		
VSC	n/a	Health Professional Training	-			
VVH	n/a	Vermont Veterans Home				
			22,664,232	24,613,969	-	-
						47,278,201

What We Do

At the Lund Residential Treatment Program, women and their children receive a broad range of services and supports such as case management, education, substance abuse and mental health treatment. Women, their children and the clinicians work together on treatment goals in five areas: clinical treatment, parent education, health and wellness, life skills and education and vocational development. During treatment women engage in both individual and group work with their clinicians to achieve their goals. The treatment team develops an individualized plan that coordinates all the services appropriate to the family's needs. Women are matched with a peer mentor to help them acclimate to the program.

Transition planning begins early in the process and women leave with established connections to community resources. Many women continue to access support from the Lund Program after leaving the program. Some of the supports that are available are aftercare support groups, individual outpatient substance abuse counseling, on-going case management and family education services.

Who We Serve

Women with substance use disorders and their children involved with the Family Services Division, Department of Corrections, the Reach Up Program (TANF), and other community-based providers. Self-referrals are also accepted.

How We Impact

Lund services help women with substance use disorders (SUDs) recover from SUDs and other co-occurring mental health issues. In addition, it builds strong and healthy families by allowing women to engage in treatment while living with their children and by providing parent education and other life skills education and supports.

Measures

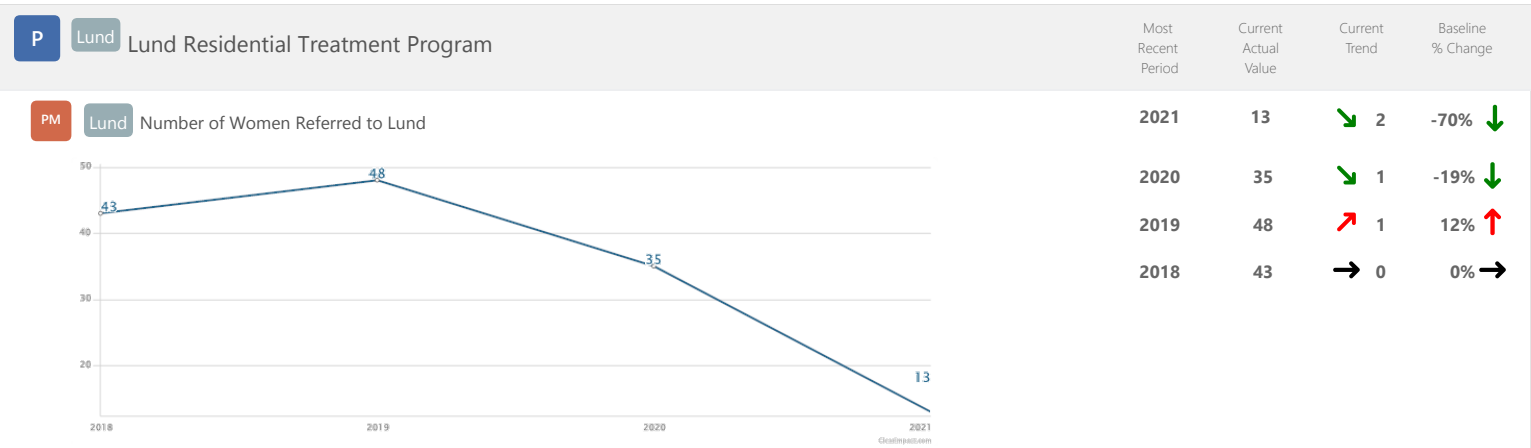
		Most Recent Period	Current Actual Value	Current Target Value	Current Trend	Baseline % Change
PM	Lund	Number of Women Referred to Lund				
		2021	13	—	↘ 2	-70% ↓
PM	Lund	Percentage of residents not readmitted after successful discharge at 30, 90 and 180 days				
		2021	94	90	↗ 2	8% ↑

Actions

Name	Assigned To	Status	Due Date	Progress
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Lund Residential Treatment Program

The Lund Residential Treatment Program supports women in their recovery from substance use disorders and to develop strong and healthy families. Lund is the only program in Vermont where mothers can engage in treatment while living with their children.



