State of Vermont
Agency of Human Services

Global Commitment to Health
11-W-00194/1

Annual Report
For Demonstration Year 2021
January 1, 2021 to December 31, 2021

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Attachments

I. Background and Introduction

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The Global Commitment to Health demonstration was amended May 22, 2020, to add an Emergency Preparedness and Response Attachment K in order to respond to the COVID-19 pandemic. Additionally, the demonstration was amended December 3, 2020, to modify the requirement, at 42 CFR 438.406(b)(4), to allow beneficiaries to provide evidence and testimony "in person" to appeal an adverse benefit determination during the COVID-19 public health emergency. The STCs were amended to grant flexibility during public health emergencies where, the Department of Vermont Health Access (DVHA) must provide enrollees reasonable opportunity, in writing, telephonically, and video or virtual communication, to present evidence and testimony and make legal factual arguments.

One of the Terms and Conditions of the Global Commitment Waiver requires the State to submit an annual report. This is the report for the fifteenth waiver year, demonstration year 2021, which ended on December 31, 2021. This report encompasses fourth-quarter updates for this demonstration year (10/1/21- 12/31/21).

II. Highlights and Accomplishments

- By the end of 2021, more than 222,999 Vermonters were enrolled in Vermont Health Connect (VHC) health plans either through the marketplace or directly through an insurance carrier. This enrollment consisted of 152,875 in Medicaid for Children and Adults (MCA) and 70,124 in Qualified Health Plans (QHPs), with the latter divided between 24,072 enrolled with VHC, 6,068 direct enrolled with their insurance carrier as individuals, and 39,984 enrolled with their small business employer.

- DVHA received a compliance score of 95.8% during this year's External Quality Review Organization (EQRO)Review of Compliance with Medicaid Managed Care Standards Audit.

- DVHA met 100 percent of the requirements in the Design stage, Steps 1 through 6, for its new Performance Improvement Project.

- During CY 2021, VCCI continued to be a resource in the state's response to the public health crisis with both licensed and non-licensed staff available for COVID vaccination in the roles of either vaccinator orintake/exit worker.

- Most of Vermont's primary care practices are now Blueprint-participating Patient-Centered Medical Homes, as 135 of Vermont's estimated 169 primary care practices are Blueprint-participating practices (and an estimated 148 employ more than one provider).

- Vermont continues to demonstrate increased access to medication-assisted treatment for Vermonters with opioid-use disorder. As of 2021-Q4 the average monthly number of Medicaid beneficiaries served by Office-Based Opioid Treatment (OBOT/Spoke) programs increased to 3,930.

- The Quality Team maintained a COVID-19 dashboard throughout the year to monitor the response to the pandemic: both the impact it has had on operations and the activities staff have engaged in.

- DAIL implemented the CBA minimum wage increase, as well as a 3% rate increase for HCBS services, impacting all consumer surrogate self-directed programs.

- The Medicaid Program continues to support Vermont's broader efforts to develop an integrated health care delivery system under an All-Payer Model through future program planning and implementation.

- ADAP's centralized intake and resource center, "VT Helplink: Alcohol and Drug Support Center" has received over 1,900 calls and 60,000 website visits since its launch.

- The 21st Century Cures Act required states to initiate Electronic Visit Verification (EVV) Systems for Personal Care Services (PCS). Program Integrity (PI) supported the project, which required a post-claim validation process. The EVV system successfully achieved CMS Certification.

III. Project Status

i. Enrollment Information and Member Month Reporting

The State of Vermont certifies the accuracy of the member month reporting. The enrollment report is produced on the 15th of every month. The member months are subject to revision throughout twelve months due to a beneficiary's change in enrollment status.

The table below contains Member Month Reporting for 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, *subject to revision*, with CY2020 and CY2019.

Demonstration Population	Medicaid Eligibility Groups	Total CY 2021	Total CY 2020	Total CY 2019	Change in Members (2020-2021)	Percent Change from 2020-2021	Change in Members (2019-2021)	Percent Change from 2019-2021
1, 4*, 5*	ABD - Non-Medicare - Adult	79,738	79,846	81,293	-108	-0.14%	-1,555	-1.91%
	SUD - IMD - ABD	71	106	149	-35	-33.02%	-78	-52.35%
	SMI - IMD - ABD	66	71		-5	-7.04%	66	
1	ABD - Non-Medicare - Child	19,037	20,060	23,855	-1,023	-5.10%	-4,818	-20.20%
1, 4*, 5*	ABD - Dual	265,553	260,532	257,866	5,021	1.93%	7,687	2.98%
	SUD - IMD - ABD Dual	121	136	158	-15	-11.03%	-37	-23.42%
	SMI - IMD - ABD Dual	26	12		14	116.67%	26	
2	Non ABD - Non-Medicare - Adult	153,446	112,654	104,150	40,792	36.21%	49,296	47.33%
	SUD - IMD - Non ABD	145	161	222	-16	-9.94%	-77	-34.68%
	SMI - IMD - Non ABD	24	26		-2	-7.69%	24	
2	Non ABD - Non-Medicare - Child	744,876	713,979	703,957	30,897	4.33%	40,919	5.81%
	Medicaid Expansion				0		0	
7	Global RX	77,560	78,064	77,498	-504	-0.65%	62	0.08%
8	Global RX	40,123	41,565	44,169	-1,442	-3.47%	-4,046	-9.16%
6	Moderate Needs	1,697	1,963	2,208	-266	-13.55%	-511	-23.14%
	New Adults						0	
3	New Adult without Child	545,896	453,635	423,150	92,261	20.34%	122,746	29.01%
	SUD - IMD New Adult w/o Child	971	1,157	1,352	-186	-16.08%	-381	-28.18%
	SMI - IMD New Adult w/o Child	203	211		-8	-3.79%	203	
3	New Adult with Child	310,660	267,004	233,294	43,656	16.35%	77,366	33.16%
	SUD - IMD New Adult with Child	220	209	259	11	5.26%	-39	-15.06%
	SMI - IMD New Adult with Child	53	44		9	20.45%	53	
	Total	**2,240,486**	**2,031,435**	**1,953,580**	**209,051**	**10.29%**	**286,906**	**14.69%**
	Average Members	**186,707**	**169,286**	**162,798**	**17,421**		**23,909**	

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ii. Global Commitment to Health Post Award Forum

A post award forum for the latest Global Commitment to Health 1115 waiver renewal will be held on Monday, April 25, 2022. This forum will be conducted following Special Terms & Condition 44 of the Global Commitment to Health 1115 Demonstration waiver. Public comments will be solicited and accepted at this forum and public notice of the forum was posted to the Global Commitment Register on March 25th, 2022. A summary of any public comment received will be included in the next Global Commitment quarterly report.

iii. Vermont Health Connect

Key updates:

- By the end of 2021, more than 222,999 Vermonters were enrolled in Vermont Health Connect (VHC) health plans either through the marketplace or directly through an insurance carrier. This enrollment consisted of 152,875 in Medicaid for Children and Adults (MCA) and 70,124 in Qualified Health Plans (QHPs), with the latter divided between 24,072 enrolled with VHC, 6,068 direct enrolled with their insurance carrier as individuals, and 39,984 enrolled with their small business employer.
- Vermont Health Connects ninth open enrollment period launched successfully on November 1, 2021. In October 2021, 99.5% of eligible QHP renewals were handled through a single, clean, automated process.
- Vermonters visited the online Plan Comparison Tool 77,019 times between January 1, 2021, and December 31, 2021. This accounts for 9% increase over the prior year. Please note that the annual number of visits was previously reported as 47,574 in 2020. Reevaluation of this figure found that the tool was visited 70,707 times in 2020.

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

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

By the end of 2021, more than 222,999 Vermonters were enrolled in Vermont Health Connect (VHC) health plans either through the marketplace or directly through an insurance carrier. This enrollment consisted of 152,875 in Medicaid for Children and Adults (MCA) and 70,124 in Qualified Health Plans (QHPs), with the latter divided between 24,072 enrolled with VHC, 6,068 direct enrolled with their insurance carrier as individuals, and 39,984 enrolled with their small business employer.

Medicaid Renewals

MCA renewals remained substantially impacted by the Public Health Emergency (PHE) in 2021. MCA redeterminations are processed only for cases that can be renewed ex parte. Cases that require a renewal application have coverage extended. Those new renewal dates, and other details about restarting manual renewals, will be finalized during planning for post-PHE activities.

A total of 41,034 households were successfully renewed via ex parte. Ex parte success rate for the calendar year of 2021 was 52%.

QHP Renewals

DVHA kicked off a series of meetings with its internal stakeholders and Maintenance and Operations vendor in early summer 2021 to prepare for the coming Open Enrollment. These meetings focused on testing, notices,

business, and transactional planning activities. QHP renewals presented major challenges for the marketplace in its early years. The last six years have gone increasingly well.

The first step in the renewal effort involves determining eligibility for the coming year's state and federal subsidies and enrolling beneficiaries in new comparable versions of their health and/or dental plans. In October 2021, this step was operated with a single, clean, automated run that took care of 99.5% of eligible cases. The 0.5% failure rate meant that only a small number of cases needed to be renewed by staff the following day, allowing all beneficiaries to have updated accounts and 2022 information before the start of Open Enrollment. This meant that they could log onto their online accounts on the first day of Open Enrollment, see their benefits and net premiums for the coming year, and select a new plan if they wanted to do so. Beneficiaries also had the option to call the Customer Support Center or meet with an In-Person Assister and go through the same steps if they did not want or were unable to use the online option.

The second step involves sending these files to the insurance carriers to ensure appropriate billing and effectuation. This is the first year in which QHP premiums are no longer being handled by our previous premium processor, WEX Health. In November 2021, this initial integration run was completed with 99.9% accuracy for the insurance carriers. DVHA and its partners collaborated to clean up and re-send the remaining cases well in advance of the new year.

The third step consists of a year-end business process that allows changes to be made on cases if the beneficiary reports changes in household or income information.

Altogether, performance on these three steps made the 2022 QHP renewal experience markedly different than the early years of the marketplace and left DVHA staff both optimistic and well-positioned to tackle other challenges.

Applying Online

Five years ago, DVHA set a goal for a continual 10% year-over-year increase in the adoption of self-service functionalities. Since that time, the actual growth in online applications has far exceeded the goal. The percentage of Vermonters applying for coverage online has more than tripled over the last five years, increasing from 16% of VHC applications in June 2016 to 65% in December 2021. The online option has the potential for improved customer experience as Vermonters can log in at their convenience. The increased automation can also allow state staff to spend less time processing applications and more time delivering on other priorities for Vermonters.

Change Requests

During the first few years of Vermont's health insurance marketplace, many beneficiary change requests took several weeks or months to complete. For 2018, DVHA set a target to complete 95% of requests within ten days and met this goal for beneficiaries managed in the Vermont Health Connect system. In the last quarter of 2021, 99% of requests were completed within ten days – exceeding this goal.

Integration and Reconciliation

DVHA set a goal of integrating enrollment files across its insurance carrier partners' systems with no more than a 1.0% error rate and achieved this goal for all months in 2021. DVHA and its partners also acted quickly to resolve errors that did arise. DVHA's goal was to ensure that no more than one-twentieth of one percent of cases sat in error status for more than ten days. That equates to an inventory of 15 or fewer errors open for more than ten days.

DVHA also executed monthly reconciliation of the marketplace's enrollment systems in 2021. Multiple enrollment systems (Vermont Health Connect, payment processing vendor WEX, and the three insurance carriers) create the risk of discrepancies for Medicaid and QHP members across systems. In 2019, DVHA set a target of addressing 100% of potential discrepancies each month. In 2021, DVHA met the goal every month with Blue Cross Blue Shield of Vermont (BCBSVT) and Northeast Delta Dental (NEDD). As a caveat, Medicaid buckets were put on hold, due to the public health emergency.

DVHA also honed its Medicaid reconciliation process in 2021. As previously mentioned, the public health emergency limited certain actions.

Customer Support Center

Callers to VHC's contracted Customer Support Center experienced prompt service throughout 2021 except in December. During this month, the percentage of phone calls answered within 24 seconds was 10% less than the 75% goal. There was an increase in call volumes during that time due to questions about the public health emergency and Open Enrollment. Typically, November and December have higher call volumes due to Open Enrollment. However, during the other eleven months of 2021, the percentage of phone calls answered within 24 seconds was 75% or higher.

The overall inbound call volume in 2021 was lower (24%) than the corresponding months in 2020. Additionally, there was a minimal increase in the percentage of calls that Maximus needed to escalate to DVHA in 2021. In 2021, 8.4% of all calls were transferred to DVHA compared to 8.2% being transferred in 2020.

DVHA's Tier 2 call center maintained prompt service on escalated calls through 2021. In 2017 DVHA set a goal of answering 90% of calls within five minutes. In 2021 they met that goal by 8%. In 2021, 98% of all calls transferred to DVHA were answered within five minutes.

In-person Assisters

DVHA is currently supported by 108 Assisters (98 Certified Application Counselors, 7 Navigators, and 3 Brokers), with 18 Assisters in training, working in 53 organizations including hospitals, clinics, and community-based organizations. Assister support is available in all of Vermont's 14 counties to help Vermonters enroll in health coverage through Vermont's health insurance marketplace.

The program has continued to leverage state-based technology to significantly improve data management and online education opportunities.

Many Vermont hospitals continued to provide ongoing in-person assistance throughout 2021.

Outreach & Education

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

Throughout 2021, DVHA leveraged its stakeholder network to communicate important changes, events, and opportunities for Vermonters.

DVHA hosted a series of live Virtual Town Hall Events for the public to learn about the increased financial help offered by the American Rescue Plan Act (ARPA). DVHA paired this with an online toolkit making the information accessible and shareable in multiple mediums including, social media, articles, flyers, and the recorded town hall events.

DVHA's educational work in advance of and during open enrollment focused on health insurance literacy and helping customers understand the total cost of insurance. VHC hosted several open enrollment events and partnered with stakeholder organizations in events aimed at helping customers and potential customers better understand health insurance terms, financial help, and how to interact with the VHC system.

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

DVHA continued to heavily promote usage of the Plan Comparison Tool in addition to other resources. The Plan Comparison Tool was visited over 6,300 more times in 2021 than in 2020. During the final quarter of 2021, which included most of the annual open enrollment period, the tool was visited more than 31,000 times. On par with annual results, the final quarter saw a 9% increase during this period.

Future Development

To make it easier for Vermonters to submit pay stubs and other personal documents to verify their eligibility for marketplace benefits, along with other health care and economic services programs, the State's Integrated Eligibility & Enrollment (IE&E) Program designed a technical solution that utilizes mobile and online technology to submit documents. This solution will improve the efficiency of the eligibility determination process and result in a better customer experience for Vermonters. In 2019 the pilot version went live and within Q3 2020 authentication was completed to allow this tool to be used by all Vermonters. Due to COVID-19, VHC has not been able to advertise this tool for use as verifications are on hold due to the Public Health Emergency

IV. Findings

i. External Quality Review

Key updates:

- DVHA received a compliance score of 95.8% during this year's EQRO Audit.
- DVHA received an overall PIP validation score of Met – with 100% of all applicable evaluation elements receiving a score of Met.
- All DVHA performance measures reported to AHS were determined to be reliable and valid.

Also, during this year, the state spent time preparing subject matter experts for the 2021 EQRO compliance audit. This included an orientation to the audit standards and the audit timeline. In addition, the EQRO, HSAG, performed a fully

remote version of their annual review of compliance with standards. Activities included a desk review of documents and conducting virtual interviews with key staff members. These annual audits follow a three-year cycle of standards. During this year's review, HSAG evaluated the degree to which DVHA complied with federal Medicaid managed care regulations and the associated AHS intergovernmental agreement (IGA) in three performance categories (i.e., standards). The three standards (i.e., Practice Guidelines, Quality Assessment and Performance Improvement Program, and Health Information Systems) included requirements found at CFR §438.236, §438.242, and §438.330.

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

Also, during this year, the EQRO conducted the Performance Measure Validation (PMV) activities remotely. The validation activities were conducted as outlined in the Centers for Medicare & Medicaid Services (CMS) publication, *EQR Protocol 2: Validation of Performance Measures Reported by the MCO: A Mandatory Protocol for External Quality Review (EQR), Version 2.0, September 1, 2012.* Information was collected using several methods, including interviews, virtual system demonstration, review of data output files, primary source verification, virtual observation of data processing, and review of data reports. The virtual activities are described as follows: opening session, claims and encounter data system, membership and enrollment data system and processes, provider data, data integration/reporting, primary source verification, closing summation conference, and next steps.

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

EQRO Audit Results:

During Q4 2021, the state-supported their External Quality Review Organization (EQRO), HSAG, as they prepared this year's set of reports for each of the mandatory EQR activities listed below.

Validation of the PIP

HSAG validated DVHA's PIP, Managing Hypertension. The PIP topic addresses the management and control of hypertension and is based on the HEDIS 2021 Controlling High Blood Pressure (CBP) measure and technical specifications. For this year, HSAG's validation evaluated the technical methods of the PIP (i.e., the PIP design). HSAG used CMS' PIP validation protocol as the methodology to validate the PIP. HSAG's validation assessed Steps I through VI. Based on its technical review, HSAG determined the overall methodological validity of the PIP. The topic selected by DVHA addressed CMS' requirements related to quality outcomes—specifically, the timeliness, and accessibility of care and services.

Overall, 100 percent of all applicable evaluation elements received a score of Met. The following subsections highlight HSAG's findings associated with the completed Design stage. DVHA met 100 percent of the requirements in the Design stage, Steps 1 through 6. DVHA selected a topic based on data analysis showing an opportunity for improvement and it is a topic of priority for the MCE. The goal of the project is to improve health outcomes for the targeted members served. DVHA's Aim statement set the focus of the PIP and the framework for data collection and analysis of results. DVHA clearly defined the eligible population and set up a performance indicator that was methodologically sound and aligned with the HEDIS specifications. DVHA's sampling and data collection processes were also found to be

methodologically sound. The PIP had not progressed to the Implementation or Outcomes stage during this validation cycle.

Validation of Performance Measures

HSAG validated rates for a set of performance measures selected by AHS for 2021 reporting. The validation also determined the extent to which the Medicaid-specific performance measures calculated by DVHA followed the HEDIS 2021 specifications. AHS identified the measurement period for all measures as calendar year (CY) 2020. AHS required that the measures be calculated according to the National Committee for Quality Assurance's (NCQA's) *Healthcare Effectiveness Data and Information Set (HEDIS®) 20, Volume 2, Technical Specifications for Health Plans*. Although most measures were reported using administrative data, DVHA was required to report three measures using both administrative and medical record data, known as the hybrid methodology, to ensure that the rates more accurately reflected the services provided to beneficiaries.

The validation findings confirmed that all rates were reportable. Excluding information-only measures, DVHA demonstrated strength, with 10 measure rates meeting or exceeding the 90th percentile. Of the 53 reportable rates with comparable benchmarks, four rates met or exceeded the 95th percentile.

DVHA performed at or above the 75th percentile for 23 of 53 (43.4 percent) measure rates appropriate for comparison to benchmarks, demonstrating strengths in sufficient follow-up care following ED visits for mental illness and AOD abuse dependence, appropriate ambulatory care (ED utilization), and engagement of AOD abuse or dependence treatment. Conversely, 24 of 53 rates (45.3 percent) fell below the 50th percentile, indicating efforts should be focused on ensuring adults have access to preventive and ambulatory care services, ED ambulatory care, and prenatal care. DVHA also should focus on educating members on the importance of preventive care screenings. Initiation of AOD abuse or dependence treatment and controlling high blood pressure are additional areas of focus for DVHA.

Monitoring Compliance with Standards

AHS requested that HSAG continue to review one of the three sets of federal Medicaid managed care standards during each EQR contract year. For EQR contract year 2021–2022, AHS requested that HSAG conduct a review of the federal Medicaid managed care standards described at 42 CFR §438.236 (Practice Guidelines), §438.242 (Health Information Systems), and §438.330 (QAPI Program), and the related AHS/DVHA IGA (i.e., contract) requirements. HSAG conducted the review consistent with CMS *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, October 2019. HSAG reviewed DVHA**'s** written operating policies and procedures, program plans, meeting minutes, numerous written reports, and other data and documentation related to DVHA**'s** performance during the review period. Reviewers also conducted staff interviews related to each of the eight standards to allow DVHA staff members to elaborate on the written information HSAG reviewed, assess the consistency of staff responses given during the interviews against the written documentation, and clarify any questions reviewers had following the document review.

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

HSAG reviewed DVHA's performance related to 24 elements across the three standards. Of the 24 elements, DVHA obtained a score of Met for 22 elements (91.6 percent) and a Partially Met score for two elements (8.3 percent). As a

result, DVHA obtained a total percentage-of compliance score across the 24 elements of 95.8 percent

Preparation of the External Quality Review Annual Technical Report

During Q4, 2021, the state supported HSAG as they compiled and analyzed all data from its 2021 EQR activities to develop the Annual Technical Report. This report summarizes findings on access to and quality of care including a description of how the data from all activities conducted per the Medicaid Managed Care regulations were aggregated and analyzed, and conclusions were drawn asto the quality and timeliness of, and access to the care furnished to its Medicaid beneficiaries.

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 year, the state calculated the monitoring metrics identified in the monitoring protocol. In addition to reviewing the technical specifications manual, the state considered which monitoring metrics may be useful to include in the formal waiver evaluation.

SMI/SED Monitoring Protocol

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

Components of the Monitoring Protocol must include 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. Where possible, baselines will be informed by state data, and targets will be benchmarked against performance in best practice settings.

The state received Monitoring Protocol Template approval from CMS this year.

During this year, the state also worked with CMS to identify a SMI Mid-Point Assessment due date. The original due date per the STCs was December 31, 2020. After considering the short time during which the SMI component has been authorized under the current demonstration and the desire to ensure several years of metrics from which to draw an analysis of trends, the due date for SMI/SED Mid-Point Assessment was extended to June 30, 2024.

SMI/SED Mid-Point Assessment

As mentioned above, the due date for SMI/SED Mid-Point Assessment was extended to June 30, 2024.

ii. Quality Assurance and Performance Improvement Activities

Key updates from QE122021/Annual:

- DVHA continued work on the formal PIP topic of managing hypertension and met 100% of the PIP protocol standards within its Annual Summary submission.
- The Quality Team maintained a COVID-19 dashboard throughout the year to monitor the response to the pandemic: both the impact it has had on operations and the activities staff have engaged in.
- Staff from DVHA's Quality, Oversight & Monitoring and Compliance units began developing a comprehensive risk assessment for Vermont's Medicaid program at the end of 2021.

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

PIHP Quality Committee

The Quality Committee remained active throughout 2021 and consists of representatives from all departments within AHS that serve the Medicaid population. The committee continues to structure its work around the federal managed care quality program guidelines and the triple aims of health care: improving the patient experience, improving the health of populations, and reducing the per capita cost of health care. During this period, the Quality Committee reviewed our performance for the measures within *DVHA's Global Commitment to Health* Core Measure Set. These measures are chosen to represent the breadth of services provided to Vermont Medicaid members and to act as an indicator of our overall Medicaid members' health. Most of these measures are validated each year by an external quality review (EQR) organization. As a result of the Quality Committee's review, a short list of potential quality improvement topics is identified.

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

Formal CMS Performance Improvement Project (PIP)

At the end of CY 2020 DVHA followed our standard operating procedure (SOP) for the selection of a new formal CMS PIP topic. Through that process, managing hypertension was chosen as our recommended study topic. The project team is assembled and has performed a root cause analysis exercise. Barriers were reviewed and prioritized by the project team. Intervention activities were chosen, and sub-groups were created to work on activities related to policy/reimbursement, provider and patient education and community resources. Sub-group

intervention planning, and implementation continued throughout CY 2021. DVHA met 100% of the PIP protocol standards within its Annual EQRO Summary submission.

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 CY 2021:

- 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 inpatient psychiatric hospital. 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 CY 2021, a Vermont team was accepted into and began participating in the CMS/Mathematica-sponsored learning collaborative focused on youth in foster care. DVHA's Quality Unit is 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.

Quality Measure Reporting

- CMS Medicaid Quality Core Measure Sets –
    - The Quality Unit and the Data Unit prepared the Adult and Child Quality Core Set rates that we plan to submit when the new CMS reporting platform is unrolled.

- Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey - the DVHA Quality Unit's Director of Quality Management coordinated the 2021 Consumer Assessment of Healthcare Providers and Systems (CAHPS) Children's and Adults Medicaid 5.0H survey. Of note this year, DVHA included the new AHRQ supplement questions regarding access to mental health care services. The contracted vendor, DataStat, Inc., distributed and collated the surveys according to AHRQ and NCQA protocols in the fall of 2021. The results of the surveys were delivered to DVHA in February 2022 and will be presented by the Director of Quality Management to the PIHP Quality Committee and DVHA's Management Team in March 2022.

- HEDIS measure production – In addition to producing administrative (claims-based) measures, the Clinical Services Team produced four (4) HEDIS hybrid measures in 2021. DVHA performs internal training and record abstraction for two of those hybrid measures, while our vendor produces the remaining two. DVHA's administrative and hybrid measure rates were validated by our EQRO. Individual measure results were confirmed, and areas of strength were highlighted, as were opportunities for improvement.

  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 resumed at the end of 2021.

Results Based Accountability (RBA)/Process Improvement

Results Based Accountability (RBA) scorecards are developed at DVHA for both internal and external performance management purposes. The use of this performance management framework and corresponding presentation tool has been spearheaded by the Agency's Central Office QI staff. The DVHA Quality Unit staff received training and has used this tool to create a *Global Commitment to Health* Core Measure scorecard, Experience of Care, and other performance budgeting scorecards. 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 2021 include the following initiatives: Adult Core Set of Health Care Quality Measures, Child Core Set of Health Care Quality Measures, and DVHA Dental Program.

The Clinical Services Team also maintained its Green Belt status during 2021 by attending development courses and participating in regular Agency-level meetings. Green Belt is the highest level of internal training offered through the State based on LEAN/RBA principles. The training is centered around process improvement and contributes to the Governor's initiative called PIVOT, or Program to Improve Vermont Outcomes Together.

COVID-19 Dashboard

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

Vermont Next Generation Medicaid ACO

In 2021 DVHA's Director of Quality Management received, reviewed and approved the quarterly VMNG ACO quality management reports. Quality and Clinical staff from both organizations met quarterly with a focus on quality measurement and ongoing QI efforts. A representative from the VMNG ACO is a standing member of DVHA's formal PIP, the topic ofwhich is managing hypertension.

Comprehensive Risk Assessment

Staff from DVHA's Quality, Oversight & Monitoring and Compliance units began developing a comprehensive risk assessment for Vermont's Medicaid program at the end of 2021. The purposes of the project are to:

- identify, analyze, prioritize and correct compliance risks across all departments and programs responsible for Medicaid service delivery;
- take advantage of opportunities to move beyond compliance and look for ways to improve the services we deliver to Vermonters.

The assessment entails collaboration with other Agency departments. In 2022, this project will also inform the DVHA Compliance Committee work plan and updates to DVHA's Intra-Governmental Agreements (IGAs).

AHS Performance Accountability Committee

The COVID-19 public health emergency continued to divert the AHS resources allocated to the Performance Accountability Committee. AHS will continue to assess the needs associated with the pandemic and reallocate resources when appropriate. It is hoped the committee can reconvene during the first quarter of next year.

Global Commitment (GC) Investment Review

AHS Departments are required to monitor and evaluate the performance of their investments on an ongoing basis and subject them to formal review according to a periodic schedule. Performance monitoring is accomplished via a quarterly and annual review of performance information contained in a web browser-based software application (Clear Impact Scorecard). The scorecard includes the following data elements: investment description (i.e., the goal 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 the most recent reporting period), and an interpretation of the results (i.e., comparing actual to expected rates using performance targets and/or benchmarks and to characterize trends or patterns in the data). During this year, DMH, DVHA, DCF, DOC, VDH, and DAIL highlighted the performance of a subset of their investments using the scorecard in one of the quarterly reports to CMS. During this most recent quarter, DVHA highlighted the performance of a subset of its investments. The Clear Impact Scorecards for these investments are 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).

The scorecard includes the following data elements: payment model description (i.e., the goal of the payment model, the activities being supported, and information on how they are provided), performance measures (i.e., the data being collected and analyzed to determine if the payment model is achieving its desired goal), results (performance measure rates for the most recent reporting period), and an interpretation of the results (i.e., comparing actual to expected rates using performance targets and/or benchmarks and to characterize trends or patterns in the data). During this year, scorecards for the following payment models were published in one of the quarterly reports to CMS: Dental Incentive Program, Children's Integrated Services, Vermont Medicaid Next Generation (VMNG) Accountable Care Organization (ACO), DMH, and all three Blueprint for Health payment models: Patient-Centered Medical Homes, Community Health Teams, and the Women's Health Initiative. During this most recent quarter, DCF highlighted the performance of its Children's Integrated Services 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 past year, the state resubmitted the Statewide Transition Plan (STP) in response to CMS feedback. On March 17, 2021, and June 4, 2021, CMS provided additional feedback. These changes did not necessitate another public comment period. The state subsequently addressed all issues and resubmitted an updated version of the STP on October 11, 2021. The technical changes made by the state were related to the following items: site-specific settings assessment process, provider self-assessment surveys, individual, private homes, validation of HCBS settings, remediation strategies, reverse integration strategies, non-disability specific settings, ongoing monitoring of settings, and heightened scrutiny. The state is awaiting CMS review – with the hopes of receiving final approval of its STP

during the next quarter.

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

During this year, the existing Global Commitment to Health demonstration evaluation contract with Pacific Health Policy Group, PHPG, to perform the evaluation activities outlined in the CMS-approved evaluation design. Activities included identifying additional data element requirements associated with performance measures used to support evaluation-related research questions and hypotheses, developing a standardized instrument to collect the required data elements, and supporting the calculation of the rates associated with the measures submitted via the tool to the evaluator.

GC Final Evaluation Design

The GC Final Evaluation Design is the state's plan for how it will accomplish the evaluation of their 1115 wavier. Specifically, the design identifies the state's hypotheses, evaluation questions, associated measures, and analytic methods. During the year, the state continued to work with its independent evaluator to incorporate the Serious Mental Illness (SMI) amendment provisions into the existing Global Commitment to Health demonstration evaluation design. Specifically, the document was revised to meet the requirements specified by the demonstration's Special Terms and Conditions (STCs), include CMS SMI monitoring and evaluation tools, and align with CMS SMI evaluation design guidance. During this year, the state submitted and received CMS approval for the final version of the GC Evaluation Design.

GC Interim Evaluation Report

The state's GC Interim Evaluation Report (IER) was submitted to CMS during Q4 2020. The report was produced by an independent evaluator using CMS tools and guidance to ensure alignment with the state's special terms and conditions and CMS expectations. Specifically, the draft interim evaluation report discusses evaluation progress and presents findings to date using hypotheses, evaluation questions, and measures identified in the CMS-approved evaluation design. During this year, the state worked with the independent evaluator to modify the IER to respond to the CMS feedback. A final version of the report was submitted and approved by CMS during the year.

During the quarter, the state continued to work with its independent evaluator, PHPG, to collect the necessary data to support the development of the Summative Evaluation Report. The report includes the information in the CMS-approved Evaluation Design. 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. The state will reach out to those supplying data for the evaluation during the next quarter.

Intra-Governmental Agreement (IGA) between AHS and DVHA

During this year, the AHS QIM submitted the 2021 Agency of Human Services (AHS) and the Department of Vermont Health Access (DVHA) IGA to CMS for approval. All requested changes to the 2020 agreement were incorporated into the 2021 version.

iii. Member and Provider Services

Key updates from QE122021:

- 2021 Summary
- Quarter 4 Updates

The Member and Provider Services (MPS) unit ensures Vermont Medicaid members have access to appropriate health care for their physical health, mental health, and dental health needs. Member and Provider Services also works to ensure Vermont Medicaid members are informed, member issues are addressed promptly, and members are satisfied with the answers received. The Customer Support Center is the point of initial contact for members' questions and concerns. If questions or concerns exist after talking with Customer Support, they come to Member and Provider Services staff for additional information/review. In addition to these responsibilities, the Member and Provider Services unit monitors the adequacy of the Vermont Medicaid network of providers and is responsible for the implementation of enrollment, screening, and revalidation of providers following Federal requirements.[1] All professionals providing services under the State plan, or under a waiver of the State plan, must be enrolled as participating providers with Vermont Medicaid.

2021 Summary

The Member and Provider Services (MPS) unit, like all units within the Department of Vermont Health Access, faced many challenges throughout 2021 due to the ongoing COVID-19 pandemic; however, staff and state partners effectively acted to ensure that standards were met, and services properly delivered.

COVID-19 Response

To support Vermont Medicaid-enrolled providers in providing health care services for Vermont Medicaid members in a safe and timely way, and to ensure Vermonters have access to necessary care, Vermont Medicaid instituted the following changes in 2021, and communicated the following in response to requests from providers for additional guidance:

- Although the State of Emergency was lifted for Vermont, the federal COVID-19 public health emergency and associated waivers are still in place. Prior authorizations that are currently waived continue to be waived under the federal public health emergency.
- In addition, as of June 1, 2021, prior authorizations were no longer required for imaging services, most durable medical equipment and supplies through the medical benefit and most dental services.

1 42 CFR § 455.410 and § 455.450.

- Prior authorizations are still required for services with the potential to cause imminent harm, services found on the Fee Schedule indicating a prior authorization is required, and for items not found on the Waived Prior Authorization List (updated October 28, 2021).
- For pharmacy prior authorization requirements, refer to the Preferred Drug List and Clinical Criteria.
    - Beginning January 1, 2021, the Department ceased extending existing pharmacy prior authorizations beyond their normal expiration date.

As of September 2021, Vermont Medicaid re-started provider enrollment and revalidation processes, allowing providers the flexibility to continue to waive these requirements if a provider indicates they need the flexibility to continue to offer timely access to care for Medicaid members per Vermont law. This approach has been well-received by providers to date, with many understanding that Vermont Medicaid could experience a significant backlog of provider enrollments once the public health emergency ends and the impact could adversely affect the level of service providers are accustomed to receiving. As a result, provider participation in enrollment and revalidation processes has been high.

The Member and Provider Services unit dedicated a lot of staff time to answering questions from Vermont Medicaid members and providers related to COVID-19 testing, obtaining test results, diagnosis, treatment, or vaccination services. While Vermont Medicaid's co-payment requirements before the public health emergency were limited to outpatient hospital services, dental services, and prescription medications unless Medicaid members were exempt, and Vermont Medicaid eliminated co-payments for outpatient hospital services and certain prescription medications (i.e., used to treat the symptoms of COVID-19) to ensure co-payments did not apply for those services, members and providers had a lot of questions, particularly during periods of rising COVID-19 case counts, and when at-home COVID-19 antigen testing began to be promoted as broadly available without any co-payment. Member and Provider Services provided frequently updated guidance for providers related to billing for testing, diagnosis, treatment, and vaccination services (including booster doses) to support providers in being reimbursed for these services when caring for Vermont Medicaid members. Finally, Member and Provider Services dedicated a lot of time to the Non-Emergency Medical Transportation program given the ongoing need for transportation to medical appointments and constantly changing COVID-19 community conditions, as well transportation for COVID-19 positive cases for isolation for Vermont's homeless population.

Implementation of New Electronic Data Interchange (EDI) Translator and Resolving Provider Issues Post-Implementation

The State of Vermont uses Electronic Data Interchange (EDI) standards to define the format of healthcare-related information (e.g., claims, payments, eligibility) when it is transferred from healthcare providers to their Trade Partners and the State of Vermont. The Sybase EDI Translator, a component of the Medicaid Management Information System, was no longer supported and needed to be replaced. Implementing the new Oxi EDI Translator was needed for adherence to the established EDI standards and to align with other states and payers. The new Oxi EDI Translator launched on May 9, 2021, and technical development continued throughout the summer of 2021 to stabilize the system and support providers who experienced issues submitting the 837 professional, institutional, and dental transactions. Migration was completed for Real-Time Eligibility and Claim status transactions in 2021.

Healthcare Effectiveness Data and Information Set (HEDIS): Supporting Participation in Medical Record Review for Maximum Retrieval

The Healthcare Effectiveness Data and Information Set (HEDIS) is a tool used by more than 90 percent of America's health plans to measure performance on important dimensions of care and service. Altogether, HEDIS consists of 90+ measures across 16 domains of care. Vermont Medicaid runs the full set of HEDIS administrative measures and in 2022 is producing 4 hybrid measures. Hybrid measures combine administrative claims data with data abstracted from member records during a medical record review. The 4 hybrid measures are:

- Controlling High Blood Pressure (CBP);
- Comprehensive Diabetes Care (CDC);
- Prenatal & Postpartum Care (PPC); and
- Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC).

Cotiviti is the medical record retrieval contractor for Vermont Medicaid and contacts providers to request medical records to support the Medical Record Review. Member and Provider Services staff, in cooperation with Quality Unit staff, worked with Vermont Medicaid providers to ensure participation and achieve

maximum medical records retrieval in 2021.

Interoperability and Patient Access: Implementing Daily Exchange for Improved Access

Interoperability & Patient Access is a project to implement multiple policies required to improve patients' access to their health information. Part of this project requires states to increase the exchange frequency of enrollee data for individuals dually eligible for Medicare and Medicaid, by requiring MMA1 and Buy-In2 file exchanges daily. Increasing these file exchanges from monthly to daily is expected to improve the dual eligible beneficiary experience by ensuring almost "real-time" access to appropriate programs and ensuring services are billed appropriately the first time, eliminating waste and burden. States are required to implement this daily exchange starting April 1, 2022. The requirement impacts current processes as the State works to implement this daily exchange for April 1, 2022.

Impacts for Vermont Medicaid:

- Buy-in accretions, deletions, and changes will be sent to CMS daily;
- Buy-in accretions, deletions, and changes will be almost immediate;
- Notices that result from Buy-in will be generated daily;
- Decrease in Best Available Evidence requests to Medicare Part D Plans;
- Decrease in access to care, pharmacy interventions; and
- Decrease in retro-billing.

Payment Error Rate Measurement (PERM): Audit Support for Provider Participation in Reducing Improper Payments

The Centers for Medicare and Medicaid Services (CMS) developed the Payment Error Rate Measurement (PERM) program in response to the Improper Payment Information Act. This act requires federal agencies to annually review programs they oversee that are susceptible to significant erroneous payments, estimate the number of improper payments, report those estimates to Congress, and submit a report of the actions the federal agency is taking to reduce erroneous expenditures. The Improper Payments Elimination and Recovery Act further enhanced the Improper Payment Information Act and aims to further reduce improper payments.

Member and Provider Services staff provided an update to providers on December 10. 2021, indicating that the Payment Error Rate Measurement (PERM) audit had commenced and claims from July 1, 2021, through June 30, 2022, will be sampled. Providers selected for the audit are required to submit all requested claim medical records and documentation. Providers have 30 days from the date of receipt of notice to submit required claims medical records and adjoining documentation to NCI Information Systems, Inc. If additional information is needed, providers have 14 days from the date of receipt of notice to send in the information. Member and Provider Services staff provide support for the Payment Error Rate Measurement audit.

Green Mountain Care Website Transition: Improving Website Experience for Members and the Public

To improve Vermont Medicaid members' experience with web-based information and to ensure the delivery of timely, accurate information for Medicaid members and the public, Member and Provider Services staff successfully transitioned all Green Mountain Care website information to the Department of Vermont Health Access website. As of December 6, 2021, all Member Resource information about Vermont Medicaid health insurance programs can be found by visiting the Department of Vermont Health Access website: https://dvha.vermont.gov/apply.

The website transition allows for a "no wrong door" approach to accessing Vermont Medicaid programmatic information while also reducing the number of websites or clicks that a visitor may have experienced with the previous multiple website approach.

V. Cost Containment Initiatives

i. Vermont Chronic Care Initiative (VCCI)

Key updates from QE122021:

- COVID-19 Response
- Report on Inpatient and Emergency Department utilization decreased post VCCI enrollment for CY 2020
- Collaboration with Department of Corrections
- CMS certified Care Management System - contract extension approved

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

During CY 2021, VCCI continued to be a resource in the state's response to the public health crisis with both licensed and non-licensed staff available for COVID vaccination in the roles of either vaccinator or intake/exit worker. In the spring of 2021, as eligibility for the vaccine expanded to include those with at-risk conditions, registered nurses helped with condition validation for unsure individuals, and strived toward the bias of inclusion, vs exclusion. Development of the workstream included working with sister departments for data about vaccine registration, with two medical providers for condition validation screening tools, and with vaccination sites for scheduling appointments. Staff appreciated being part of these states' efforts. The pandemic has certainly highlighted telehealth services as an important tool for both patients and healthcare providers, but lack of technology access can be a barrier for some. To increase 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 and the team continued to distribute both iPads and/or Wi-Fi extenders to beneficiaries with identified needs and with the ability to navigate the use of the technology. At end of this CY 2021, VCCI has been able to distribute technology to 63 unique beneficiaries.

The start of CY 21 continued with the backdrop of the pandemic, and face-to-face visits with beneficiaries remained suspended due to the then status of COVID-19, with virtual and phone as primary modes of interaction. (**Figure 1).** In June, VCCI field-based case managers resumed face-to-face visits with a small cohort of the population, following specific criteria as developed with our medical providers. Criteria included those with recent discharge from hospital for medical/psychiatric; those with cognitive/intellectual disabilities; those with barriers to phone/virtual; with AMS changes. Currently, in-person encounters remain limited, and we remain hopeful to continue to expand who we see in person and will continue to follow

public health guidance and work with our medical providers.