Story Behind the Curve

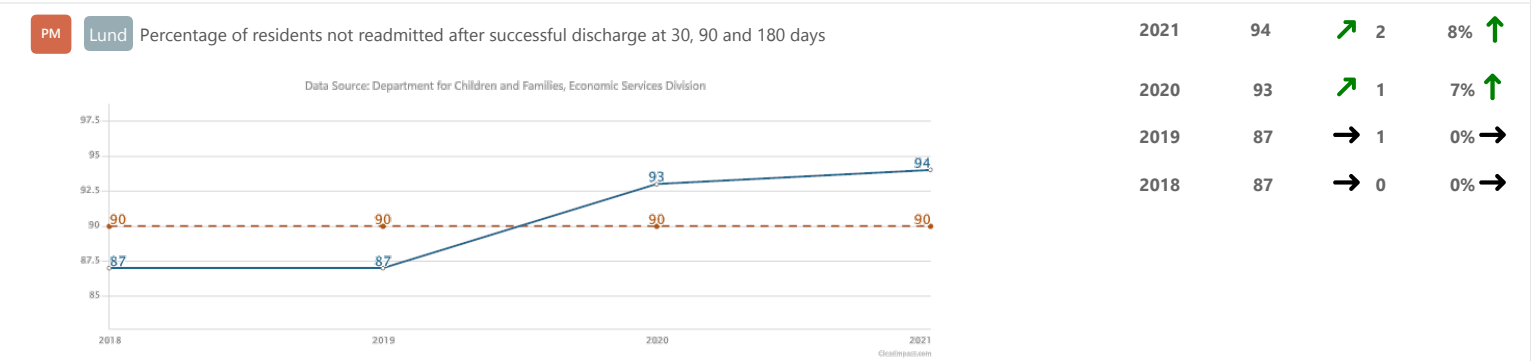
The drop in referrals was a result of the COVID-19 pandemic and we expect to see referrals increase during 2022 and beyond.

Partners

Referrals come from the Family Services Division (Vermont's child welfare system), the Reach Up Program (TANF), Department of Corrections, other community-based providers and self-referrals.

What Works

Action Plan



Story Behind the Curve

Prior to the COVID-19 pandemic, 87% of women did not relapsed at the 30, 90 and 180 day benchmarks, very close to the 90% performce measure set by the state. During the pandemic, the performance measure increased to 93% in 2020 and 94% in 2021. This may have more to do with women not be able to leave the program due to COVID. The length of stay doubled to 602 days during 2020 and 2021. Prior to COVID, the average length of stay was one year.

Partners

What Works

Action Plan

Transitional Housing



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

Why Is This Important?

Transitional housing programs are a critical component of offender reentry. Independent or stable living is a core determinant of offenders' successful reintegration into the community. Independent or stable living is also strongly associated with reduced recidivism rates.



GCI Transitional Housing Services

Most
Recent
Period

Current
Actual
Value

What We Do

Transitional housing programs are an integral component in an offender's reentry process. The goal of the program is to move residents recently released from incarceration into stable living situations within one year. With the support of transitional housing, participants can live in the community, find employment opportunities, engage in education, or participate in other programs that will support their long term stability in the community. In this way, transitional housing helps encourage the formation and maintenance of public-private partnerships in health care, including initiatives to support and improve the health care delivery system.

Who We Serve

Reintegrative housing funded by the Department of Corrections is targeted to support those with complex needs to rejoin their community safely. The individuals we serve have conditions (including, but not limited to) mental health challenges, substance misuse, developmental disabilities, severe functional impairment, and adaptive needs. Housing providers partner closely with local agencies and non-profits specializing in community & mental health support, substance use treatment, restorative justice, affordable housing, and independent living.

How We Impact

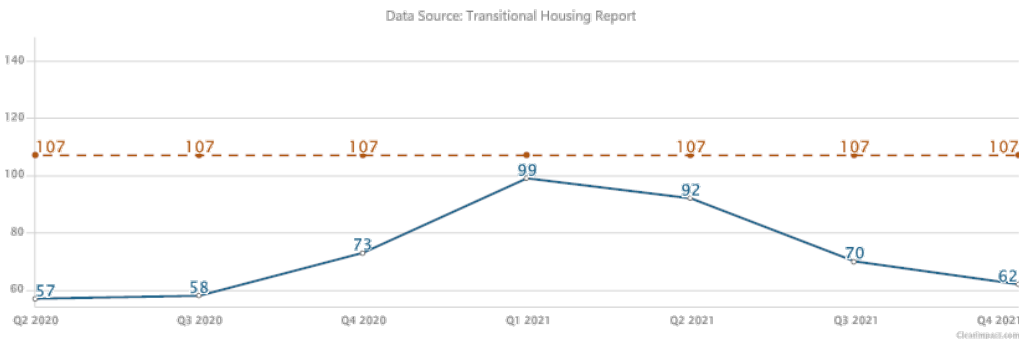
Our program activities are designed to facilitate our targeted outcomes:

- Participants will be insured and have priority access to health services (mental, physical, substance abuse);
- Participants will have access to stable housing;
- Reincarceration will be reduced;
- Personal and family relationships will improve;
- Employment opportunities will be explored; and
- Quality of life for participants will improve



GCI Number of Individuals Served

Q4 2021	62
Q3 2021	70
Q2 2021	92
Q1 2021	99
Q4 2020	73
Q3 2020	58
Q2 2020	57
Q1 2020	71
Q4 2019	82



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 (FY21) for number of people served was 107; the actual number of people served in FY21 was consistently below this target. The decrease in the number of individuals served throughout FY21 can be explained by the following. The Vermont Achievement Center (VAC) only received MCO funding for three quarters: the last quarter of FY20 and the first two quarters of FY21. The VAC and the Department mutually decided to close the two VAC programs (totaling 20 beds) in the middle of FY21. The occupancy rate of the program beds was low as they phased out of operation near the end of Q2. Additionally, Northern Lights (a program of the Howard Center) had low utilization in FY21 and was not selected for continued funding in FY22. Therefore, their occupancy rate was very low toward the end of FY21 as they phased out of operation.

Partners

What Works

Action Plan

PM HW Bed Days Utilized

Q4 2021 1,389

Q3 2021 1,558

Q2 2021 1,830

Q1 2021 2,625

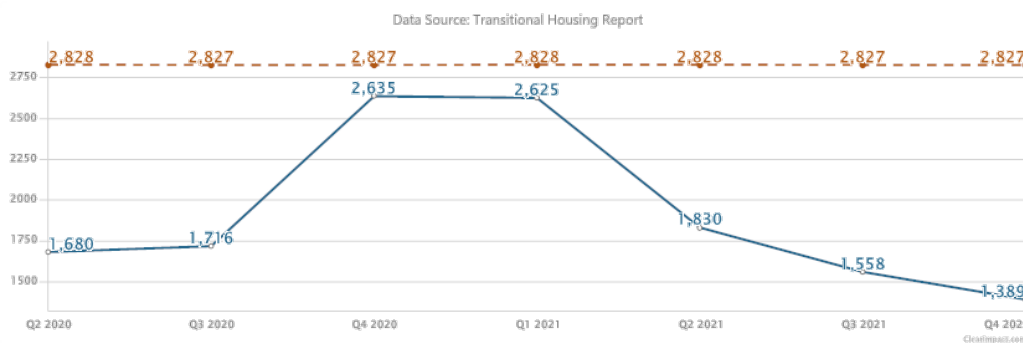
Q4 2020 2,635

Q3 2020 1,716

Q2 2020 1,680

Q1 2020 1,747

Q4 2019 1,691



Story Behind the Curve

Bed utilization fluctuates each quarter because of the variability in individuals' circumstances. The bed days for FY21 totaled 7,402, which was 65% of our annual target (11,310). The quarterly target for FY21 is 2,827/2,828. While we are below our annual targets, with the exception of quarter 2 we are meeting at minimum 59% of our target bed days utilized.

The decrease in the number of bed days utilized throughout FY21 can be explained by the following. The Vermont Achievement Center (VAC) only received MCO funding for three quarters: the last quarter of FY20 and the first two quarters of FY21. The VAC and the Department mutually decided to close the two VAC programs (totaling 20 beds) in the middle of FY21. The occupancy rate of the program beds was low as they phased out of operation near the end of Q2. Additionally, Northern Lights (a program of the Howard Center) had low utilization in FY21 and was not selected for continued funding in FY22. Therefore, their occupancy rate was very low toward the end of FY21 as they phased out of operation.

Partners

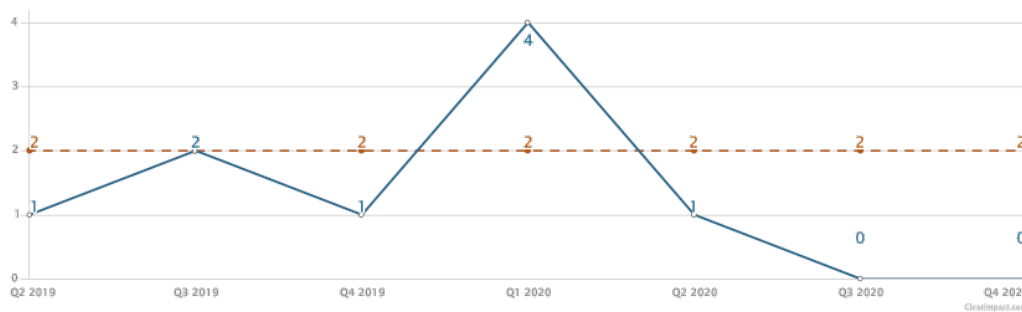
What Works

Action Plan

PM HM Individuals Housed (Search and Retention Services)

Q4 2020 0

Data Source: Transitional Housing Report



Q3 2020	0
Q2 2020	1
Q1 2020	4
Q4 2019	1
Q3 2019	2
Q2 2019	1
Q1 2019	2
Q4 2018	0

Story Behind the Curve

The number of individuals housed (search and retention services) fluctuates each quarter because of variability in individuals' circumstances. We exceeded our quarterly target of housing 2 individuals (search and retention services) for quarter 1 of FY21 but did not meet that target in the other three quarters in FY21.