Figure 1. Beneficiary Face to Face Visits

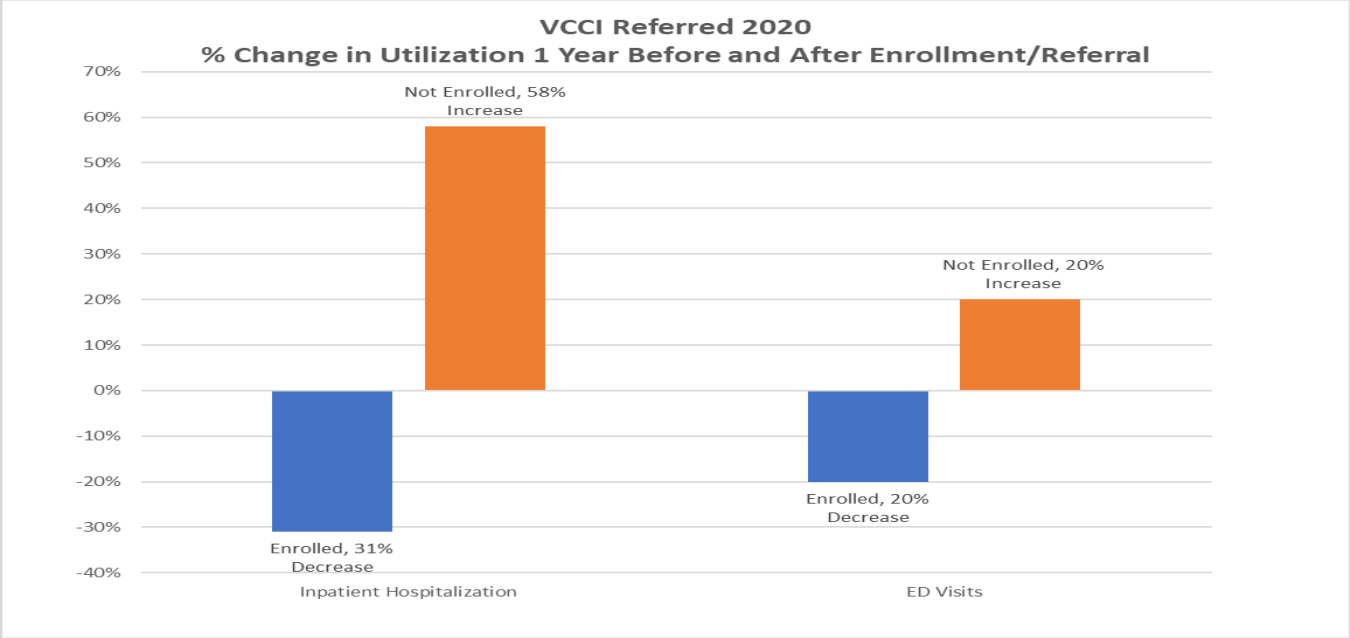
	SFY21						SFY22				
	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Oct-21	Nov-21	Dec-21
Measure	2/15/2021	3/15/2021	4/15/2021	5/15/2021	6/15/2021	7/15/2021	8/15/2021	9/15/2021	10/15/2021	11/15/2021	12/15/2021
% of VCCI enrolled members with a face to face visit during the month	1.58%	0.00%	0.00%	0.34%	0.33%	3.51%	20.96%	25.58%	23.15%	23.62%	23.66%

The pandemic has certainly impacted the healthcare communities and the necessary prioritization of their healthcare operations, responding to acute concerns of their healthcare communities. As the demands of the stabilization response to the pandemic have decreased, communities feel the impact of healthcare organizations being understaffed, burnt out +/or changes in staff roles. The medical home care coordinators with whom the VCCI case managers closely collaborate have either left their positions or been redeployed to other roles, by their organizations. Mental health, long-term care, and housing agencies have also not been immune to staffing challenges. This has directly affected the opportunity to convene care team meetings for beneficiaries with complex health and social needs, and VCCI looks forward to helping to support Vermont's efforts toward standardizing the delivery of the complex care model in the upcoming year.

VCCI aims to support appropriate transitions of care, recognizing that beneficiaries may be most vulnerable at this time. These transitions of care (TOC) may be commonly thought of with discharges from either a medical or psychiatric admission. In the Spring of this CY 21, VCCI cooperated with the Agency of Human Services and its Department of Corrections, in looking at how systems support the population leaving incarceration with reentry into their communities. Through TOC, beneficiaries identified receive an assessment, medication reconciliation, ensure provider follow-up, develop a personalized plan of care, and appropriate communication to providers involved in the care. Planning on workflow included staff from Department of Corrections (DOC) healthcare and field operations, their Chief Medical Officer, DOC's contracted health vendor, regional probation, and parole offices. This work remains in its plan/do phase, and yet some systems challenges have been identified: structured employment/training opportunities are lacking, and procurement of housing may be even more challenging for the population affiliated with DOC. Looking ahead to 2022, it is anticipated that as this work evolves, VCCI will be able to move through the study phase.

Prevention of readmissions remains a priority of the VCCI; helping members manage their transition from an inpatient stay, back to their communities. The VCCI receives referrals directly from inpatient/facility case managers, as well as from utilization reviews within Vermont Medicaid. The VCCI team strives to facilitate safe transitions of care including medication reconciliation and medical/behavioral health appointment follow-up appointments. CY 2020 report demonstrated a continued reduction in both IP and ED utilization in the VCCI intervened population. Beneficiaries enrolled in VCCI services had a 31% decrease in hospitalizations and a 20% decrease in emergency room visits, while beneficiaries not enrolled in VCCI services experiences increases in hospitalizations and emergency room visits. **(Figure 2).** VCCI intervention contributes to reduced burdens on the already taxed healthcare systems and cost savings.

Figure 2. Inpatient and ED Utilization



VCCI field-based case managers continued to serve beneficiaries throughout this past year and continued to meet in person with those most at risk while using virtual and telephonic platforms for those with more stable conditions and status. As seen below, VCCI provided care management services to 770 unique individuals in CY2021. The length of time and regularity of visits is dependent on the complexity and severity of the needs of the beneficiaries. VCCI case managers work with beneficiaries until the goals of their care plans are met.

Measure	1/1/2021	2/1/2021	3/1/2021	4/1/2021	5/1/2021	6/1/2021	7/1/2021	8/1/2021	9/1/2021	10/1/2021	11/1/2021	12/1/2021	Unduplicated Total
# new VCCI eligible members enrolled monthly in care management	45	55	53	40	52	39	31	52	43	39	42	39	515
Total Open Cases (including newly enrolled - above)	317	305	313	294	306	285	272	301	298	271	262	274	770

VCCI continued work started in 2019, of telephonic outreach and screening to beneficiaries new to the health plan. The new Medicaid screening tool poses questions related to access to health care and healthcare-related issues including Primary Care, Dental, housing, transportation, and food, with direct facilitation to those services desired by the beneficiary. The numbers new to the health plan began to ebb in the Spring of 2021, from what is thought to be higher numbers in mid-2020 due to pandemic-related changes in circumstances for individuals. (**Figure 3).** Timely access to some services desired by beneficiaries, continued to present as a challenge this past year - dental practices were closed to new patients, including VT Medicaid; were experiencing long wait times.

Figure 3. Number of New Medicaid Beneficiaries Screened

Received from data unit	1/15/2021	2/15/2021	3/15/2021	4/15/2021	5/15/2021	6/15/2021	7/15/2021	8/15/2021	9/15/2021
# of new to Medicaid members (Adults 18+)	764	523	367	379	525	473	453	607	472
# of new to Medicaid members reached	272	121	110	79	153	116	118	370	156
# of new to Medicaid members screened	246	214	157	163	237	208	174	254	226
% of new to Medicaid members screened	32.20%	40.92%	42.78%	43.01%	45.14%	43.97%	38.41%	41.85%	47.88%

Successful facilitation of access to PCP appointments to establish new patient care presented as a challenge this past year, with barriers including long wait times for new patient appointments, the requirement for former health records, and practices closed to new patients. These factors may have impacted the low data point for successful care establishment (**Figure 4).** Wait times for new patient appointments varied throughout the state; one practice was citing a 7-12 month wait time. Several practices require former health records before even scheduling a new patient appointment. Work is anticipated with state colleagues and VITL to provide reinforcement and training on Vermont's information exchange as an initial mechanism to obtain a health history and medication list while awaiting a more comprehensive health record set.

Figure 4. % Successful PCP Establishment

% of New to Medicaid members who accepted help with PCP establishment and who successfully established care with practice/medical home	
Measure	10/15/2021
# of "New to Medicaid" members who already had a PCP they saw regularly (of those screened)	463
# who didn't have a PCP and declined help	27
# who didn't have a PCP and accepted help	133
# of members who successfully established care	11
% of members who successfully established care	8.27%

The care management platform utilized by VCCI, eQ Health is CMS certified and DVHA has exercised the option to extend the contract with the vendor for one year, with an option of 2 one-year extensions. eQ Health provides evidenced-based surveys, personalized plans of care, clinical trackers, both member, and provider correspondence, receives claims/data feeds from SOV, and provides the platform for case managers to document their case notes. This past year, 3 clinical assessments were updated - Heart Failure, Asthma, and Diabetes- all reviewed by eQ Health's medical team, then tested and approved by VCCI. The system contains clinical information via an interface with Vermont's HIE vendor, VITL, and alerts the case manager to ED or IP utilization, enhancing case managers' ability to formulate and put into motion a truly patient-centered, clinically focused plan of care. This CY 2021, a data use agreement was completed with the state's ACO, and VCCI assessments and screenings were shared with the goal of the ACO completing data analysis on ACO attributed member responses to sdoh status questions. Although able to cite the benefit of the screening answers being member-driven/responded, the ACO opted not to pursue any future agreements based on the small cohort numbers.

This CY 2021, VCCI continued to adapt in response to the pandemic, while continuing to serve at-risk beneficiaries and identified needs ranging from high ED utilization, hospital discharges without access to outpatient community supports, the prevalence of destabilization of mental health conditions, prevalence of substance use, housing insecure and transient. At the start of 2021, VCCI staffing was at 19 with 3 vacancies; and ended with 18 staff and 4 vacancies, remaining relatively stable.

Goals CY 2022:

1. Increase in the resumption of face-to-face visits with beneficiaries enrolled in VCCI.

2. Increase the number of members who successfully establish primary care with VCCI intervention.
3. Improve and clarify referrals processes throughout and within the 6 departments of the AHS, and develop further clarified integration of the Agency of Human Services Field Services Division and VCCI.
4. Work with our state systems to develop and provide training on evidence-based practices and the complex care models to help create efficiencies and effectiveness in community-based care.

ii. Behavioral Health

Key updates from QE122021:

- Inpatient psychiatric placements
- Applied Behavior Analysis

The Behavioral Health Team is responsible for concurrent review and authorization of inpatient psychiatric and detoxification services for Medicaid primary members. Team members work closely with discharge planners at inpatient facilities to ensure timely and appropriate discharge plans. DVHA collaborates with Agency partners to support the coordination of care. The team refers members to VCCI services and helps ensure continuity of care for members already enrolled with VCCI.

As of March 1, 2021, Vermont Medicaid modified the reimbursement methodology for inpatient services delivered by the Brattleboro Retreat (the Retreat). Before 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 several 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. A clinical review of all available data supports the continued review of current enrollees' need to remain in the program. 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 the enrollment of potential new members. Team Care program members are also referred to VCCI when appropriate. An outreach plan was created and has been implemented which has included connecting with other AHS departments and posting advisories for providers. There have been minimal external referrals to the program. The lack of referrals may demonstrate the success of the Vermont Prescription Monitoring System (VPMS) and new opioid prescribing standards and practices associated with VPMS.

Team members participate in the State Interagency Team and the Youth Service System Enhancement Council (a collaborative with ADAP, DMH, VCRIP, Vocation Rehabilitation, DCF, and more). Team members are active in ensuring that members with multi-department involvement are getting appropriate services delivered most efficiently. This is accomplished through participation in state interagency team meetings, the Mobile Crisis Response Initiative, by participating in weekly case reviews, and the 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.

In 2019, DVHA implemented an alternative payment model for Applied Behavior Analysis (ABA) services, characterized by a tiered monthly case rate, with tier payments depending on the intensity of services. In 2021, DVHA changed the timing of the tier submissions and payments from prospective submissions and payments to post-service delivery submissions and payments after receiving feedback from providers regarding the difficulty of prospectively determining treatment hours for the subsequent month. Providers received their first post- service delivery ABA payment in August for services rendered in July. An important goal of this program is to increase access to direct services for Medicaid members by giving providers the flexibility to innovate and to use staff more efficiently. To assess progress toward this and other goals, DVHA has established a monitoring framework that includes measures of access, utilization, service intensity, quality, and cost. Early data for some of these measures shows promising results. For example, since the implementation of the payment reform program, a higher proportion of services are in the form of direct services to members rather than assessments and parent education. In addition, total hours of service have been increasing year over year (despite the impacts of the COVID-19 public health emergency). The average monthly census has increased since the implementation of the payment model and has held fairly steady during the past three years, again despite the impacts of COVID-19. The intensity of service has also increased; there have been substantial increases each year in the average service hours per member per month.

Before the COVID-19 pandemic, the DVHA ABA team was conducting in-person site visits/audits with Vermont Medicaid enrolled ABA providers who were providing services to Vermont Medicaid members. The purpose of these visits/audits is to assure that members are receiving quality care, that providers are accurately reimbursed for provided services, assuring that required documentation is included in members' charts and that clinical documentation aligns with ABA Policy and Clinical Practice Guideline standards. Site visits/audits resumed in January 2021 are completed in a virtual format due to social distancing restrictions. This process entails a virtual tour of the provider's Electronic Health Records system, and the provider electronically submits clinical documentation to be reviewed independently by the DVHA ABA team. In 2021 the Autism Specialist conducted site visits for seventeen ABA agencies/providers who are enrolled with VT Medicaid and provide ABA services to Medicaid members.

iii. Mental Health System of Care

Key updates from QE122021:

- Updates on the continued impact of the Covid-19 pandemic on the mental health system of care
- Integrating Family Services Activity
- Update on Mental Health Integration Council

System Overview

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

- Community Rehabilitation and Treatment (CRT) services for adults with severe mental illness;
- Adult Outpatient for adults who are experiencing emotional or behavioral distress 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.

Vermonters in need of psychiatric hospitalization are provided treatment at either the state-run inpatient facility, the Vermont Psychiatric Care Hospital (VPCH), or one of six Designated Hospitals throughout the state. The capacity is founded upon the balance between hospital admissions and discharges for people with acute mental health conditions. When this balance is unequal, which is to say, when more admissions than discharges occur, hospitalization capacity is reduced over time.

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.

With the onset of the Coronavirus Disease 2019 (Covid-19) pandemic in early 2020, Vermont's health care system has adapted to shifts in public health guidelines and workforce capacity fluctuation to ensure a safe response for all Vermonters following the Governor's executive orders put in place March 2020. Providers managed staffing shortages as the workforce juggled caring for children unexpectedly home from school, managing shifting domestic responsibilities or financial stressors all while adapting to new workplace environments. The result has been reduced capacity across the system of care. Capacity continues to shift in response to workforce challenges and any changes in COVID-19 guidelines.

Enhancements of the Mental Health System of Care:

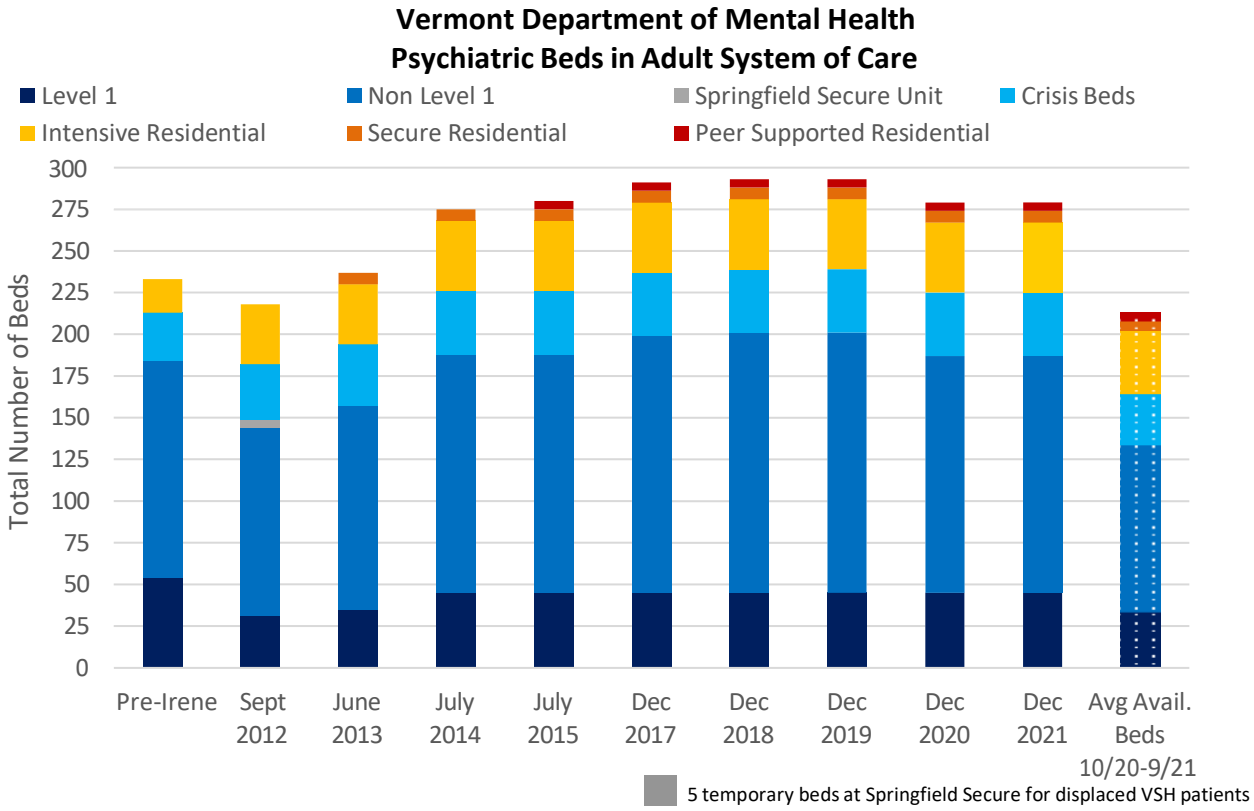
Hospital Services

Level one care is for individuals who require the most intensive level of clinical support and services within the system. General inpatient units are for individuals facing significant mental health challenges and struggling to manage the symptoms to a degree that requires consistent, intensive clinical care and support to

ensure their safety and wellbeing in daily living. Currently, there are 57 Level 1 beds and a total of 177 adult psychiatric inpatient beds across the system of care. During the Covid-19 pandemic, several beds closed due to low staffing, converting double occupancy rooms to single occupancy, the need for quarantine spaces, and an initial decrease in individuals presenting with a need for a higher level of care.

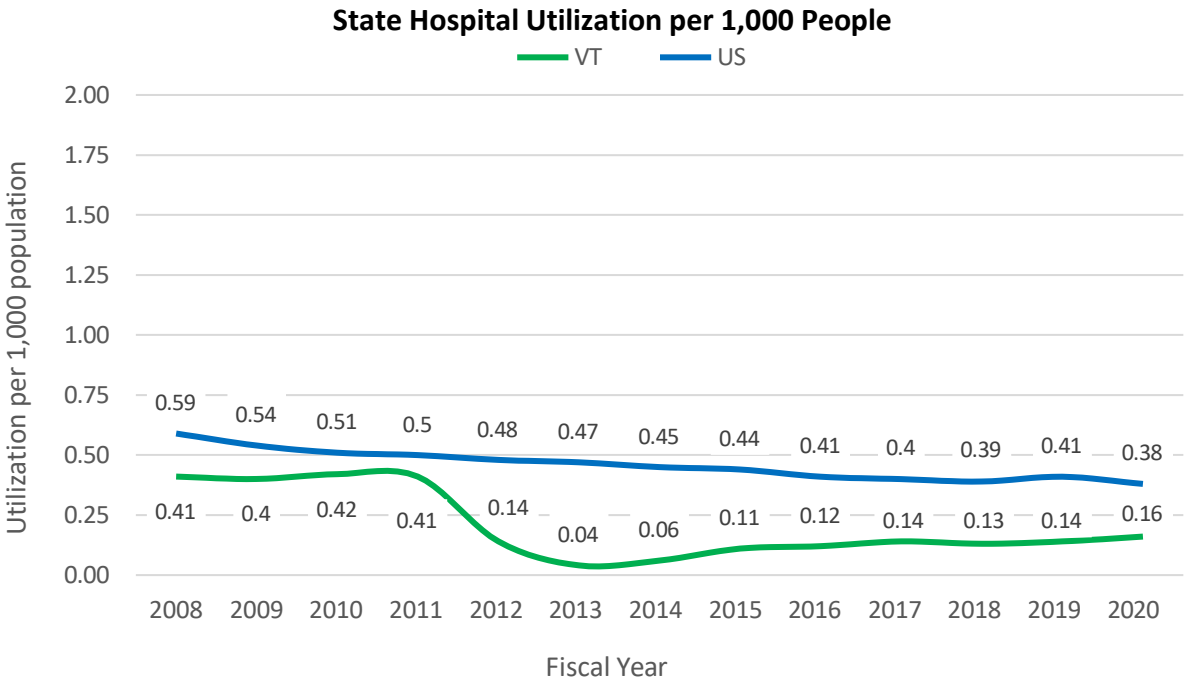
In addition to this temporary loss of adult beds, the Covid-19 pandemic had a ripple effect across the adult psychiatric system of care during this same period. In the below table, a bar illustrating Average Available Beds reflects a system-wide impact across inpatient and community-based crisis beds 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 2020 is the most recent data available.

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



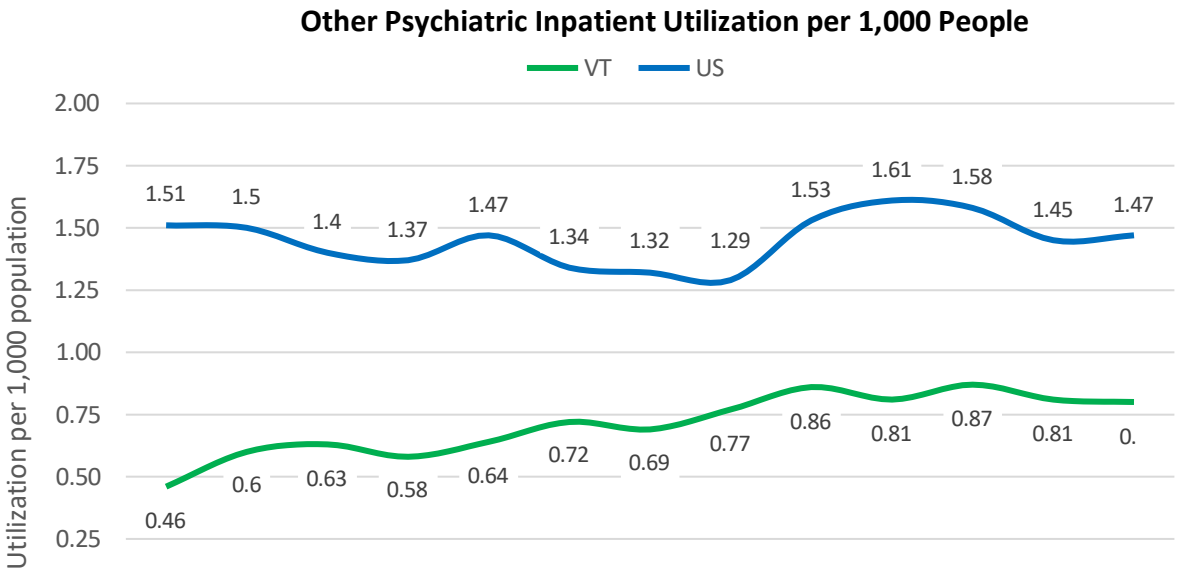
Based on URS data provided by the US States and Territories per annual reporting guidelines for fiscal years 2008 - 2020.

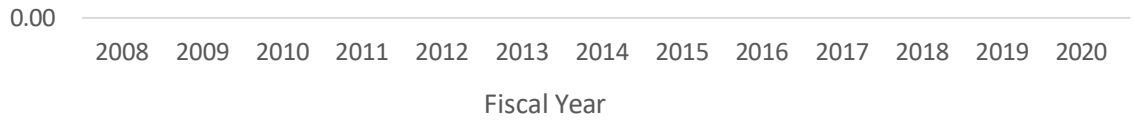
The national rate of state hospital utilization continues to decline year over year. Vermont Psychiatric Care Hospital opened in FY 2015 with 25 beds and Vermont's rate of inpatient utilization continues to be lower than the national average in the United States. The significant decrease from FY 2011 to FY 2012 represents the closure of Vermont State Hospital due to flooding from Tropical Storm Irene in August 2011. The Vermont hospital utilization data is showing a slowly progressing upward trend since 2012.

Vermont is one of a handful of states that only has one state hospital. Nationally, the number of state hospital beds and residents at the end of the year has been steadily decreasing. DMH will be paying close attention to these rates as there is anticipation and evidence already that this pandemic and the social isolation that has occurred because of it will increase the need for mental health treatment and support.

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

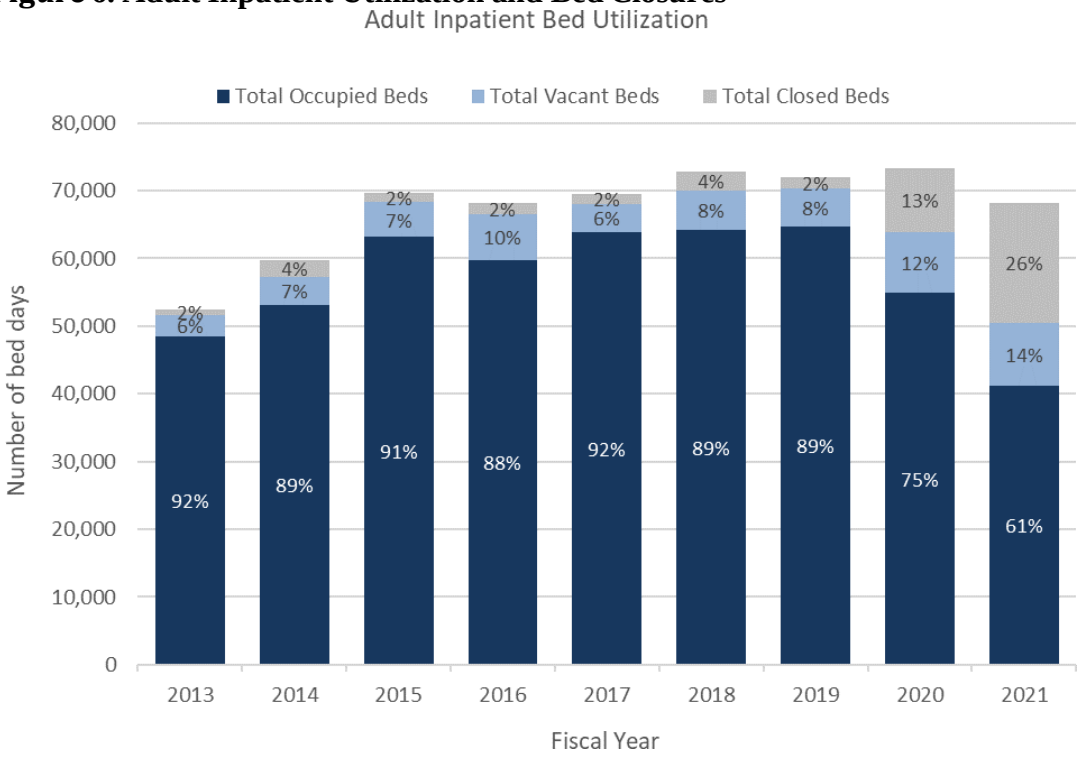
Figure 5. Other Psychiatric Hospital Utilization per 1,000 people (in Vermont and the United States)





Based on URS data provided by the US States and Territories per annual reporting guidelines for fiscal years 2008 - 2020.

Figure 6. Adult Inpatient Utilization and Bed Closures



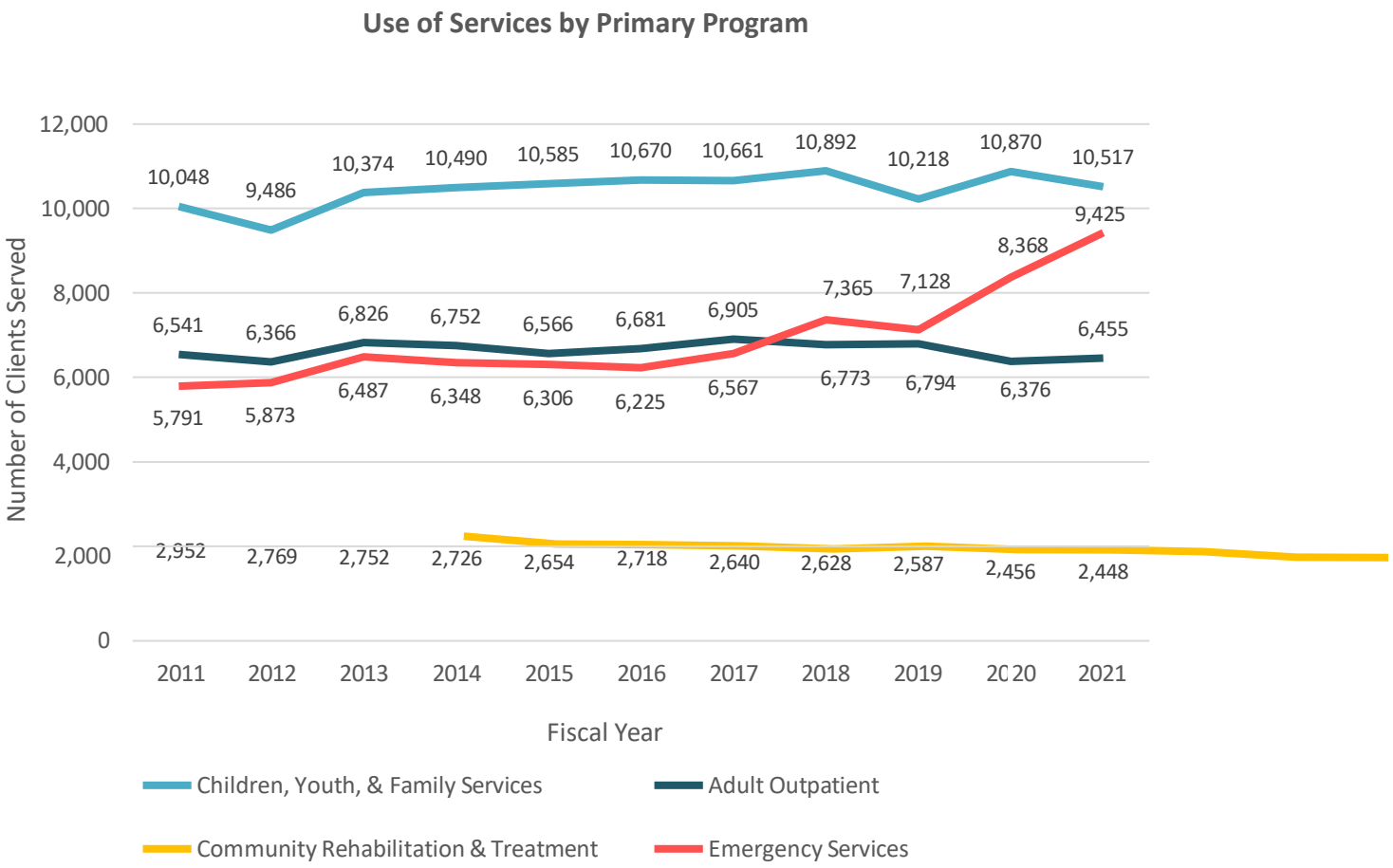
The Adult Inpatient Utilization and Bed Closures chart depicts the total bed day capacity across the Vermont Designated Hospital system through FY 2021. The total bed day availability across the system had remained relatively constant in 2018 and 2019 with bed day utilization decreasing 14% from 2019 to 2020. The impact of the Covid-19 pandemic has contributed to the 6% increase in bed vacancies and a 24% increase in beds closed through FY 2021. Over these nine years, 2021 has seen the lowest level of adult inpatient bed utilization.

Community Services

- Extensive provider stabilization packages are continuing to be developed and provided to community service providers to assist with the stabilization of their programming in response to the Covid-19 pandemic and ensuing staffing crisis
- Established 24/7 in-state coverage for the National Suicide Prevention Lifeline. Continued planning for the shift to a 3-digit 988 suicide prevention number to access the Lifeline for the July 2022 nationwide start date
- Established Community Outreach Team in Washington County (Collaboration with Public Safety)
- The Mobile Crisis Response team pilot began in Rutland County
- Expansion of peer-supported warmline hours to 24/7
- Increased capacity within CRT and peer programs to provide community support, outreach, and crisis response continues to develop
- Broad utilization of non-categorical case management services for Adult Outpatient and Emergency Services programs
- Increased capacity to provide mobile crisis responses to those needing screening and intervention in the community
- Increased and additional training for Team Two collaboration between law enforcement and mental health responders
- Additional availability of soft restraints for law enforcement transports for involuntary mental health hospitalizations
- Resources to assist individuals in finding and keeping stable housing

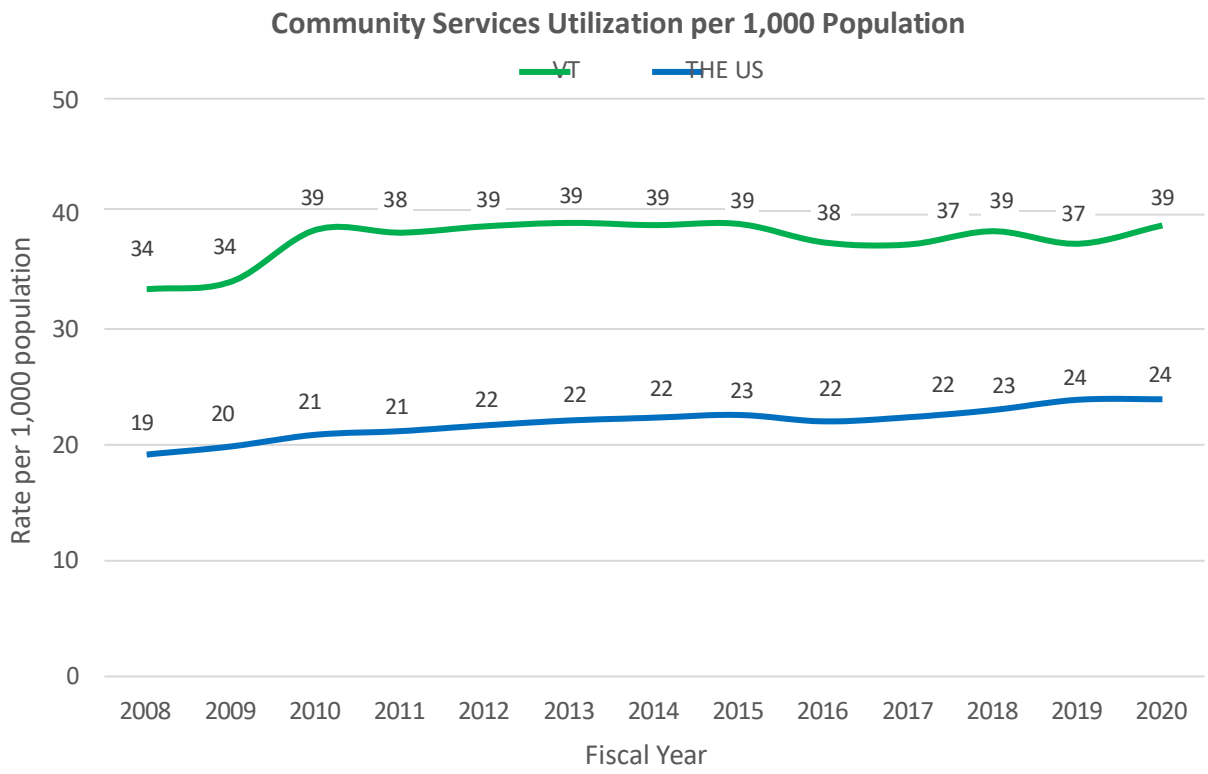
Enhanced community services funding provided by the legislature through increased appropriations to key mental health programs in the community over the last several years has helped, but staff recruitment and retention necessary to meet and expand these service capacities continues to be a struggle. The payment reform initiative beginning 1/1/2019 has also been an effort to reduce barriers to access and promote more "needs" driven service delivery that can be more responsive to individuals seeking mental health services. The new payment reform methodology, more flexible service delivery, and value-based incentive payment framework focused on quality and outcomes support a more streamlined approach to adult program access and the service capacity available in each DA catchment area.

Figure 7. Designated Agency Volume by Program



The highest number of persons served by programs offered by the Designated Agencies (DAs) continues to be in services for children, youth, and families. The 6% decrease noted in 2019 appears to have self-corrected and closely approximates the previous average utilization. Emergency Services programs continued an upward trend overall in 2021 which may reflect the increased support needs associated with the impacts of Covid-19. In FY 2021, Adult Outpatient programs saw a slight increase in utilization while the CRT programs continued a decline that started in FY 2016. FY 2021 has shown a more reflective impact of the Covid-19 pandemic on the system of care, specifically the impacts on the use of services by programs.

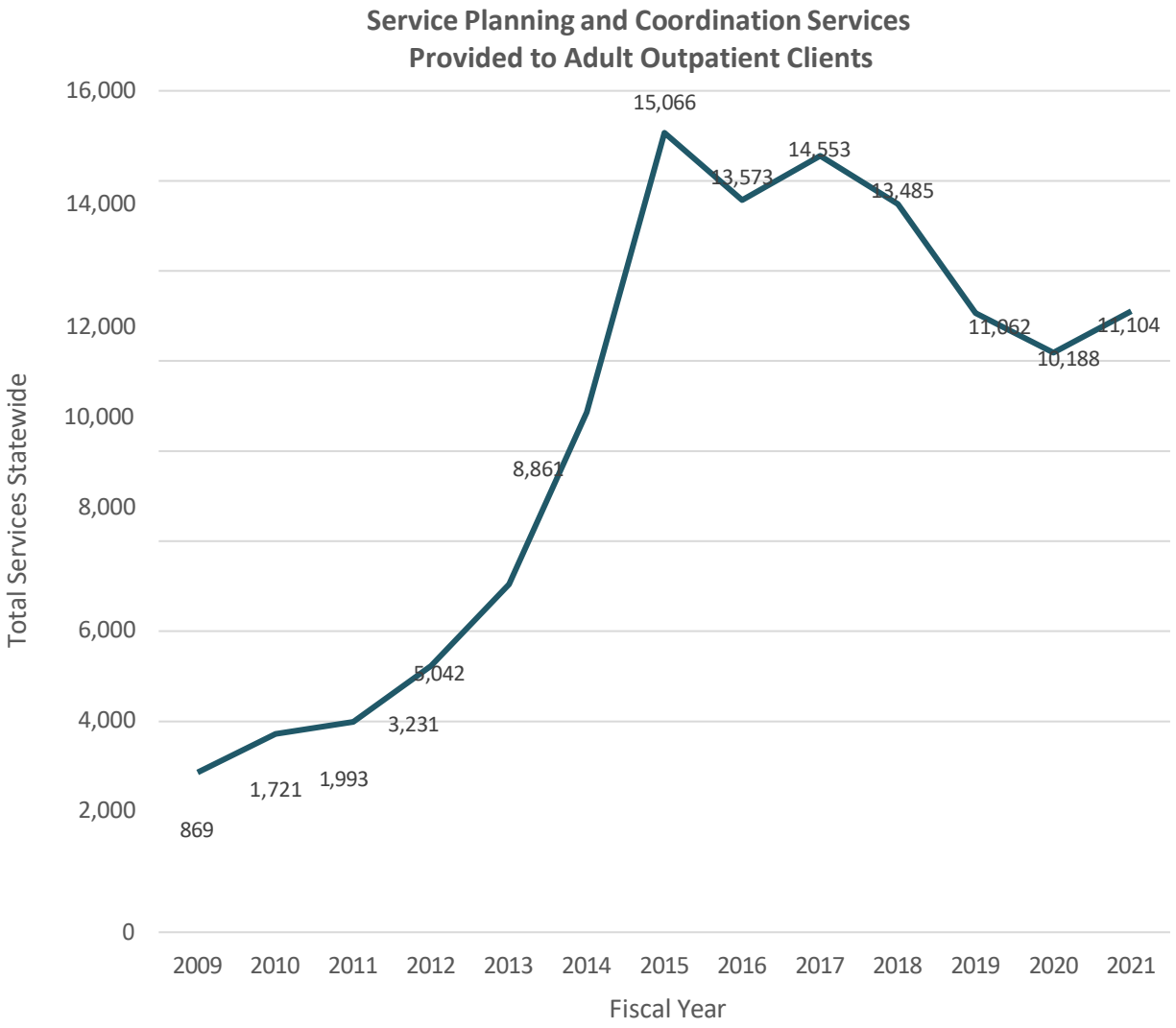
Figure 8. Community Utilization per 1,000 Populations



Based on URS data provided by the US States and Territories per annual reporting guidelines for fiscal years 2008 - 2020.

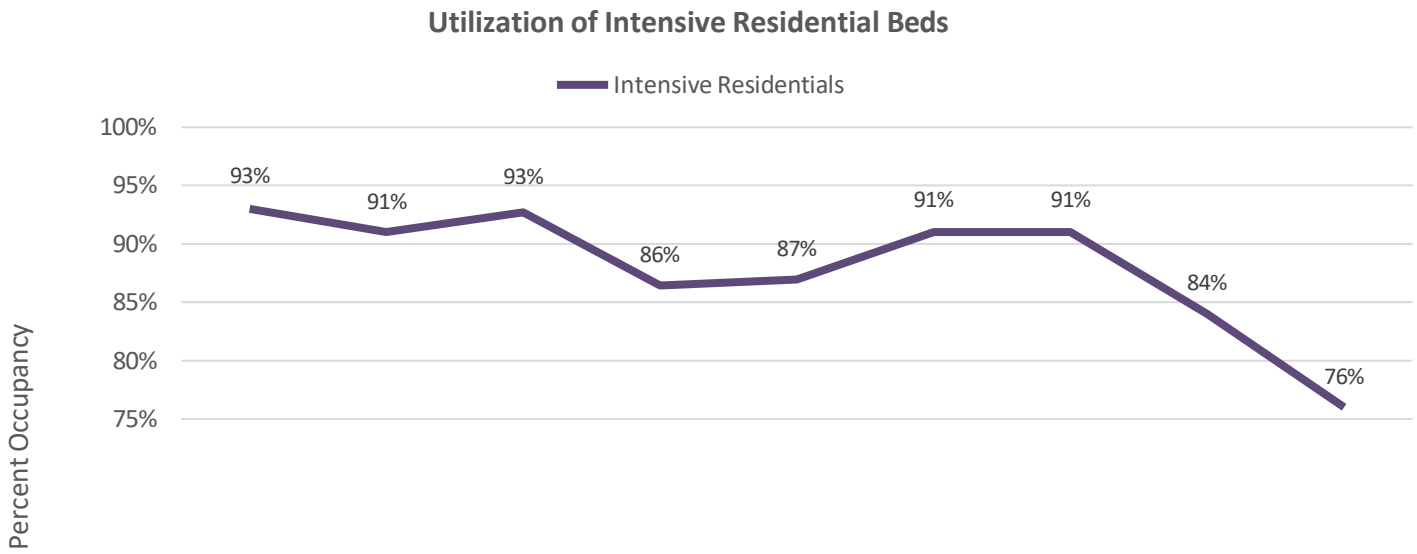
The Vermont community mental health system serves nearly 40 out of every 1,000 Vermonters, which is higher than the national utilization rate. The most recent national data available through FY 2020 shows that Vermont has a strong and consistent record of service delivery in community-based programs. 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 as necessary to support them. For many who have a chronic illness, this is more challenging, as they continuously require a higher level of service needs within the system. Others 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.