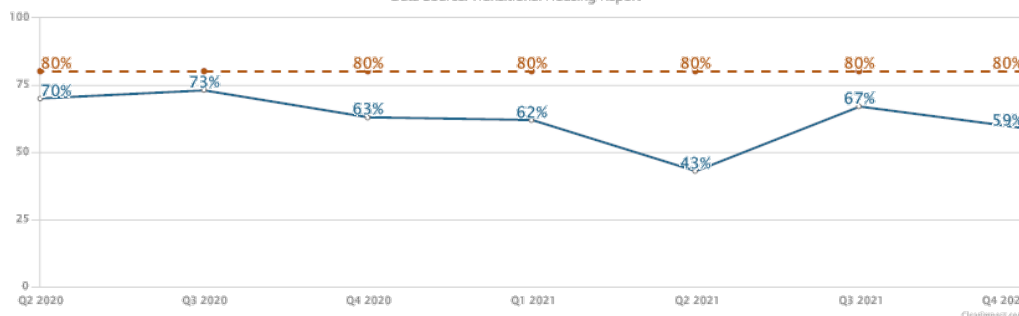
Partners

What Works

Action Plan

PM HW Percent of Beds Utilized

Data Source: Transitional Housing Report



Q4 2021	59%
Q3 2021	67%
Q2 2021	43%
Q1 2021	62%
Q4 2020	63%
Q3 2020	73%
Q2 2020	70%
Q1 2020	73%
Q4 2019	64%

Story Behind the Curve

Overall utilization for FY21 was 58%. The target for FY21 was 80%; thus, we were below the target percent of beds utilized by an average of 22% for FY21. The dip in the percent of beds utilized for quarter 2 can be explained in part by the Vermont Achievement Center (VAC) and the Department mutually deciding to close the two VAC programs (totaling 20 beds) in the middle of FY21. The occupancy rate of the program beds was low as they phased out of operation near the end of Q2.

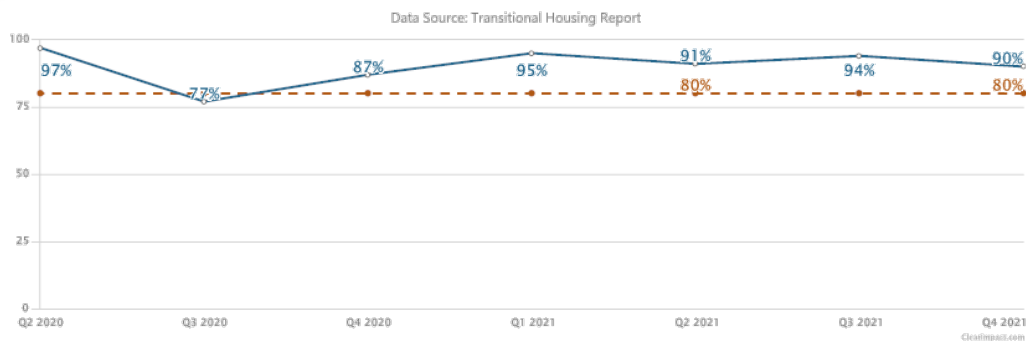
Partners

What Works

Action Plan

PM HW Percent of Referrals Accepted

Q4 2021 90%



Q3 2021	94%
Q2 2021	91%
Q1 2021	95%
Q4 2020	87%
Q3 2020	77%
Q2 2020	97%
Q1 2020	86%
Q4 2019	75%

Story Behind the Curve

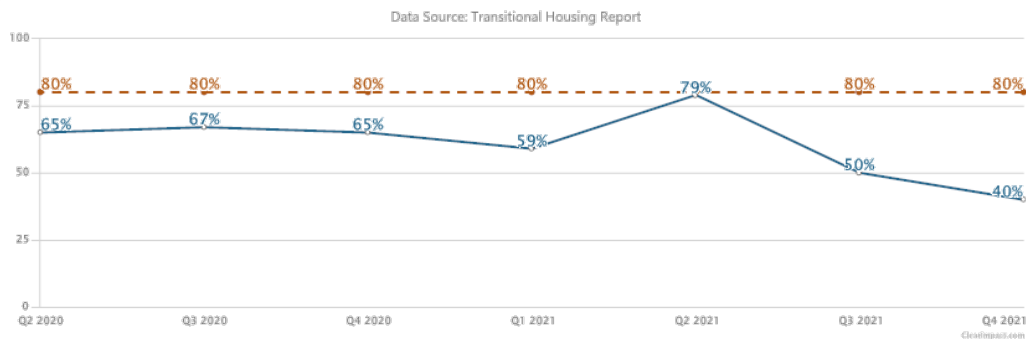
Overall percent of referrals accepted for FY21 was above target, at an average of 92.5%. In Q1 of FY21, we were above our quarterly target for percent of referrals accepted by 15%.

Partners

What Works

Action Plan

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



Q4 2021	40%
Q3 2021	50%
Q2 2021	79%
Q1 2021	59%
Q4 2020	65%
Q3 2020	67%
Q2 2020	65%
Q1 2020	76%
Q4 2019	71%

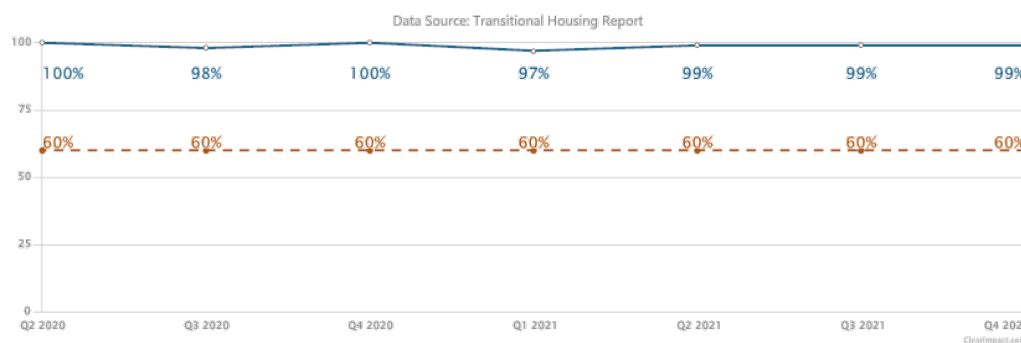
Story Behind the Curve

Overall the percent of participants employed, enrolled in an educational/training program, or receiving benefits at exit for FY21 was 57%, which is 23% below our annual target of 80%. The low percentage of those enrolled in an educational/training program, or receiving benefits at exit is a reflection of the lower overall number of participants being served due to program closures. There were also several participants who absconded from the program, so outcomes were unknown.

Partners

What Works

Action Plan



Q3 2021	99%
Q2 2021	99%
Q1 2021	97%
Q4 2020	100%
Q3 2020	98%
Q2 2020	100%
Q1 2020	94%
Q4 2019	93%

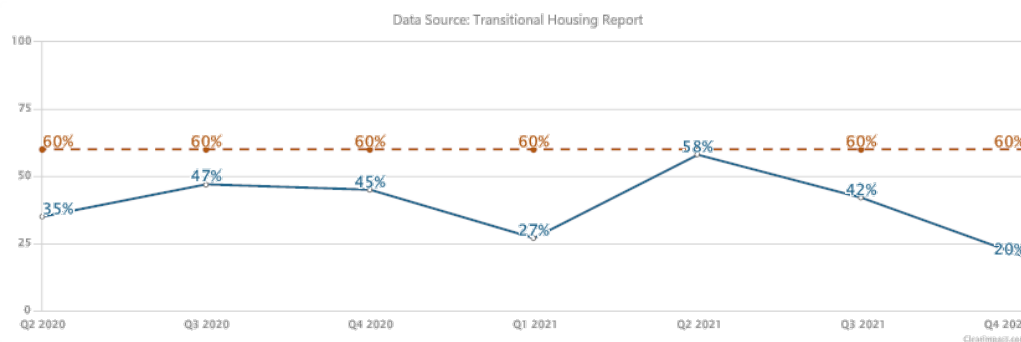
Story Behind the Curve

Remaining crime free is significantly associated with successful reentry. In FY21, an average of 98.5% of program participants remained crime free while in the program (well above our 60% annual target). We have been consistently above our FY21 quarterly target (60%); for quarters 2 through 4 in FY21, 99% of individuals in our programs have remained crime free.