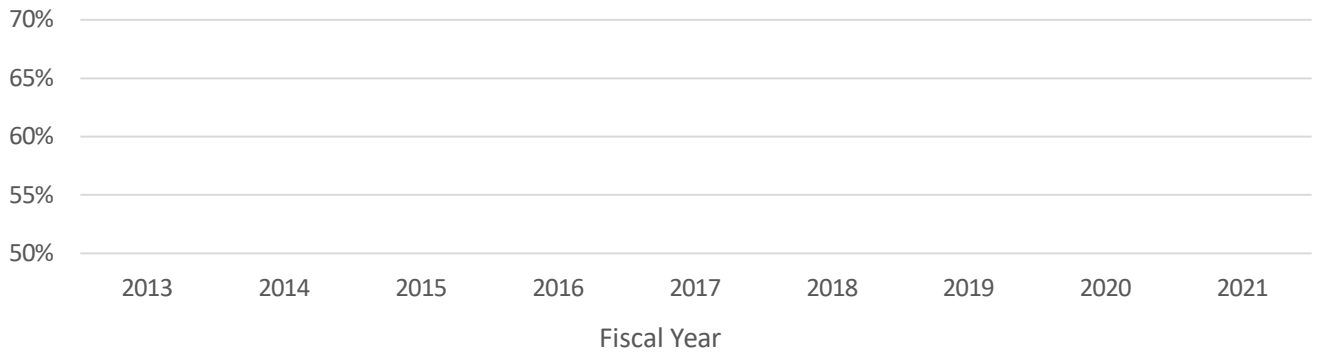
Figure 9. Service Delivery: Planning and Coordination



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 CRT services through FY 2015. Levels remain elevated for this population from FY 2016 through FY 2018, but the data shows a decline in recent years. It is 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 continues to support flexible service delivery including case management services when needed.

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. FY 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- to an 18-month time frame for residents.

2021 saw the greatest decrease in utilization over the nine years to 76%. The influence of the Covid-19 pandemic 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 2021 data appear evident throughout this reporting period.

Performance and Reporting

- Along with AHS, DMH has adopted the Results-Based Accountability (RBA) framework for assessing the performance of providers via grants and contracts
- DMH utilizes performance scorecards to assess the performance of value-based payment measures focusing on access to and quality of care
- DMH created a payment reform service utilization scorecard that can be accessed by the DAs to ensure transparent accounting of service reporting
- Exploration of visualization tools to create more responsive reporting
- Participation in the development of the AHS Community profiles
- DMH has several public RBA scorecards containing data and performance measures related to the system of care

Regulation and Guidance

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

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

Payment Reform

DMH continues to work on payment reform, building off the Medicaid Pathways work and aligning necessary changes in the provider system with the All-Payer Model. The Department has created a case rate for children/youth mental health services, and a case rate for adult mental health services. The goal of this work is to move toward a simple, 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 toward full integration.

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 the consolidation of over 30 state and federal funding streams into one unified whole funding stream through one AHS Provider Grant agreement. The State created an annual aggregate spending cap for two providers in Addison County (the Designated Agency and the Parent Child Center) and one in Franklin/Grand Isle (this provider is both the Designated Agency and Parent Child Center). This implementation has created a seamless system of care to ensure no duplication of services for children and families.

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

Both IFS regions continue to utilize the Child and Adolescent Needs and Strengths (CANS) to look at the needs and strengths of the children they are serving. The agencies are using this progress monitoring tool to track progress over time. They are showing that in the majority of situations children and youth are increasing in their strengths and decreasing needs.

During the Covid-19 pandemic, as has been true with all mental health agencies, there has been additional stress on providers and a strong commitment to providing services and support in new and creative ways. Both IFS regions, have significantly increased their offering of telehealth, treatment, and interventions in outdoor spaces and providing services to students whether they are doing online or in-school learning.

Vision 2030

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

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

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

Mental Health Integration Council

Following the plan submission to the legislature in January 2020, DMH was anticipating convening a Mental Health Integration Council in the fall of 2020, however, the demands of the Covid-19 pandemic on Vermont's health systems delayed this work until July 2021. Since that time the council has successfully met monthly, and their work has focused on identifying areas of opportunity to integrate mental health into a holistic health care system. National and state experts have engaged in panel discussions and presentations with the council to explore holistic models of care and identify actions the state can take to meet the intended goal.

Additionally, four subcommittees have been established to take action on the following targeted subspecialties:

- Integration of Primary Care
- Integration of Pediatric Care
- Integration of Funding & Alignment of Performance Measures
- Integration of Workforce Development

iv. Blueprint for Health

Key updates from QE 12/2021:

- The majority of Vermont's primary care practices are now Blueprint-participating Patient-Centered Medical Homes, as 135 of Vermont's estimated 169 primary care practices are Blueprint-participating practices (and an estimated 148 employ more than one provider).
- Vermont continues to demonstrate increased access to medication-assisted treatment for Vermonters with opioid-use disorder. As of 2021-Q4 the average monthly number of Medicaid beneficiaries served by Office-Based Opioid Treatment (OBOT/Spoke) programs increased to 3,930.
- Vermont Continues to increase access to enhanced preventative health, psychosocial screening, and comprehensive family planning services, as evidenced by the commitment of 46 practices and all 12 Planned Parenthood sites to participate in the Women's Health Initiative as of October 2021.

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. Vermont's Patient-centered Medical Home (PCMH) model supports care for all patients that is patient-centered, team-based, comprehensive, coordinated, accessible, and focused on quality and safety, regardless of insurance type. The model is based on the National Committee for Quality Assurance (NCQA) criteria, which are required for Blueprint participation and have been met by almost all of Vermont's primary care practices. The model also promotes care that is provided when and where the patient needs it, and in a way that the patient understands. 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.

PCMHs in Vermont are supported by Community Health Teams (CHTs)**,** which are multi-disciplinary teams of dedicated health professionals in each of the state's HSAs. The CHTs support primary care providers and their patients with case management, care coordination, and screening for mental health needs, substance use, and social determinants of health (SDOH). They discuss and support patient-centered goals while addressing whole-person health with effective interventions that support mental and physical wellbeing. They also provide additional opportunities to support improving chronic conditions.

Blueprint Program Managers provide leadership in each community to coordinate healthcare delivery system improvement efforts. While they are employed by the hospital or FQHC in the HSA, they help organize, lead, and staff collaborative initiatives with the ACO, local human service agencies, health departments, specialty care providers, mental health providers, and primary care providers to facilitate the integration of services. They are responsible for contacting all primary care practices within their HSA to encourage, engage, and support practice participation in the Blueprint and other health system reform activities. Additionally, Program Managers are responsible for administering funds and staffing plans for the local CHTs on behalf of all participating payers, including core CHT, Spoke staff, and WHI staff. Program Managers set up the systems through which integrated services can be delivered in the community.

In addition to Program Managers, the Blueprint supports participating practices with a quality improvement coach, called a Quality Improvement (QI) Facilitator. QI Facilitators support practices with Blueprint-generated all-payer data on practice performance and their own training and expertise in process improvement methodologies (such as Clinical Microsystems, Model for Improvement, and Lean process improvement). Quality Improvement Facilitators initially help primary care practices to secure National Committee for Quality Assurance (NCQA) PCMH recognition. After the 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 priorities include:

- focusing quality improvement activities on All-Payer ACO Model and ACO quality measures
- promoting team-based care

- implementation of Blueprint and other health care reform initiatives (e.g., Spoke program, Women's Health Initiative, improving opioid prescribing patterns)
- prevention and management of chronic conditions (e.g., for diabetes and hypertension through connections with learning collaboratives, self-management programs, health coaches, registered dieticians, and care management).

Q4 Highlights

Community Health teams members and QI facilitators within the Patient-Centered Medical Homes, specialty practices, and Spokes continue to be flexible in our ever-changing health care landscape to quickly provide continuity of care during our ongoing pandemic response. The network utilizes its 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, the potential for fragmented care, mental health and substance use diagnosis, and high healthcare resource usage. They also cross-referenced patients who missed appointments and who needed follow-up as soon as possible. The Community Health Teams reached out to the patients who met these criteria. On these calls, they would also inquire about other social determinants of health, such as access to food, medication, and other factors that could impact health and well-being. While in-person visits have increased substantially 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 while screening for social determinants of health and supporting whole-person health. Our QI facilitators also continued to ensure our PCMH was meeting all the criteria to continue to meet the standards for certification.

Q4 Covid

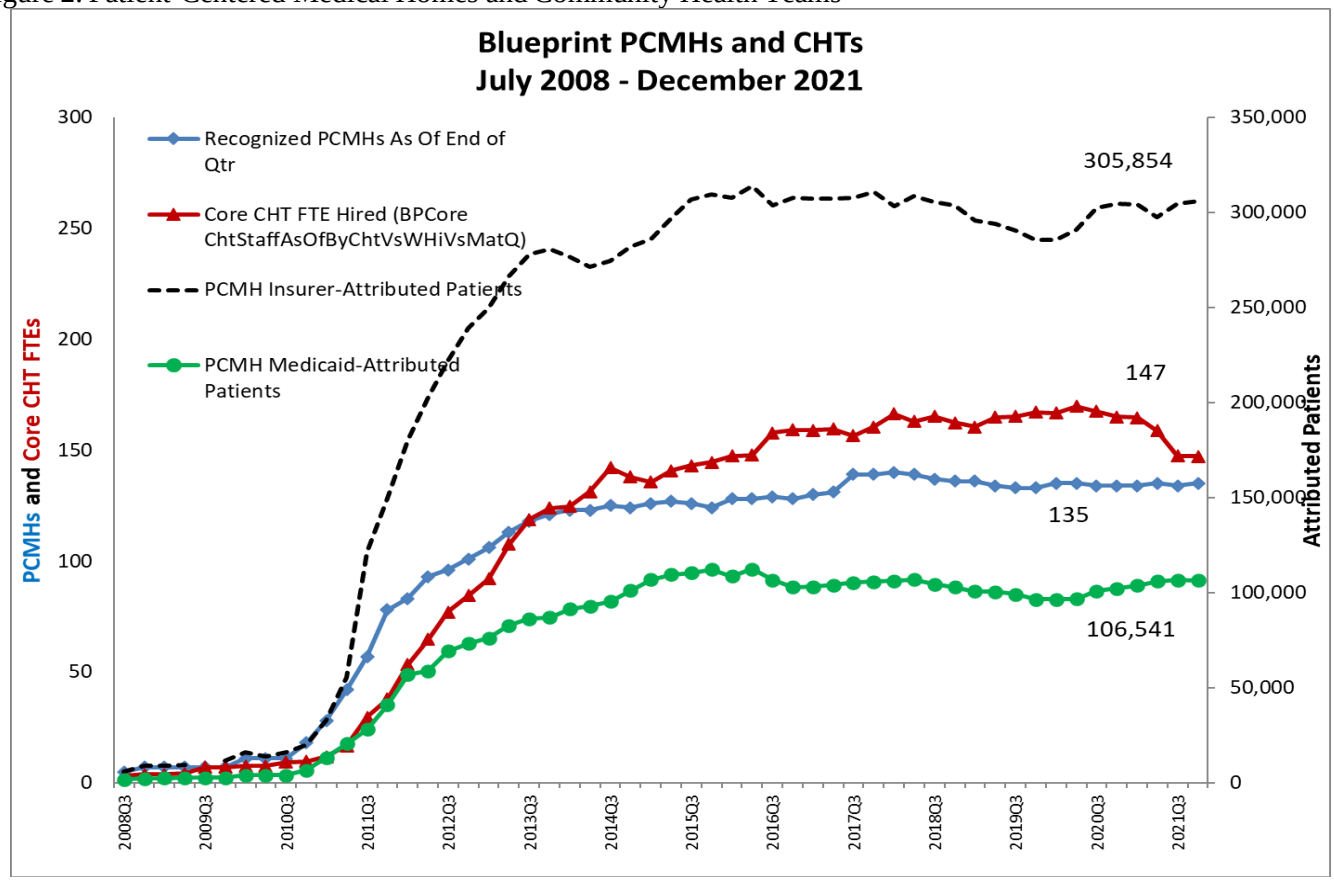
The quarter has been a year of lessons about gratefulness, adaptability, resilience, patience, and continued persistence. Blueprint staff and partners have used the lessons learned to further meet the needs of their communities in what has become our 'new normal'. Incorporating telehealth as appropriate, routinely keeping patients and staff physically and emotionally safe with new protocols, facilitating vaccine distribution, and attending to Vermonters' growing mental health needs were commonplace across the state in 2021. Additionally, Blueprint central office personnel contributed staff hours of support to the Agency of Human Services in planning, management, coordination, and provider surveys related to COVID-19 vaccine distribution and clinic planning throughout the state. As always, Vermonters come together when there is a need.

Blueprint-participating Patient-Centered Medical Homes currently serve 305,854 insurer-attributed patients, of which 106,541 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 before the date the attribution process is conducted. These practices and patients are supported by 147full- time equivalents of Community Health Team staff.

In Quarter 4 (October- December 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.

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



Community Health Profiles

Since 2013, 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 hospital service area and, until 2019, patients in each Patient-Centered Medical Home. Unfortunately, due to budget constraints, practice-level profiles have been suspended since 2019

Hospital Service Area (HSA) community profiles are posted at http://blueprintforhealth.vermont.gov/community-health-profiles.

The Blueprint Annual Report to the Vermont Legislature 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 latest report is available at:

https://blueprintforhealth.vermont.gov/annual-reports

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, and decreased infectious disease transmission, and increased social functioning and retention in treatment.

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.

Q4 Highlights

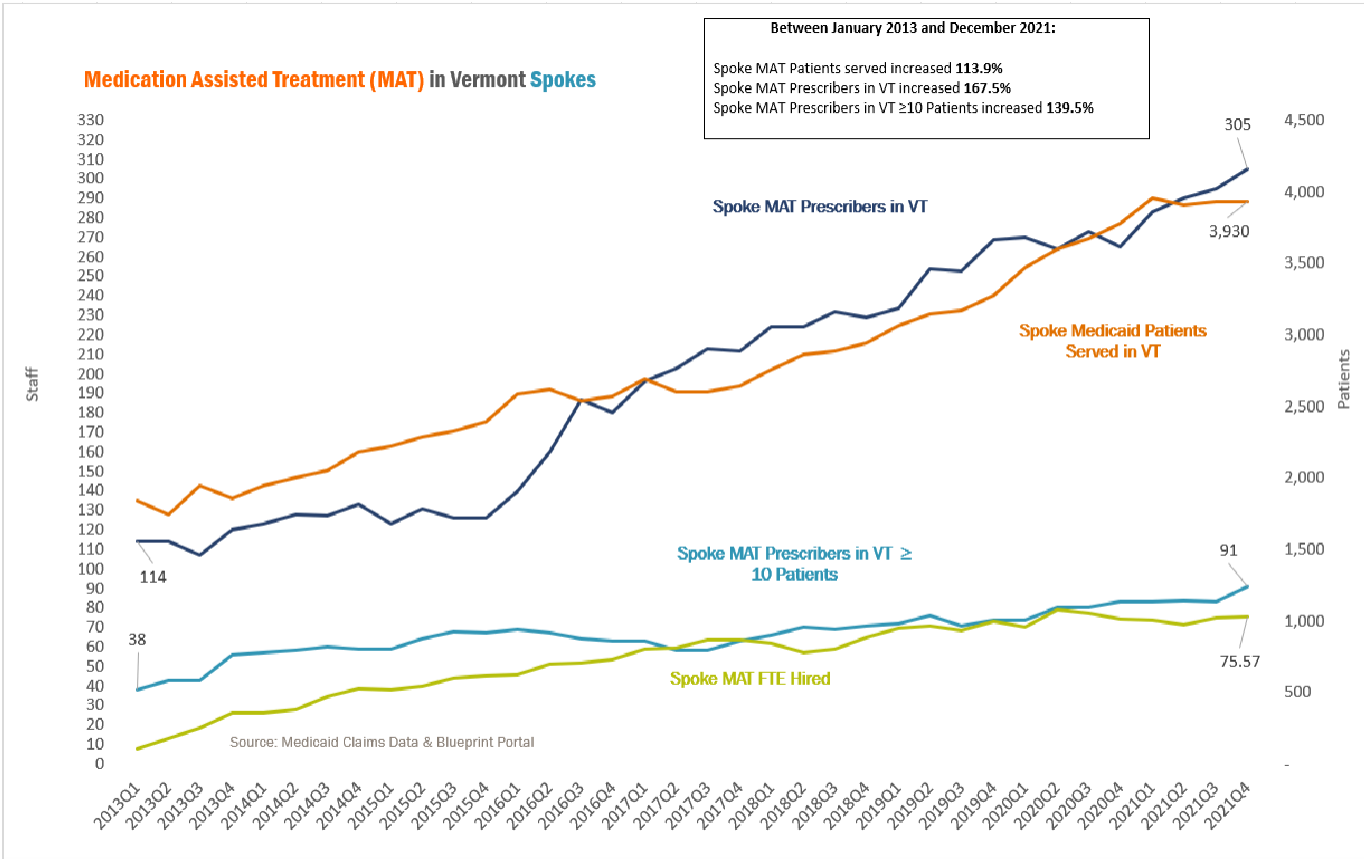
The Blueprint, in partnership with the Division of Alcohol and Drug Abuse Programs (Department of Health), in conjunction with a contract with Dartmouth college allows us to continue to offer learning sessions with expert-led, and peer-supported, training in best practices for providing team-and evidence-based medication-assisted treatment for opioid use disorder The curriculum calendar for these events ran from January 2021 through October 2021. Sessions alternated between didactic webinars related to medication management and virtual workshops related to comprehensive care management. Four webinars were paired with four workshops on thematically related content. Topics addressed management of alcohol use disorder and other substance use disorders, long-term MAT management, mental illness, and MAT continuing OUD symptoms in MAT. A fifth webinar was held in September on developing consensus within MAT care teams. A two-day October conference consisted of presentations and panel discussions on improving engagement among people with OUD in MAT and developing awareness of and responsiveness to MAT health care inequities.
The average participant attendance at these ten event dates was 85 professionals. These nine events on average were rated as being very relevant to their work by 86% of the respondents, and an average of 87% of respondents rated presenters as demonstrating topic understanding very well. Video recordings and slides for these events are or will be made available for viewing on the Vermont Health Learn website. 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 becomes a critical part of their care team, working together towards long-term recovery and improved health and well-being.

At the end of the 4th quarter of 2021, Vermont continues to demonstrate substantial access to medication-assisted treatment for Vermonters with opioid use disorder. Medication- assisted treatment is being offered across the State of Vermont by more than 75 different Spoke settings (as of December 2021). The capacity to serve Vermonters continued to increase, as evidenced by a monthly average of 3930 Medicaid beneficiaries served by Office-Based Opioid Treatment (OBOT/Spoke) programs. There are 305 medical doctors, nurse practitioners, and physician assistants who work with 75.57 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 full-time equivalent Spoke staff working as teams.

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

Figure 2. MAT-SPOKE Implementation Jan 2013 – December 2021



Women's Health Initiative

The Women's Health Initiative (WHI) began as a state initiative to support pregnancy intention.

The Women's Health Initiative (WHI) strives to support any persons who can become pregnant in their efforts to experience healthy pregnancies, avoid unintended pregnancies, and build thriving families. The WHI provides increased mental health and social service staffing at specialty practices and utilizes the existing CHT at Blueprint PCMH practices. If a patient identifies as at-risk, they have immediate access to a WHI mental health clinician for brief interventions, counseling, and navigation to community-based services and treatment as needed.

The Blueprint partners with participating women's specialty providers and PCMH primary care practices to support patients of child-bearing age WHI providers engage with patients at a new patient and annual visits to screen for mental health needs, substance use, and SDOH. They ask about 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 receive services to support a healthy pregnancy. If the woman would like to prevent pregnancy, providers conduct comprehensive family planning counseling and provide patients with options for most and moderately effective contraception, which could include access to same-day long-acting reversible contraceptives (LARC) if clinically indicated.

Comprehensive screening includes questions about SDOH needs of food/housing insecurity, interpersonal violence, depression, anxiety, and harm to self or others, in addition to screening for mental health needs and substance use. Positive screens are addressed with referrals to services, and brief interventions and treatment may be provided by the WHI-supported mental health clinician if indicated. WHI clinicians develop mutual referral agreements with community partners to help establish meaningful relationships to support patients.

Q4 2021 Highlights

WHI practices can access the program's central WHI Quality Improvement (QI) Facilitator to ensure the goals of the program are being met. In 2021, the QI Facilitator and WHI Program Lead met regularly with representatives from all WHI practices to identify process improvement opportunities, ensure the program elements are in place and support improved patient experience of care.