Partners

What Works

Action Plan



Q3 2021	42%
Q2 2021	58%
Q1 2021	27%
Q4 2020	45%
Q3 2020	47%
Q2 2020	35%
Q1 2020	34%
Q4 2019	33%

Story Behind the Curve

The percentage of people who exit transitional housing to permanent housing varies across time due to the high variable nature of individuals' circumstances. In FY21, an average of 37% of program participants exited the program to permanent housing, which is 23% below our 60% annual target. The low percentage of participants exiting to permanent housing is a reflection of the lower overall number of participants being served due to program closures. There were also several participants who absconded from the program, so outcomes were unknown.

Partners

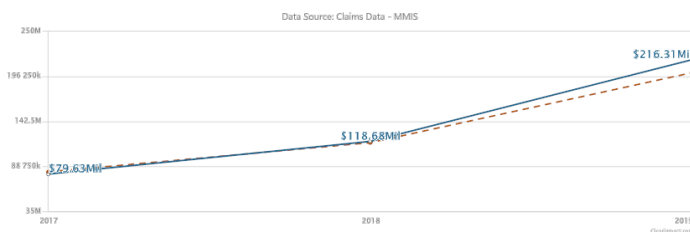
What Works

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

PM **DVHA** Expected and Actual Total Cost of Care for Medicaid enrollees aligned with an ACO



Most Recent Period	Current Actual Value	Current Target Value	True	Current Trend	Baseline % Change
2019	\$216.31Mil	\$200.81Mil	—	↗ 2	172% ↑
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.

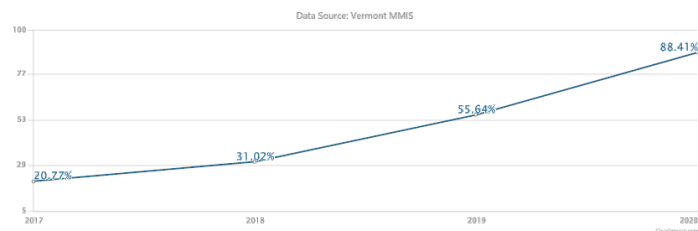
The actual total cost of care (ATCOC) for the ACO is the sum of the Fixed Prospective Payment (FPP) paid to the ACO and the total actual Fee-For-Service expenditures paid by DVHA on behalf of the ACO to its providers for services not covered by the FPP.

[Please note that final 2020 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.



2020	88.41%	—	—	↗ 3	326%	↑
2019	55.64%	—	—	↗ 2	168%	↑
2018	31.02%	—	—	↗ 1	49%	↑
2017	20.77%	—	—	→ 0	0%	→

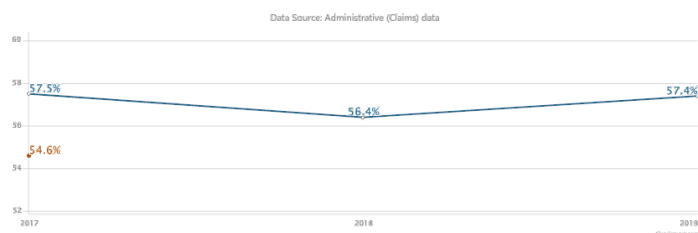
Notes on Methodology

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.



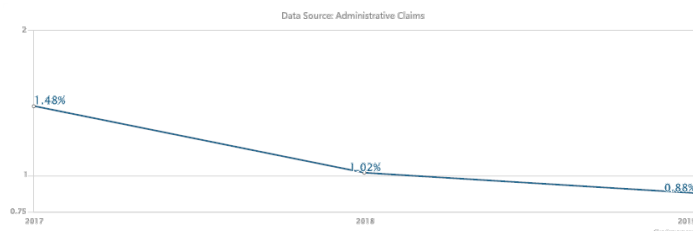
2019	57.4%	—	—	↗ 1	0%	→
2018	56.4%	—	—	↘ 1	-2%	↓
2017	57.5%	54.6%	—	→ 0	0%	→

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.



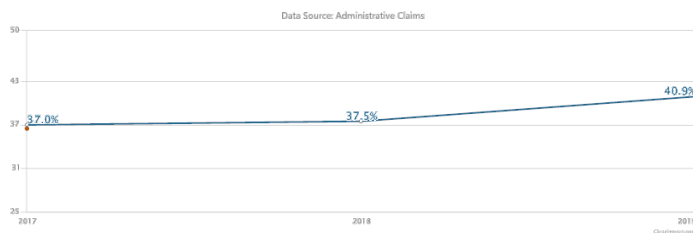
2019	0.88%	—	—	↗ 2	-41%	↓
2018	1.02%	—	—	↗ 1	-31%	↓
2017	1.48%	—	—	→ 0	0%	→

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.



2019	40.9%	—	—	↗ 2	11%	↑
2018	37.5%	—	—	↗ 1	1%	↑
2017	37.0%	36.5%	—	→ 0	0%	→

Notes on Methodology

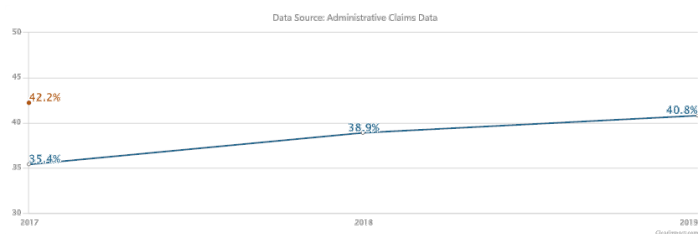
The red dot above represents the CY 2017 50th percentile for National Medicaid All Lines of Business (ALOB). The solid blue trend line represents the ACO's actual annual performance rates.

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% →

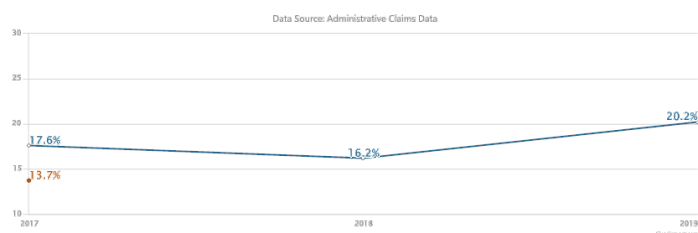
Notes on Methodology

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.

PM DVHA 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% →

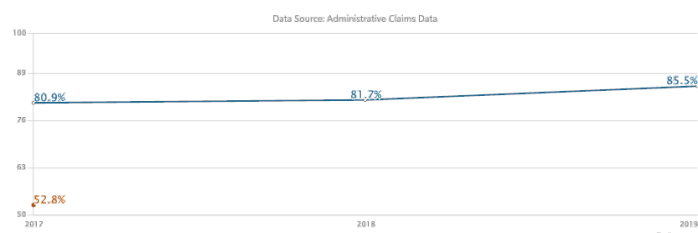
Notes on Methodology

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)



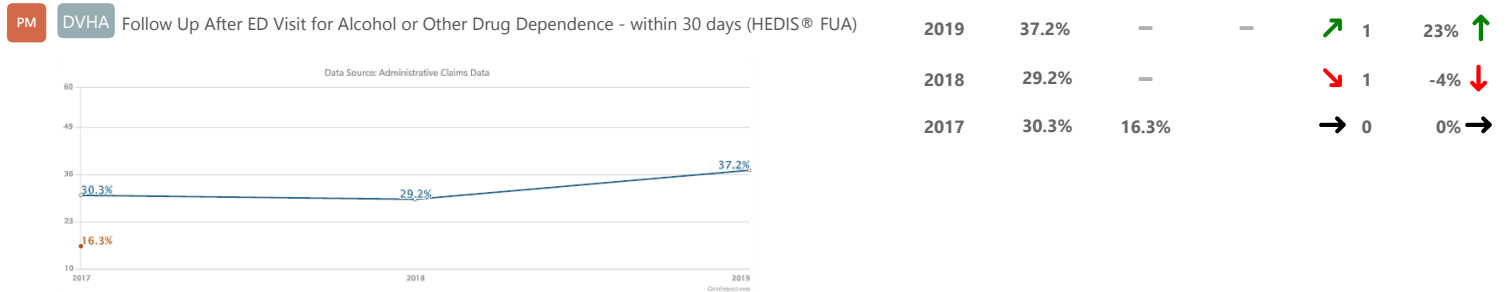
2019	85.5%	—	—	↗ 2	6% ↗
2018	81.7%	—	—	↗ 1	1% ↗
2017	80.9%	52.8%	—	→ 0	0% →

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.