In 2021 we brought new practices into the WHI program. We also spent time with practices that are considering becoming a part of this initiative to discuss the benefits of the program

The Blueprint provided several pieces of training for practices that included best practices for comprehensive family planning counseling by Planned Parenthood of New England and learning sessions regarding same-day LARC insertion by Dr. Lauren MacAfee.

We have collected new attestation forms from each WHI practice. Practices are working hard to engage community partners in referral agreements. These agreements enhance relationships and pathways to care. We have presented a WHI

data dashboard to the field in our monthly call. We received feedback on what would be useful data for the field from claims and will continue to support the field with this information.

Middlebury Health Service was the hiring entity for PPNNE staff and when their staff member left, they decided to transition their position to the PPNNE team as the hiring entity and this position has been filled.

Figure 3 below shows WHI enrollment and staffing over time. In 2021, the number of PCMHs enrolled is 46. 24 women's specialty health care sites and 22 PCMH to participate in the Women's Health Initiative as of October 2021.

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

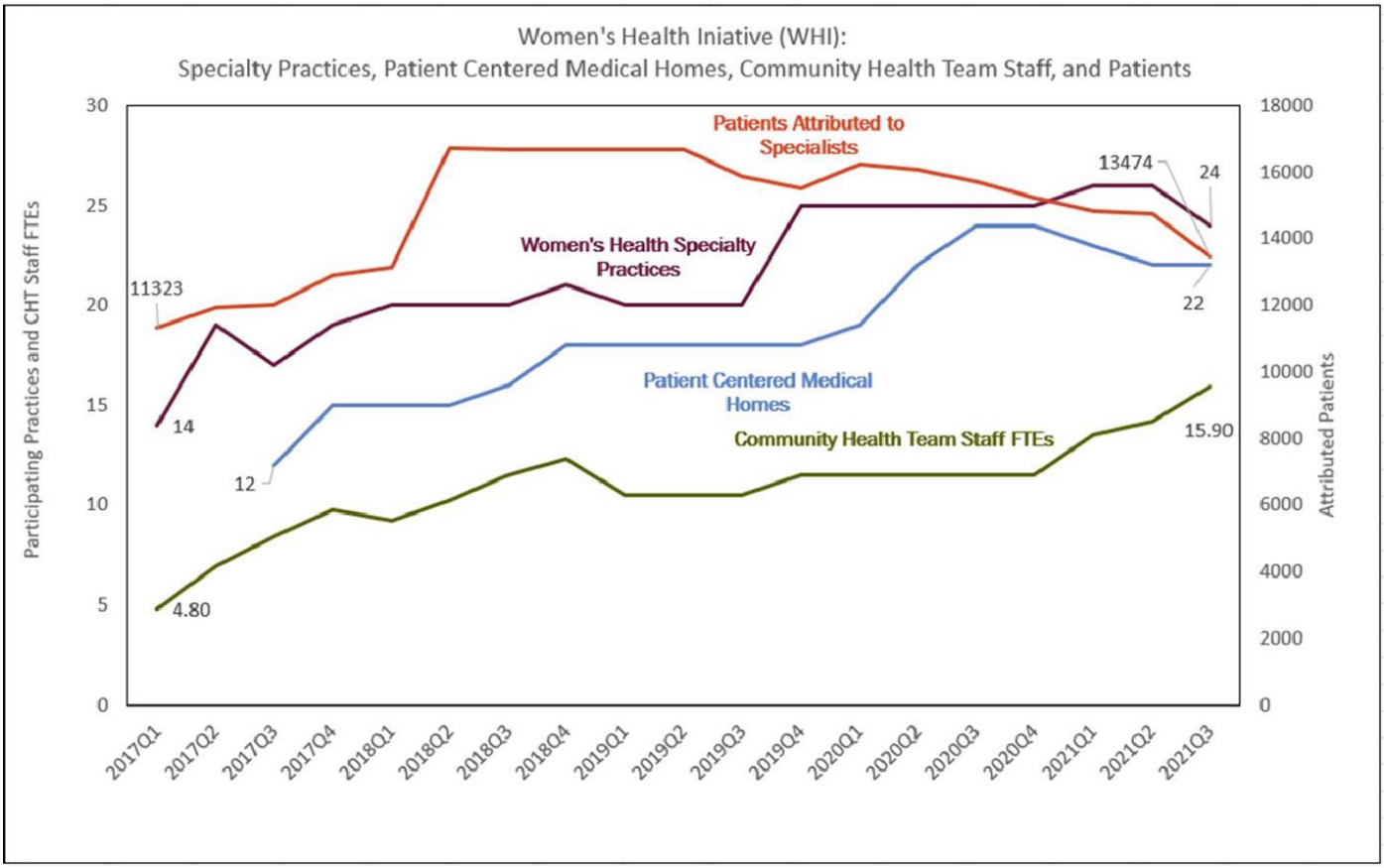


Table 4. Women's Health Implementation by Region

Health Service Area / Team	WHI Specialist Practices as of October 2021	WHI PCMH Practices as of October 2021	WHI CHT Staff FTE Hired as of October 2021	WHI Specialist Quarterly Attributed** Medicaid Beneficiaries as of October 2021	WHI PCMH Quarterly Attributed** Medicaid Beneficiaries as of October 2021
Barre	1	1	1.5	636	204
Bennington	1	2	0.50	933	268
Brattleboro	1	0	.6	899	0
Burlington	2	9	2	2580	4864
Middlebury	1	0	0.75	646	0
Morrisville	1	3	0.50	325	1401
Newport	1	0	1	903	0
Randolph	2	0	0.50	484	0
Rutland	2	0	3	1395	0
Springfield	0	5	0	0	1744
St. Albans	0	0	0.00		0
St. Johnsbury	1	2	0.75	873	829
Windsor*	0	0	0.00	0	0
Planned Parenthood (Statewide)	12	0	4.8	4157	0
Total	24	22	15.9	13474	9310

*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 the PPNNE statewide field. Patients are allocated to the Rutland and Middlebury HSA's. Total WHI Specialist practice count is deduplicated.

v. Pharmacy Program

Key updates from CY2021

- Operational Activities
  - Prior Authorization (PA) Data
  - Paid Claims and Drug Spend
  - Provider Communications
- Clinical Activities
  - Pharmacist enrollment
  - Pharmacy Cost Management (PCM) Program

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 support 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 $231 million in gross drug spending 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 the Department of Mental Health (DMH) related to the 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 4	459,630	90	44,928	322	73	6,676	18,494	530,213
	87%	<1%	8%	<1%	<1%	1%	3%	100%
Quarter 3	460,502	123	45,924	422	84	7,922	19,381	534,358
	86%	<1%	9%	<1%	<1%	1%	4%	100%
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

Period	# Claims	# Of Members	State Paid Amounts
4Q2021	470,094	81,064	$63,595,590
3Q2021	469,012	80,502	$63,165,489
2Q2021	444,037	74,168	$58,138,668
1Q2021	476,386	81,314	$62,102,891

VPHARM

Period	# Claims	# Of Members	State Paid Amounts
4Q2021	62,800	6,972	$1,047,459.90
3Q2021	67,294	7,201	$1,209,326.22
2Q2021	70,811	7,339	$1,337,018.07
1Q2021	72,027	7,834	$1,873,161.14

COVID-19 Communications

Pharmacy COVID-19 Antigen Test Coverage	As of December 1, 2021, Vermont enrolled pharmacies may now bill for select over-the-counter (OTC) COVID-19 tests for use by Medicaid members in a home setting when prescribed by a Vermont enrolled provider.
Updated Billing Information for COVID- 19 Vaccines	Effective 10/14/21 pharmacies may submit claims for the administration of a booster dose of the Pfizer-BioNTech COVID-19 vaccine for dates of services on or after September 10, 2021.
COVID-19 Vaccine Booster Billing	Effective 9/09/2021, pharmacies can submit claims for reimbursement for the administration of the 3rd dose ("Booster") of the Moderna or Pfizer-BioNTech COVID-19 vaccine retroactive to dates of service on or after August 12, 2021.

Provider Communications

Preferred Drug List (PDL) Changes	Changes to the Preferred Drug List (PDL) for 2022
Clozapine REMS Requirements Change	Clozapine Risk Evaluation and Mitigation Strategy (REMS) requirements change that all prescribers and pharmacies must re-certify by 11/15/21 or no longer be able to prescribe/dispense clozapine and re-enroll patients who will continue clozapine by 11/15/21 or they will no longer be able to receive clozapine.
PrEP Medication Copay waiver	Effective 10/1/21 no copay is applied to Pre-Exposure Prophylaxis (PrEP) drug therapy.
Pharmacy Newsletter	A pharmacy newsletter went out in October 2021 giving updates on the 2021/2022 Influenza and COVID-19 Booster vaccines, coverage changes for continuous Glucose Monitoring (CGM) systems and supplies, Team Care program, DUR Board meeting, and website updates.
Changes to Coverage for Continuous Glucose Monitoring (CGM) Systems and Supplies	As of 10/1/2021, continuous Glucose Monitoring (CGM) systems and supplies will be available ONLY through pharmacy channels and will no longer be accepted via DME provider channels. Prior authorization requirements that had been waived temporally because of the COIVD-19 Public Health Emergency will be reinstated. Prescribers may send prescriptions electronically to the pharmacy or write prescriptions for patients. Claims will adjudicate in "real-time" through the Pharmacy Point of Sale (POS).

Influenza (Flu) 2021/2022 Season	Communication around the Influenza (Flu) vaccines 2021/2022 season for enrolled Medicaid providers on guidance and reimbursement.
Synagis Atypical 2021 Summer Season	RSV is on the rise and in response to this atypical inter-seasonal change in RSV activity, the American Academy of Pediatrics (AAP) issued "Interim Guidance" supporting the use of Synagis® in patients who qualify for coverage per current clinical guidelines during periods when RSV incidence is epidemic in the area. DVHA will continue to monitor RSV activity and may end the atypical Synagis® "season" when the percent positives on antigen tests are ≤ 10% for 2 weeks or the percent positives on PCR tests is ≤ 3% for 2 consecutive weeks
Updated Age Edits for Codeine Pain and Cough Medication	The DUR Board reviewed pharmacy dispensing data from 2019-to 2020 and identified that codeine pain and cough mediations continue to be prescribed in a small but significant percentage of patients 12 and under. As a result of the analysis, the Board recommended additional edits be placed on the use of codeine in children 12 and under. Effective July 30th, 2021, the prior authorizations requirement of the use of codeine in anyone 12 and under was implemented.
Team Care Program	The Team Care Program is a federally mandated prescription lock-in program to prevent misuse, abuse, and diversion of medications on the FDA Controlled Substance Schedule. The program is intended to identify and help address unmet healthcare and/or addiction treatment needs. A communication was sent to pharmacies and pharmacists that included links to the Team Care new brochure, referral form, and additional links for more information regarding the Team Care Program.
Pharmacist- Provided Tobacco Cessation Services	Effective July 1, 2021, the Vermont Medicaid program allows reimbursement for pharmacists providing tobacco cessation counseling. The change was made to support the provisions of Act 178 of the 2020 legislative session.
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 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 their 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 on 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 be 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 8:00 PM on Wednesday, June 23, 2021, for system maintenance. Pharmacy claims will not be adjudicated during this time

Reminder: Vermont Medicaid Billing with Closed	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

Primary Commercial Insurance	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) that the primary insurance is no longer active, the pharmacy can submit the claim to Medicaid as the primary payer.
Important Update on Early Refill Overrides with Submission Clarification Code (SCC)=13 for 90-Day Maintenance Medications	Effective 2/19/2021, DVHA will no longer be the automatic on- line override of the 90-day maintenance rule, and pharmacies must call the Help Desk for an override. Prior authorization must be submitted to continue dispensing less than a 90-day supply of maintenance medications. This is the most drug shortages related to the PHE have been resolved.
Update on Synagis (palivizumab) Dispensing	No further orders of Synagis® for Respiratory Syncytial Virus (RSV) prophylaxis will be authorized after 3/4/2021 since the positivity rate on PCR and Antigen tests for RSV remain below 2% for over 2 consecutive weeks. This is most likely due to social distancing and emergency guidelines put into place related to the PHE.
New Coverage of Omnipod DASH Insulin Pump	Coverage of Omnipod® DASH products has been added to the pharmacy benefit effective 4/1/21. The manufacturer is making it available through the pharmacy channel, not through DME. This will not require prior authorization.
Pharmacy Newsletter	A pharmacy newsletter went out in January 2021 giving updates on Pharmacist Enrollment for billing and reimbursement of COVID-19 vaccine administration, how to bill for COVID-19 vaccine administration, Prior Authorizations Extensions related to the PHE, Changes to Preferred Albuterol Inhalers, Coverage changes for Taltz, Preferred Drug List (PDL) 2021 Changes, and Drug Utilization Review Board (DURB) 2021 Meeting Schedules

Clinical Activities

Pharmacist Enrollment

Effective September 1, 2020, Vermont Medicaid allowed pharmacists to enroll in the Medicaid program as licensed providers to provide Medicaid services following their scope of practice, and state and federal law. This includes ordering and administering COVID-19 diagnostic tests and COVID-19 vaccines during the public health emergency.

Pharmacists who plan on administering or supervising the administration of a COVID-19 vaccine must be enrolled with Vermont Medicaid for the pharmacy to be eligible for reimbursement for such vaccinations.

Provisions of Act 178 of the 2020 legislative session authorizes pharmacists to prescribe tobacco cessation products. Effective July 1, 2021, the Vermont Medicaid program allows reimbursement for pharmacists

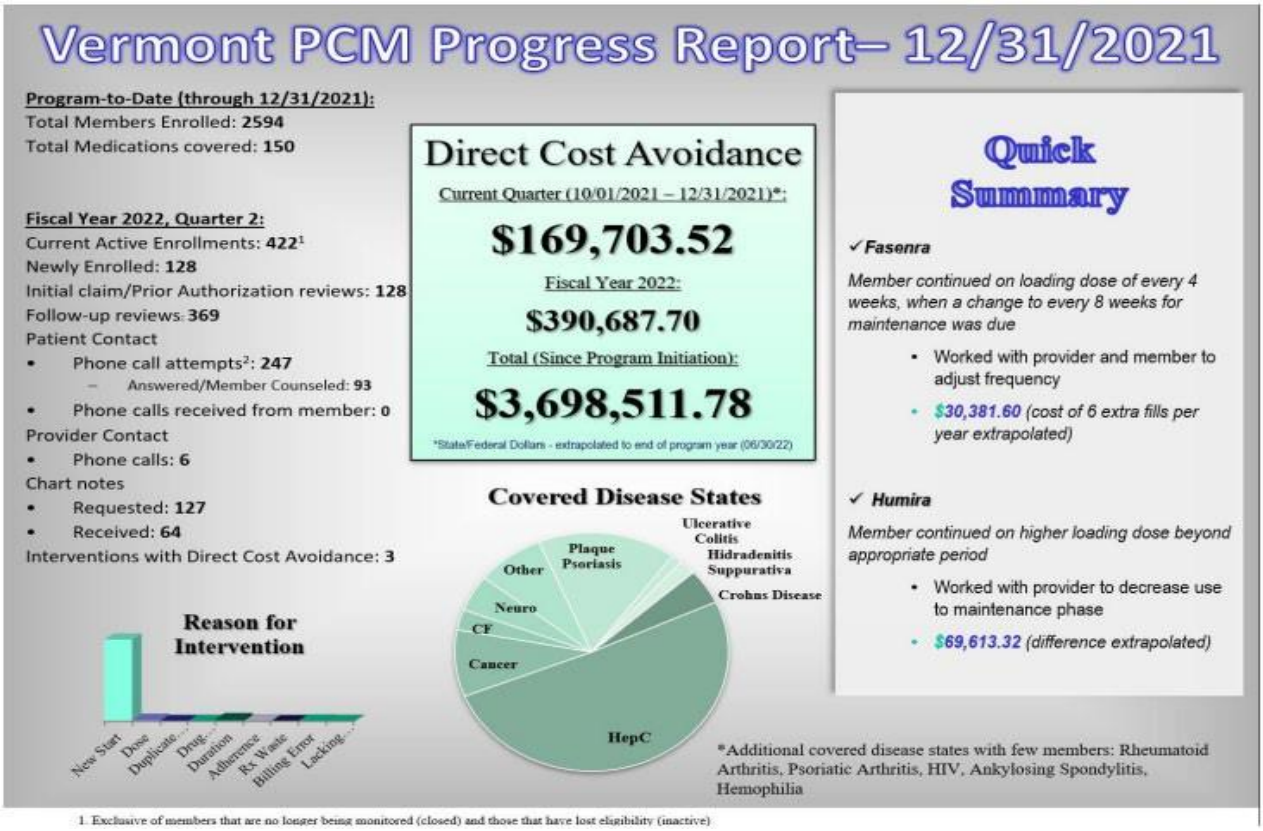
providing tobacco cessation counseling. Pharmacists will be paid according to the Resource-Based Relative Value Scale (RBRVS) fee schedule. Tobacco Cessation CPT codes 99406 and 99407 will be open for pharmacists to bill with no PA required. Pharmacists must enroll with Vermont Medicaid as providers to prescribe smoking cessation products and to be reimbursed for counseling Medicaid members. https://vermont.hppcloud.com/Home/Index/. DVHA has over 300 actively enrolled pharmacists.

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, biological, and genetic markers. In addition, they communicate directly with pharmacies to ensure that the medications are dispensed to the patients at the correct times and are billed appropriately. Prescribers are notified when a patient demonstrates poor adherence.

The Vermont Medicaid Pharmacy Cost Management (PCM) program continued throughout the calendar year 2021. The entire year was during the COVID-19 pandemic and social distancing protocols, and the PCM program adapted to these changes. The clinical pharmacist continued outreach to members and providers although making a connection has been more challenging during the Public Health Emergency. We are now seeing a gradual transition from telehealth appointments back to the in-person laboratory and provider visits, although not to pre-pandemic levels. The PCM program continues to operate normally while allowing for longer response times from providers.



Change Healthcare (January 1, 2021, through December 31, 2021). Change Healthcare Pharmacy Management Reporting Suite by a collection of reports recording the process and progress of PCM.

In the fourth quarter of 2021, the PCM program enrolled an additional 128 members for a total of 2,594 members on 150 unique medications. The program is actively monitoring 422 enrollees. A total of 247 outgoing telephone calls were placed to members, 93 of which resulted in member counseling. During this quarter of the Vermont PCM program, three interventions led to direct and measurable cost avoidance.
Furthermore, interventions that do not bring about direct cost avoidance are in place to encourage adherence and thus improve member outcomes and avoid unnecessary medical costs. Through interventions in the PCM program, unnecessary drug spend of nearly $757,000 was avoided in state fiscal year 2021, and $ 390,867 so far in SFY2022. More than $3.68 million in unnecessary drug spend was avoided for the program.

vi. Choices for Care and Traumatic Brain Injury Programs

Key updates from QE122021:

- DAIL implemented the CBA minimum wage increase, as well as a 3% rate increase for HCBS services, impacting all consumer surrogate self-directed programs.
- DAIL has received a 5-million-dollar Capacity Building supplemental grant

Summary of Individuals served through CFC and BIP in SFY2021:

Choices for Care (CFC)	**SFY 2021**
Unique People Served by CFC	**6775**
High/Highest	**5697**
Moderate Needs	**1220**
HCBS High/Highest	
Total Unique People Served	**2781**
Percentage of High/Highest CFC	**49%**
ERC	
Total Unique People Served	**752**
Percentage of High/Highest CFC	**13%**
Nursing Facility High/Highest	
Total Unique People	**2692**
Percentage of High/Highest CFC	**47%**
TBI	**SFY 2021**
Total Unique People Served	**81**

<u>Brain Injury Program</u>:

In 2021, the Brain Injury Program:

- Had 46 individuals enrolled in the Long-Term Program
- Had 34 individuals enrolled in the Rehab Program
- Closed out Year Three (final year) of the TBI State Partnership grant.
- Has implemented the program name change of Brain Injury Program (BIP) formerly Traumatic Brain Injury Program to more accurately reflect the scope of individuals served.
- Worked closely with the Brain Injury Association of Vermont to develop a proposal to use

Money Follows the Person Supplement Grant Funds to support the development of a Neuro Resource Facilitation program to support Vermonters with brain injury who may not meet BIP program clinical eligibility requirements but are struggling to remain stable in their communities.

Choices for Care:

Money follows the Person Grant:

In 2021 the Money Follows the Person Grant

- Transitioned 83 participants
- Received notice of award of $5 million in Supplemental Grant funding
- For CY2021 MFP transitioned 83 CFC participants, 156.6% of the approved target of 53 individuals for the year.
- At the end of CY2021, MFP had 65 active enrollees.
- For CY2022, Vermont is requesting funds to support approximately 71 Choices for Care (CFC) participants transitioning from a skilled nursing facility.

In August 2021, MFP received notice of the award of a $5million Capacity Building Supplemental Grant. The money was awarded to support the following CMS-approved demonstration activities:

- Increased mental health support for CFC participants and their family caregivers
- Scholarship mentorship support to Direct Services Workers
- Increasing volunteer capacity and training for Area Agencies on Aging
- Piloting the use of Neuro Resource Facilitation to better identify CFC and MFP participants with brain injury
- Expanding funding for home modifications to support individuals seeking to remain in community settings of their choice
- Piloting the CAPABLE program for falls prevention
- Increasing the use of AT to promote independence for CFC and MFP participants
- The supplemental grant runs through September 2025

DAIL continues to respond to the COVID-19 pandemic by supporting increased flexibility in the established Waiver.These flexibilities will be continued through the duration of the pandemic.