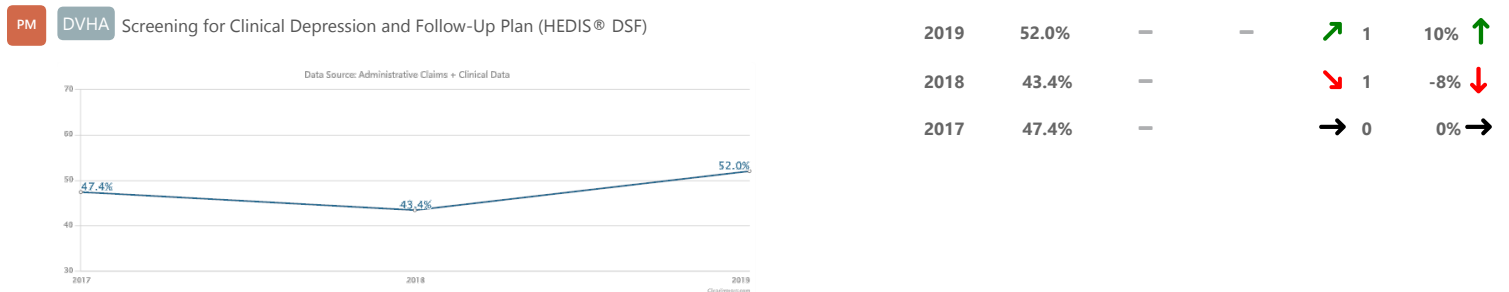


Notes on Methodology

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.



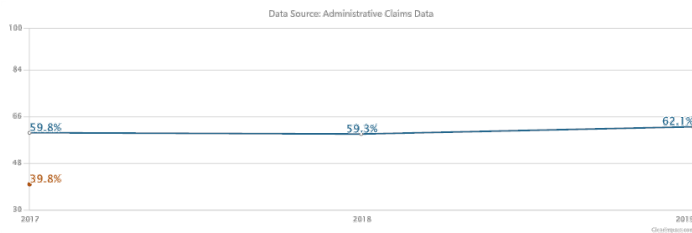
Notes on Methodology

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.





2018	59.3%	—	↘ 1	-1% ↘
2017	59.8%	39.8%	→ 0	0% →

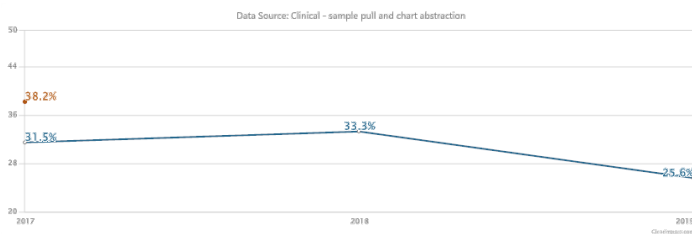
Notes on Methodology

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 DVHA 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% →

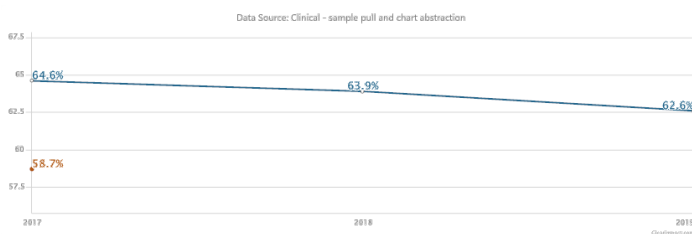
Notes on Methodology

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.

PM DVHA Hypertension: Controlling High Blood Pressure (HEDIS® CBP)



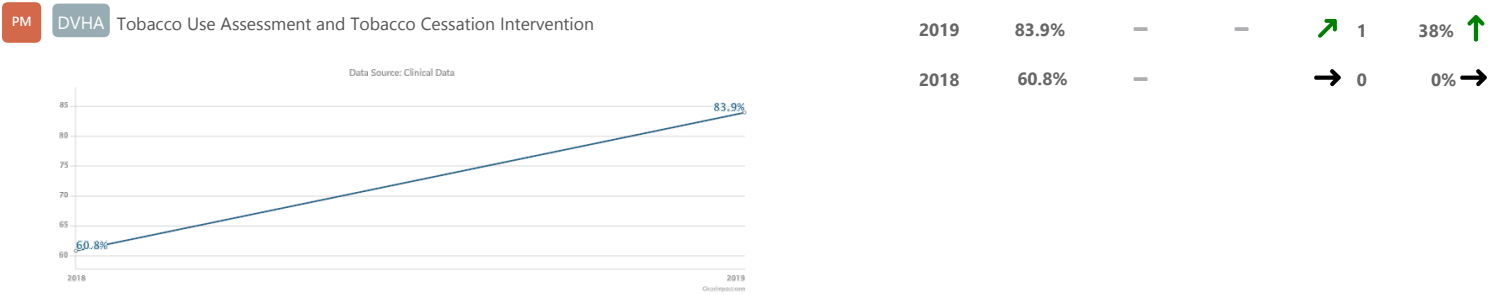
2019	62.6%	—	↘ 2	-3% ↘
2018	63.9%	—	↘ 1	-1% ↘
2017	64.6%	58.7%	→ 0	0% →

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.



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