Choices for Care Regulations

In 2021, DAIL continue to engage with stakeholders to pilot an acuity-based screening tool for use when a waitlist isrequired for the Moderate Need Program. Piloting of the screening tool was initiated on 11/2020, with statewide implementation planned for Q2 2022.

Adult Day Services

Adult Day Centers have resumed operations at a reduced capacity. Operational capacity across all Adult Day Centers varies from 0-100% of pre-pandemic capacity. Barriers to full census include workforce shortage and COVID restrictions. DAIL has engaged with Adult Day

providers to explore options for remote/telephonic services.

New Minimum Wage/Rate Increases

July 1, 2022, DAIL implemented new minimum wage requirements according to the State's Collective Bargaining Agreement for Independent Support Workers. The minimum wage increased from 12.00/hour to $12.05/hour for all employees of self-managed hourly services. Using minimum wage as a starting point, employers are allowed to set their wages for their employees within their state-approved individualized budget. DAIL also implemented a 3% increase in rates for HCBS services.

Wait Lists

There is currently no wait list for the High Needs Group. There continues to be provider wait lists for Moderate NeedsGroup, estimated at over 500 people statewide. Because the eligibility criteria for Moderate Needs services is so broad, Vermont does not expect to eliminate the wait list in the near future. However, the state is transitioning to acuity-based to serve applicants with the greatest needsfirst. There is currently no wait list for the TBI program.

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vii. Developmental Disabilities Services Division

Key updates from QE122021:

- Developmental Disabilities Services Division (DDSD) Staff and Organizational Updates
- DDSD ITS Program
- DDSD State System of Care Plan (2022-2025) and Regulations Implementing the DD Act of 1996 Updates

Developmental Disabilities Services Division (DDSD) Staff and Organizational Updates

Between June and November 2021, DDSD experienced 6 staff vacancies. Two staff were redeployed full-time to COVID-19 response needs. Additionally, early 2022 brought the retirement of 2 additional staff.

- Staff turnover at this level equates to over 1/3 of DDSD staff—outside of the Office of Public Guardianship.

Actions taken throughout CY2021 include:

- Development of internal team to develop appropriate redistribution of staff to ensure best practices in supervision, align units (such as Quality Management Unit and Specialist Team) for closer working relationships, and early discussions for future succession planning.
- Recruitment and hiring of all open positions.
- Secured temporary positions (3) to assist with onboarding of new staff (and staff promoted to new positions) and help with priority projects throughout CY2022.
- Developed a new organization model/chart reflecting recommendations from the internal team that was implemented in early CY2022.

DDSD Intensive Transition Supports (ITS) Program

Based on the identified need to develop additional support for individuals in crisis, DDSD initiated a project that has come to be known as Intensive Treatment Supports (ITS). This model includes time-limited services for recipients of Developmental Disabilities (DD) Home and Community-Based Services (HCBS) who are experiencing a crisis, and whose current needs exceed other available clinical, and crisis supports in the DD services system.

These supports are tailored to the individual needs of adults and children with intellectual and developmental disabilities, provided in a transitional service setting and, for individuals whose crisis support needs exceed the time limits and support currently available in the state's crisis intervention network (VCIN) and local provider network.

Actions taken throughout CY2021 include:

- Developed and issued an RFP.
- Selected a contractor (Vermont Care Network) and used the Master Grant process to execute the scope of work and funding.
- Associated DA/SSA identified appropriate locations for residences.
- Drafted policies and procedures for ITS residences for review and finalization.

State System of Care Plan for Developmental Disabilities (2022-2025) and Regulations Implementing the Developmental Disabilities Act of 1996 Updates

The State System of Care Plan for Developmental Disabilities and Regulations for Implementing the Developmental Disabilities Act are the guiding documents required by the Developmental Disabilities Act (DD Act).

State System of Care Plan (SSOCP) (2022-2025)

The SSOCP describes the nature, extent, allocation, and timing of services provided to individuals with developmental disabilities and their families. Additionally, the SSOCP reflects the Division's commitment to the health, safety, and well-being of people with intellectual and developmental disabilities and their families as well as to its principles and values.

DDSD staff vacancies (see previous key update), as well as ongoing COVID-19 response, have impacted progress on this initiative. However, near the end of CY2021, DDSD secured a former, long-time employee, through a temporary position, to focus efforts on completing the SSOCP and Regulations renewal.

DAIL/DDSD will consider all input during stakeholder feedback sessions. However, during this renewal, DDSD has been asked to include three specific areas of interest: allowing parents to be paid with Medicaid funds for providing care to their children with intellectual and developmental disabilities, housing, and other support services specific to the needs of adults with autism, and increased housing models for adults with intellectual and developmental disabilities beyond those currently available.

Actions taken throughout CY2021 include:

- SSOCP is currently under a legislatively approved extension to allow appropriate stakeholder input.
- A draft has been completed for presentation to stakeholders such as DDSD State Standing Committee, Vermont State Legislature, and other interested parties.

Regulations Implementing the Developmental Disabilities Act of 1996

In 2014, the DD Act was amended to require 4 categories of the SSOCP to be adopted through the rulemaking process. These areas include priorities for the continuation of existing programs or development of new programs, criteria for receiving services or funding, the type of services provided, and a process for evaluating and assessing the success of programs.

Any time the SSOCP is renewed or updated, the Regulations need to be reviewed for the interaction with any changes that are being considered and made and appropriate updates that need to be made.

There are two notable updates to the 2022 revisions. One related to eligibility to clarify language around consideration of IQ scores between 70 and 75. The other aligns the grievance and appeals section with the Federal Medicaid rules.

Actions taken throughout the CY2021 include:

- DDSD secured a former, long-time employee, through a temporary position, to spearhead efforts regarding the SSOCP and Regulations renewal.
- A draft has been completed for presentation to stakeholders such as DDSD State Standing Committee, Vermont State Legislature, and other interested parties.

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

Key updates from QE122021:

- Executed a new contract with OneCare for a 2022 performance year of the program.
- Continue to support Vermont's broader efforts to develop an integrated health care delivery system under an All-Payer Model through future program planning and implementation.

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

DVHA and OneCare entered into an agreement for the 2017 performance year as a pilot year with four possible one-year extensions to the program. Four risk-bearing hospital communities participated in the *Vermont Medicaid Next Generation* (VMNG) model for the pilot year: the University of Vermont Medicaid Center, Central Vermont Medical Center, Northwestern Medical Center, and Porter Hospital, with additional participation from FQHCs, independent practices, home health providers, Designated Agencies, and skilled nursing agencies in the four communities.

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

After issuing an RFP for ACO services and selecting OneCare as the successful bidder, DVHA and OneCare executed a new contract for a 2022 performance year of the VMNG program in Q4 of 2021. Programmatic changes to the model were minor in many areas, with more significant changes around OneCare's care model and care management requirements and adjustments to the model's Value-Based Incentive Program. A minimal number of changes in the majority of programmatic areas ensures program stability and continued alignment across payer programs as part of the Vermont All-Payer ACO Model.

The VMNG program saw provider participation remain consistent between the 2021 and 2022 performance years, which indicates that the program may have reached scale in the state. The number of risk-bearing hospital communities remained constant at fourteen for the 2021 performance year. The number of attributed

lives for the 2022 performance year increased from approximately 111,532 lives (83,685 through the traditional attribution methodology and 27,847 lives through the expanded attribution methodology) to 126,291 (95,727 through the traditional attribution methodology and 30,564 through the expanded attribution methodology).

DVHA and OneCare maintained several financial and quality component modifications in the VMNG program to hold providers harmless for negative impacts related to the COVID-19 pandemic and State of Emergency in 2021. DVHA and OneCare did not retain these modifications moving into the 2022 performance year but instead applied a COVID-19 factor when developing rates for the program to take COVID-19 costs into account in the program's Expected Total Cost of Care.

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

ix. Substance Use Disorder Program (SUD Demonstration Monitoring Report)

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

Key updates for CY2021:

- ADAP reviewed the responses to a Request for Information (RFI) related to the overall SUD treatment system.
- 12 hospitals are participating in the Recovery Coaches in the Emergency Room Program.
- Vermont Prescription Drug Monitoring System (VPMS) approved four new entities for bi-directional data sharing.
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- VT Helplink received over 1,900 calls and 60,000 website visits.

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

2. Executive Summary

The State of Vermont continued to have all ASAM levels of care available and no ongoing waitlist to access to Medication for Opioid Use Disorder. Treatment providers utilized telemedicine, where appropriate, while others adjusted daily census based on clinical risk stratification and implemented social distancing and other

strategies to continue serving patients requiring in-person services during the ongoing COVID-19 pandemic. Vermont residential providers experienced COVID-19 outbreaks among staff and clients and experienced COVID-19 positive staff and clients which did not result in outbreaks but were able to contain the spread of infections and maintained access to care.

Substance Use Disorder Treatment Standards and corresponding compliance assessment tool were effective January 1, 2020ADAP 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 has met at least biweekly with the residential providers to assess needs related to the COVID-19 pandemic and has worked to ensure the viability of the providers in response to COVID-19 expenses. Nursing expenses have grown substantially throughout the pandemic and will need to be addressed long-term. As a result, ADAP anticipates revisiting the episodic payments in 2022. ADAP released and has received and reviewed the responses to a Request for Information (RFI) related to the overall SUD treatment system. The work of the SUD system of care enhancements project is ongoing. 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" was launched for public use in March 2020. Major components include 1) a call center staffed by certified Screening & Intake Specialists and licensed clinicians, 2) a website with information related to SUD and a self- screen tool, and 3) an appointment board to connect callers in need of treatment with appointments to ADAP's Preferred Provider Network. In 2021, VT Helplink received 1,982 calls and over 60,000 website visits.

ADAP continues to onboard SUD treatment providers into the provider portal and expand the database of SUD resources available to consumers. Engagement with treatment providers and community partners continues to build momentum, and enhanced marketing efforts support increased public awareness of this resource.

The Substance Misuse Prevention Oversight and Advisory Council (SMPC) was established within the Vermont Department of Health and it 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 three goals:

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 at: www.healthvermont.gov/SMPC

The SMPC submitted its 2021 Annual Report and the Inventory of Prevention Services report to the Vermont General Assembly. The SMPC focused its efforts on three areas for the 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.

Assessment of Need and Qualification for SUD Services

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

Discuss any relevant trends that the data shows related to the assessment of need and qualification for SUD services. At a minimum, changes (+ or -) greater than two percent should be described.	DY2 Q2	Medicaid Beneficiaries with SUD Diagnosis (monthly) Medicaid Beneficiaries with SUD Diagnosis (annually) Medicaid Beneficiaries Treated in an IMD for SUD	Previously Vermont experienced a decrease in the number of Medicaid beneficiaries identified with SUD diagnoses. These changes 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. 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. It appears that Vermont is beginning to trend upward in the number of individuals identified with a SUD diagnosis, perhaps indicating that people are feeling safer in seeking out healthcare.
[Add rows as needed]			
The state has no metrics trends to report for this reporting topic.			
Implementation Update			

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

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

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

Prompts	Demonstration Year (DY) and quarter first reported	Related metric (if any)	Summary
Milestone 1 Metric Trends			
Discuss any relevant trends that the data shows related to assessment of need and qualification for SUD services. At a minimum, changes (+ or -) greater than two percent should be described.	DY2 Q2	6 Any SUD Treatment	s
		7 Early Intervention	
		8 Outpatient Services	.
		9 Intensive Outpatient and Partial	IOP services remain low due to the difficulty of providing group-based services during the pandemic. Some

		Hospitalization Services	services are being provided via telemedicine.
		10 Residential and Inpatient	Vermont's residential treatment providers continued to experience COVID-19 outbreaks and positive cases that did not rise to the level of outbreaks among staff and clients. This required the programs to at times hold admissions. There was media coverage of the COVID challenges faced by the residential programs, potentially leading to individuals feeling less safe about accessing this level of care, impacting overall admission numbers.
			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 before admission has impacted the pacing of admissions.
		11 Withdrawal Management	
		12 Medication Assisted Treatment	
		36 Average Length of Stay in IMDs	]
[Add rows as needed]			
The state has no metrics trends to report for this reporting topic.			
Milestone 1 Implementation Update			
Prompts: Compared to the demonstration design and operational details outlined in the implementation plan, have there been any changes or does the state expect to make any changes to: a. Planned activities to improve access to SUD treatment services across the continuum of care for Medicaid beneficiaries (e.g. outpatient services, intensive outpatient services, medication assisted treatment, services in intensive residential and inpatient settings, medically supervised withdrawal management)? SUD benefit coverage under the Medicaid state plan or the Expenditure Authority, particularly for residential treatment, medically supervised withdrawal management, and medication assisted treatment services provided to individuals in IMDs?			

Summary: There are no planned changes to access SUD treatment or the SUD benefit coverage.			
Are there any other anticipated program			There are no anticipated program changes.

changes that may impact metrics related to access to critical levels of care for OUD and other SUDs? If so please describe these changes.			
☒ The state has no implementation update to report for this reporting topic.			

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

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

Prompts	Demonstration Year (DY) and quarter first reported	Related metric (if any)	Summary
Milestone 2 Metric Trends			
☒ The state is not reporting any metrics related to this reporting topic.			
Milestone 2 Implementation Update			

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

a. Planned activities to improve providers' use of evidence-based, SUD-specific placement criteria?
b. Implementation of a utilization management approach to ensure:
    i. Beneficiaries have access to SUD services at the appropriate level of care?
    ii. Interventions are appropriate for the diagnosis and level of care?
    iii. Use of independent process for reviewing placement in residential treatment settings?

Summary:

The current version of the Substance Use Disorder Treatment Standards is being used. The Compliance Assessment Tool has now been utilized with all substance use disorder treatment provider locations as of December 31, 2021. 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 between March 2020 through July 2021.

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 a 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. ADAP has met at least biweekly with the residential providers to assess needs related to the COVID-19 pandemic and have worked to ensure viability of the providers in response to COVID-19 expenses. Nursing expenses have grown substantially throughout the course of the pandemic and will need to be addressed long-term. As a result, ADAP anticipates revisiting the episodic payments in 2022. ADAP has posted and received and reviewed responses to a Request for Information (RFI) related to the overall SUD treatment system. The work of the SUD system of care enhancements project is ongoing. The value-based payment component of the residential payment model is in consideration for inclusion in the larger system reform.

Milestone 2 – Table 2

Action	Date	Responsible
Develop the criteria for the differential case rate	Completed	ADAP Director of Clinical Services
Model the methodology using the identified criteria for the Vermont team to review	Completed	Payment Reform Team

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

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

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

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

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

Prompts	Demonstration Year (DY) and quarter first reported	Related metric (if any)	Summary
Milestone 3 Metric Trends			
☒ The state is not reporting any metrics related to this reporting topic.			

Milestone 3 Implementation Update

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

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

Summary:

The current version of the Substance Use Disorder Treatment Standards is being used. The Compliance Assessment Tool has been utilized with all substance use disorder treatment provider locations as of December 31, 2021. 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 between March 2020 and July 2021. ADAP has completed four remote site visits 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.			

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

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

This reporting topic focuses on provider capacity at critical levels of care including 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 the assessment of need and qualification for SUD services. At a minimum, changes (+ or -) greater than two		SUD Provider Availability SUD Provider Availability – MAT	The number of providers who were enrolled in Medicaid and qualified to deliver SUD services, including those who meet the standards to provide buprenorphine/methadone as part of MAT, has increased.
percent should be described.			
[Add rows as needed]			
☒ The state has no metrics trends to report for this reporting topic.			
Milestone 4 Implementation Update			

Prompts: Compared to the demonstration design and operational details outlined in the implementation plan, have there been any changes or does the state expect to make any changes to planned activities to assess the availability of providers enrolled in Medicaid and accepting new patients in across the continuum of SUD care?

Summary:

Vermont suspended plans to develop a value-based payment model for residential programs to align with its All Payer Model Agreement with CMS due to the COVID-19 pandemic. Vermont continues to elicit feedback from the residential providers concerning the payment model and rates. Nursing and other staffing costs have risen dramatically during the pandemic and existing workforce challenges have been significantly exacerbated. Vermont anticipates resuming work on the payment model in 2022 to begin to address these concerns.

ADAP's centralized intake and resource center "VT Helplink: Alcohol and Drug Support Center" was launched for public use in March 2020. Major components include 1) a call center staffed by certified Screening & Intake Specialists and licensed clinicians, 2) a website with information related to SUD and a self- screen tool, and 3) an appointment board to connect callers in need of treatment with appointments to ADAP's Preferred Provider Network. In 2021, VT Helplink received 1,982 calls and over 60,000 website visits. ADAP continues to onboard SUD treatment providers into the provider portal and expands the database of SUD resources available to consumers. Engagement with treatment providers and community partners continues to build momentum, and enhanced marketing efforts support increased public awareness of this resource.

Are there any other anticipated program changes that may impact metrics related to provider capacity at critical levels of care, including for medication assisted treatment (MAT) for OUD? If so, please describe these changes.			
☐ The state has no implementation update to report for this reporting topic.			

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

This reporting topic focuses on the implementation of comprehensive treatment and prevention strategies to address opioid abuse and OUD to assess the state's progress toward meeting Milestone5.

Prompts	Demonstration Year (DY) and quarter first reported	Related metric (if any)	Summary
Milestone 5 Metric Trends			
Discuss any relevant trends that the data		15 Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment 18 Use of Opioids at High Dosage in Persons Without Cancer 21 Concurrent Use of Opioids and Benzodiazepines	The percentage of adults in continuous pharmacotherapy for OUD has decreased which may be an unintended consequence of Vermont's robust access to MAT. Individuals who may be ambivalent about treatment may be less concerned about leaving treatment since they know there will be no wait to get back in; also, there are a number of cash only and other Spoke options available which may lead to more movement in and out of treatment. Additionally, Vermont had a period where Medicaid renewal was assumed and then a significant push to revalidate eligibility which may have led to more instability in people's Medicaid coverage, leading to treatment lapses.

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

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

This reporting topic focuses on care coordination and transitions between levels of care to assess the state's progress toward 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 the 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 Abuser Dependence	Recovery Coaches are dispatched to 12 emergency departments to support individuals who present with a SUD at the ED including providing linkages to follow-up visits upon discharge.
[Add rows as needed]			
☒ The state has no metrics trends to report for this reporting topic.			
Milestone 6 Implementation Update			
Prompts: Compared to the demonstration design and operational details outlined in the implementation plan, have there been any changes, or does the state expect to make any changes to the implementation of policies supporting beneficiaries' transition from residential and inpatient facilities to the 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.			
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 the assessment of need and qualification for SUD services. At a minimum, changes (+ or -) greater than two percent should be described.		Q1 PDMP Users/Checks Q2 PDMP Linkages Q3 HIT/HIE Plan	
[Add rows as needed]			
☒ The state has no metrics trends to report for this reporting topic.			
Implementation Update			
Prompts: Compared to the demonstration design and operational details outlined in STCs and implementation plan, have there been any changes or does the state expect to make any changes to: a. How health IT is being used to slow down the rate of growth of individuals identified with SUD? b. How health IT is being used to treat effectively individuals identified with SUD? c. How health IT is being used to effectively monitor "recovery" supports and services for individuals identified with SUD?			

d. Other aspects of the state's plan to develop the health IT infrastructure/capabilities at the state, delivery system, health plan/MCO, and individual provider levels?

e. Other aspects of the state's health IT implementation milestones?

f. The timeline for achieving health IT implementation milestones.

g. Planned activities to increase the use and functionality of the state's prescription drug monitoring program?

Summary:

- Vermont has a requirement and funding in the current contract with Bamboo Health (formerly Appriss) to connect VPMS to RxCheck for interstate data sharing. VPMS went live with interstate data sharing through RxCheck on May 11, 2021.
- VPMS, Dr. First, and Bamboo Health are in the process of testing and verifying Appriss's Gateway integration tool to enable direct viewing of VPMS data in Dr. First's electronic health records, eliminating the need for providers to navigate between systems. However, the 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, and the current state of PDMP activities and identifies opportunities for multi-state alignment.
- Vermont continues to offer prescriber reports quarterly.
- 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.

• VPMS approved multiple new entities for data sharing. Vermont began bi-directional sharing with the Military Health Services (10/8/21), Pennsylvania (10/20/21), Arizona (10/29/21), and Florida (12/10/21). Vermont now shares with twelve other states or entities.			
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		Emergency Department Utilization for SUD per 1,000 Medicaid Beneficiaries	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

services. At a minimum, changes (+ or -) greater than two percent should be described.		Inpatient Stays for SUD per 1,000 Medicaid Beneficiaries Readmissions Among Beneficiaries with SUD Overdose Deaths (count) Overdose Deaths (rate) 32 Access to Preventive/ Ambulatory Health Services for Adult Medicaid Beneficiaries with SUD	supply often isn't known to users until it is used. Fentanyl continues to be the most prevalent substance involved in opioid-related deaths.
[Add rows as needed]			
☒ The state has no metrics trends to report for this reporting topic.			
9.2.2 Implementation Update			

Are there any other anticipated program changes that may impact the other SUD-related metrics? If so, please describe these changes.			•

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

Budget Neutrality

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

SUD-Related Demonstration Operations and Policy

Prompts	Demonstration Year (DY) and quarter first reported	Related metric (if any)	Summary
11.1 SUD-Related Demonstration Operations and Policy			
11.1.1 Considerations			
Highlight significant SUD (or if broader demonstration, then SUD-related) demonstration operations or policy considerations that could positively or negatively impact beneficiary enrollment, access to services, timely provision of services, budget neutrality, or any other provision that has potential for beneficiary impacts. Also note any activity that may accelerate or create delays or impediments in achieving the SUD demonstration's approved goals or objectives, if not already reported elsewhere in this document. See report template instructions for more detail.			
[Add rows as needed]			
☒ The state has no related considerations to report for this reporting topic.			
11.1.2 Implementation Update			

Compared to the demonstration design and operational details outlined in STCs and the implementation plan, have there been any changes, or does the state expect to make any changes to: a. How the delivery system operates under			
the			
demonstration (e.g. through the managed care system or fee for service)? Delivery models affecting demonstration participants (e.g. Accountable Care Organizations, Patient Centered Medical Homes)? Partners involved in service delivery?			

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

SUD Demonstration Evaluation Update

Prompts	Demonstration Year (DY) and quarter first reported	Related metric (if any)	Summary
12.1 SUD Demonstration Evaluation Update			
12.1.1 Narrative Information			

Provide updates on SUD evaluation work and timeline. The appropriate content will depend on when this report is due to CMS and the timing for the demonstration. See report template instructions for more details.			Updates on the SUD evaluation work, deliverables and timeline can be found in Sections VIII. Quality Improvement and IX. Demonstration Evaluation of this report.
Provide status updates on deliverables related to the demonstration evaluation and indicate whether the expected timelines are being met and/or if there are any real or anticipated barriers to achieving the goals and timeframes agreed to in the STCs.			
List anticipated evaluation-related deliverables related to this demonstration and their due dates.			
[Add rows as needed]			
☒ The state has no metrics trends to report for this reporting topic.			
12.1.2 Implementation Update			
Are there any anticipated program changes that may impact budget neutrality? If so, please describe these changes.			
[Add rows as needed]			
☐ The state has no SUD demonstration evaluation update to report for this reporting topic.			

Other Demonstration Reporting

Prompts	Demonstration Year (DY) and quarter first reported	Related metric (if any)	Summary
13.1 Other Demonstration Reporting			

13.1.1 General Reporting Requirements

Have there been any changes in the state's implementation of the			
demonstration that might necessitate a change to approved STCs, implementation plan, or monitoring protocol?			
Does the state foresee the need to make future changes to the STCs, implementation plan, or monitoring protocol, based on expected or upcoming implementation changes?			
Compared to the details outlined in the STCs and the monitoring protocol, has the state formally requested any changes, or does the state expect to formally request any changes to: a. The schedule for completing and submitting monitoring reports? b. The content or completeness of submitted reports? Future reports?			Updates on the Monitoring Protocol work, deliverables, and timeline can be found in Section X. *Compliance* of this report.
Has the state identified any real or anticipated issues submitting timely post-approval demonstration deliverables, including a plan for remediation?			

[Add rows as needed]			
☒ The state has no updates on general reporting requirements to report for this			

reporting topic.			
13.1.2 Post Award Public Forum			
If applicable within the timing of the demonstration, provide a summary of the annual post-award public forum held pursuant to 42 CFR § 431.420(c) indicating any resulting action items or issues. A summary of the post-			

award public forum must be included here for the period during which the forum was held and in the annual report.			
[Add rows as needed]			
☒ There was not a post-award public forum held during this reporting period and this is not an annual report, so the state has no post award public forum update to report for this reporting topic.			

Notable State Achievements and/or Innovations

Prompts	Demonstration Year (DY) and quarter first reported	Related metric (if any)	Summary
14.1 Notable State Achievements and/or Innovations			
14.1 Narrative Information			
Provide any relevant summary of achievements and/or innovations in demonstration enrollment, benefits, operations, and policies pursuant to the hypotheses of the SUD (or if broader demonstration, then SUD related) demonstration or that served to provide better care for individuals, better health for populations, and/or reduce per capita cost. Achievements should focus on significant impacts on beneficiary outcomes. Whenever possible, the summary should describe the achievement or innovation in quantifiable terms, e.g., the number of impacted beneficiaries.			
[Add rows as needed]			

☒ The state has no notable achievements or innovations to report for this reporting topic.

i.

x. *Global Commitment Register*

Key updates from 2021:

- 86 policies were posted to the GCR in 2021.
- Since the Global Commitment Register (GCR) launched in November 2015, 309 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. As the Federal Register, the GCR can be used to publish a proposed policy, including information on public comment submissions, final policy, notices, and policy clarifications. The GCR is available on the AHS website to ensure that policy changes are transparent to Vermonters and to provide a forum for public comments.

The GCR listserv is a group of about 400 interested parties who have elected to receive periodic key updates about Vermont health care programs, which includes policy changes to all Medicaid programs as well as policy changes to Vermont's Health Benefit Exchange. A policy change in the GCR could be a change made under the authority of the waiver, a proposed waiver amendment or extension, an administrative rule change, or a State Plan Amendment. The GCR also contains policy clarifications for when an issue is identified that is not answered in the 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 39 proposed policies posted in 2021, including 14 in the 4th quarter of the year. A total of 44 final policies were posted in 2021, including 2 final policies in Q4. Three policy clarifications, including 1 in Q4, were posted to the GCR in 2021. Changes included updates to rates and/or rate methodologies, clinical coverage changes, administrative rulemaking notices, and changes stemming from the public health emergency and the COVID-19 pandemic, including changes to vaccine coverage.

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

VI. Utilization Management

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

i. Clinical Utilization Review Board

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

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

The CURB has the following duties and responsibilities:

1) Identify and recommend to the Commissioner opportunities to improve quality, efficiencies, and adherence to relevant evidence-based clinical practice guidelines in the Department's medical programs by:
   a) Examining high-cost and high-use services identified through the programs' current medical claims data.
   b) Reviewing existing utilization controls to identify areas in which improved utilization review might be indicated, including the use of elective, nonemergency, out-of-state outpatient, and hospital services.
   c) Reviewing medical literature on current best practices and areas in which services lack sufficient evidence to support their effectiveness.
   d) Conferring with commissioners, directors, and councils within the Agency of Human Services and the Department of Financial Regulation, as appropriate, to identify specific opportunities for exploration and to solicit recommendations.
   e) Identifying appropriate but underutilized services and recommending new services as an addition to Medicaid coverage.
   f) Determining whether it would be clinically and fiscally appropriate for the DVHA to contract with facilities that specialize in certain treatments and have been recognized by the medical community as having good clinical outcomes and low morbidity and mortality rates, such as transplant centers and pediatric oncology centers; and
   g) Considering the possible administrative burdens or benefits of potential recommendations on providers, including examining the feasibility of exempting from prior authorization requirements those health care professionals whose prior authorization requests are routinely granted.

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

3) The CURB provided a review of existing utilization controls to identify areas in which improved utilization review may be indicated. This valuable insight supported work as charged to DVHA by the 2019-2020 legislative session via Act 140.

4) With the ongoing public health emergency, there was an identified need to address how healthcare services are delivered at current and moving forward. The CURB provided recommendations related to telemedicine and remote patient monitoring, in line with identifying appropriate but underutilized services and recommending new services as an addition to Medicaid coverage.

ii. Drug Utilization Review Board

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

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

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

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

The chart below lists some of the state fiscal year 2021 activities of the Drug Utilization Review Board.

Drug Utilization Review Board Activities in 2021

Review Topic	SFY 2021 Total
Therapeutic Drug Classes: Periodic Review	43
Full New Drug Reviews	41
FDA Safety Alerts	2
New/Updated Clinical Guidelines	25
RetroDUR/ProDUR reviews	6
New Managed Therapeutic Drug Classes	4
BioSimilar Drug Reviews	1

Drug Utilization Review Board (DURB) Meetings

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

The sample agenda typically follows this format.

.DURB Board Meeting Agenda

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

iii. Appropriateness of Services

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

iv. Vermont Integrity Program

Key update:

- The 21st Century Cures Act required states to initiate Electronic Visit Verification (EVV) Systems for Personal Care Services (PCS). Program Integrity (PI) supported the project, which required a post-claim validation process. The EVV system successfully achieved CMS Certification.

Program Integrity Unit

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

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

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

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

PI works to establish and maintain the integrity of the Medicaid program by engaging in activities to prevent, detect and investigate Medicaid provider fraud, waste, and abuse. PI receives referrals from a variety of sources and uses data mining and analytics to investigate allegations of fraud, waste, and abuse.PI works with Vermont Medicaid providers and partners to identify payment integrity issues and will provide education to providers when deficiencies and incorrect billing practices are identified. PI works with providers to develop

the appropriate resolution and recovers overpayments. Cases with credible allegations of fraud are referred to Medicaid Fraud Residential Abuse Unit (MFRAU). In addition, PI assists other Medicaid program units to facilitate changes in policies, procedures, and program logic to ensure the integrity of the programs.

PI also has the responsibility to investigate, detect and prevent beneficiary healthcare eligibility and enrollment fraud in the Vermont Medicaid Program. PI works with the Health Access Enrollment & Eligibility Unit (HAEEU), as well as other state and federal partners to ensure Vermonters enrolled in the program are eligible and are current residents of Vermont. PI reviews the federal PARIS (Public Assistance Reporting Information System) Report that identifies if a recipient is receiving duplicate benefits in more than one state at the same time. PI reviews the individuals identified in this report and initiates the removal of recipients that are not eligible for Vermont Medicaid.

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

Outcomes

Vermont PI is regularly regarded by CMS, as well as other federal and state partners, as a leading and strong unit. PI takes pride in ensuring the appropriate use and spending of Medicaid federal and state dollars, which diverts dollars that could otherwise be spent to safeguard the health and welfare of Medicaid recipients. In 2021, the PI reviewed approximately 68 cases related to potential provider fraud, waste, and abuse allegations. In total, PI successfully settled and cost-avoided a collective $7,198,846.

Oversight & Monitoring Unit

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

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

Effective oversight & monitoring ensures:

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

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

Departments, State Fiscal Agents, providers, beneficiaries, and more.

Oversight & Monitoring (O&M)

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

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

Outcomes

In the calendar year 2021 the O&M unit continued its work in coordinating DVHA participation in State, Federal, and independent audits and examinations, seeking to ensure that information shared is consistent, accurate, and timely. In general, the public health emergency resulted in somewhat reduced external audit activity this year. In 2021 O&M:

- Facilitated seven state and federal audits of DVHA programs
- Monitored six state and federal audits of DVHA programs
- Provided ongoing tracking and monitoring and follow-up of Corrective Action Plans.
- Supported AHS and DVHA staff with documentation standards for better Standard Operating Procedures and policies. Five new SOPs were created and approved in 2021.

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

Payment Error Rate Measurement (PERM)

The Payment Error Rate Measurement (PERM) audit, required by CMS to review for improper payments in Medicaid or CHIP programs, runs on a three-year cycle and looks at the full scope of a paid claim including beneficiary eligibility determinations, healthcare provider enrollment, and medical records to substantiate the claim. Vermont was very near the end of the RY(Review Year)2020 PERM audit cycle when the Public Health Emergency (PHE) went into effect in March and the audit was suspended.

CMS resumed the PERM audit effective in August 2020, but with modifications. Because the reviews were suspended early, there has been no reporting of state-level errors for the cycle. Instead, CMS has provided a template of PERM audit error trends seen nationally and requires states to respond with corrective action plans where applicable.

OMU has worked with DVHA units and others to review the templates and determine the state's compliance status regarding the national error trends.

The next cycle of the audit, PERM RY2023, is underway and will examine claims from 7/1/21 – 6/30/22. This cycle will be fully remote and we have worked hard to establish remote system access and determine other support needed to ensure this new review process goes smoothly. Claims data for the first two quarters have been submitted to the CMS contractor responsible for creating the random sample. Once the first sample is ready, reviews will begin and medical record request letters will be sent to VT providers. We continue proactive outreach to prepare state providers so they know what to expect and can respond to the PERM requests appropriately.

Outcomes

The national trend CMS 2020 PERM Corrective Action Plans for Medicaid and CHIP were submitted to CMS on February 16, 2021. They were accepted by CMS, and the first quarterly implementation monitoring calls should begin in early 2022.

The preparations for the newest RY23 PERM audit cycle have been extensive and included a BPA (Business Partner Agreement), remote system access training, eligibility, and medical record questionnaires, and policies collection documents, but these preparations will ensure that the actual PERM audit review process, set to begin in the next months, runs smoothly.

Healthcare Quality Control Unit (HCQC)

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

Outcomes

- For FY 2018, 742 cases were reviewed.
- For FY 2019, 1007 cases have been reviewed.
- For FY 2020, 947 cases have been reviewed. 216 cases were submitted to CMS per the guidelines below as a summary report in the Top 10.
- For FY 2021, 660 cases have been reviewed. Caseload reduced due to COVID
- On 3/18/2020, due to the national health emergency, the MEQC audit was halted, and modifications were made to the sample size.
- Streamlined the Difference Resolution process to mirror the CMS DR process.
- On 8/17/2020 CMS issued an MEQC COVID-19 Supplemental guidance outlining the relaxed policy regarding auditing activities. Seen below are these relaxed policies specific to Cycle 2 states:
    - Sample size reduction from 800 to 200
    - Streamlined reporting (summary reports): instead of submitting comprehensive case level reports, states will submit summary reports that list the percentage of errors and technical deficiencies found in the cases that were reviewed and describe the corrective action plans developed for the top 10 most frequent errors broken out by active and negative case actions.
    - Suspension of Payment Reviews and adjustments: States will not be required to conduct payment reviews for active cases with erroneous eligibility determinations and not be required

to make payment adjustments for identified overpayments using the CMS-64 and 21reports.

- Deadline extensions for Summary reports: The CAP summary report due date has been extended to 11/1/2021from 8/1/2021.
    - CAP summary report was submitted and accepted by CMS on 11/10/2021.

□ To Date for FY 2022, 350 cases have been reviewed.

□ The next MEQC review is for RY2023 Review period will be 1/1/2023 to 12/31/2023. CMS expects that this MEQC audit will resume normal activities and the required minimum sample size will be 800, along with the resumption of the Payment Review, reporting of Case level details and not summaries, as well as normal deadlines.

Promoting Interoperability Program (HIT Auditor)

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

Outcomes

- Audits are performed following an Audit Plan, annually approved by CMS to accommodate rule changes.
- Version 9.0 of the Audit Plan, encompassing procedures for program years 2019, 2020, and 2021 Stage 3 Meaningful Use, was approved by CMS in September of 2021.
- Version 9.1 of the Audit Plan, an amendment to complete a pre-payment Medicaid patient volume check on a subset of attestations, was approved by CMS in November of 2021.
- Approximately ten percent of individual providers and fifty percent of hospitals are selected for audit each program year, following risk assessment procedures. All hospitals participated in the program for a maximum of three program years, and the last hospital audit was completed in the program year 2018.
- This year, twenty individual audits have been completed.
- Two incentive payments were returned to the state because of audit failure.
- While December 31, 2021, was the last day for incentive payments to be issued, HITECH 90/10 administrative funding for audits, appeals, and related activities, goes thru September 30, 2023. The program's MAPIR application and support from the vendor (Gainwell) will need to continue through 2023 to allow for audits to occur and to process adjustments.

v. Inpatient, Outpatient, and Emergency Department Utilization

Methods

Utilization statistics for inpatient, outpatient, and emergency department services provided under Global Commitment during FFY 2019-21 were compiled by the DVHA's Data Unit in February 2022 using paid claims data. The scope of analysis included institutional services provided under the Medicaid program between 10/1/2018 and 9/30/2021, excluding crossover claims.[2] The following areas of utilization were the

focus of this analysis:

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

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

Findings

The following table (Table 5) presents discharge counts and average length-of-stay by age for inpatient services provided in FFY 2019-21.

Table 5. Inpatient Utilization by Fiscal Year and Age Group

Total Inpatient:									
	Sum LOS Days			Discharges			Average LOS Days		
Age	2019	2020	2021	2019	2020	2021	2019	2020	2021
<1	11,119	9,984	9,534	2,667	2,565	2,467	4.2	3.9	3.9
1-9	2,834	2,740	1,721	544	439	365	5.2	6.2	4.7
10-19	8,718	7,378	9,675	1,069	930	984	8.2	7.9	9.8
20-44	29,487	27,376	27,513	5,889	5,344	5,421	5.0	5.1	5.9
45-64	25,801	27,534	27,037	3,764	3,593	37,26	6.9	7.7	7.3
65+	1,067	1,027	2,306	66	73	117	16.2	14.1	19.7
Overall	79,026	76,039	77,786	13,999	12,944	13,080	5.7	5.9	5.9

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

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

	Sum LOS Days			Discharges			Average LOS Days		
Age	**2019**	**2020**	**2021**	**2019**	**2020**	**2021**	**2019**	**2020**	**2021**
<1	10,783	9,734	9,195	2,640	2,530	2,431	4.1	3.8	3.8
1-9	2,493	2,506	1,394	464	375	295	5.4	6.7	4.7
10-19	8,133	6,857	9,130	92	819	859	8.8	8.4	10.6
20-44	23,089	22,043	20,810	4,672	4,199	4,253	4.9	5.2	4.9
45-64	19,294	21,265	19,671	2,782	2,715	2,754	6.9	7.8	7.14
65+	958	855	2,060	58	59	90	16.5	14.5	22.9
Overall	**64,750**	**63,260**	**62,260**	**11,537**	**10,697**	**10,682**	**5.6**	**5.9**	**5.8**

A1) Alcohol/Substance Inpatient Medical:

	Sum LOS Days			Discharges			Average LOS Days		
Age	**2019**	**2020**	**2021**	**2019**	**2020**	**2021**	**2019**	**2020**	**2021**
<1	-	-			-		-	-	
1-9	-	-			-		-	-	
10-19	47	49	14	12	5	6	3.9	9.8	2.3
20-44	1,774	1,583	1,049	399	356	326	4.5	4.4	3.2
45-64	1,613	1,411	893	325	322	216	5	4.4	4.1
65+	-	25	4.00	-	1	1	-	25.0	4.0
Overall	3,434	3,068	1,960	736	684	549	4.7	4.5	3.6

A2) Mental Health Inpatient Medical:

	Sum LOS Days			Discharges			Average LOS Days		
Age	2019	2020	**2021**	2019	2020	**2021**	2019	2020	**2021**
<1	27	25	5	3	1	1	9	25.0	5.0
1-9	1,323	991	427	83	54	34	15.9	18.4	12.6
10-19	6,388	5,277	7,575	519	401	446	12.3	13.2	17.0
20-44	10,909	10,330	9,726	1,174	911	810	9.3	11.3	12.0

45-64	6,718	9,212	6,643	402	331	302	16.7	27.8	22.0
65+	274	120	1,384	6	4	8	45.7	30.0	173.0
Overall	25,639	25,955	25,760	2,187	1,702	1601	11.7	15.2	16.1

A3) Other Inpatient Medical:

	Sum LOS Days			**Discharges**			**Average LOS Days**		
Age	**2019**	**2020**	**2021**	**2019**	**2020**	**2021**	**2019**	**2020**	**2021**
<1	10,756	9,709	9,190	2,637	2,529	2,430	4.1	3.8	3.8
1-9	1,170	1,515	967	381	321	261	3.1	4.7	3.7
10-19	1,698	1,531	1,541	390	413	407	4.4	3.7	3.8
20-44	10,406	10,130	10,035	3,099	2,932	3,117	3.4	3.5	3.2
45-64	10,963	10,642	12,135	2,055	2,062	2,236	5.3	5.2	5.4
65+	684	710	672	52	54	81	13.2	13.1	8.3
Overall	**35,677**	**34,237**	**34,540**	**8,614**	**8,311**	**8,532**	**4.1**	**4.1**	**4.0**

B) Inpatient Surgery:

Sum LOS Days				**Discharges**			**Average LOS Days**		
Age	**2019**	**2020**	**2021**	**2019**	**2020**	**2021**	**2019**	**2020**	**2021**
<1	336	250	338	27	35	35	12.4	7.1	9.7
1-9	341	234	314	80	64	64	4.3	3.7	4.9
10-19	574	521	531	146	111	118	3.9	4.7	4.5
20-44	6,355	5,333	6,658	1,205	1,145	1,161	5.3	4.7	5.7
45-64	6,507	6,269	7,296	982	878	962	6.6	7.1	7.6
65+	109	172	239	8	14	26	13.6	12.3	9.2
Overall	**14,222**	**12,779**	**15,376**	**2,448**	**2,247**	**2,366**	**5.8**	**5.7**	**6.5**

The following table (Table 6) presents visit counts by age for outpatient services provided in FFY2019-21, first for all outpatient clinic services, emergency department services, other outpatient services, and then the combination of ED and other outpatient.

FFY19	Age	Emergency Department		Other Outpatient		Total
		N	%Total	N	%Total	N
	<1	2,505	47%	2,816	54%	5,431
	1-9	13,358	41%	19,618	59%	33,345
	10-19	14,687	31%	32,290	68%	47,218
	20-44	34,750	25%	102,742	74%	140,929
	45-64	14,958	15%	84,431	85%	103,717
	65+	154	12%	1,165	89%	1,465
	Overall	**80,412**	**25%**	**243,062**	**75%**	**332,105**
FFY20	**Age**	**Emergency Department**		**Other Outpatient**		**Total**
		N	%Total	N	%Total	N
	<1	1,784	39%	2,753	61%	4,537
	1-9	9,550	35%	17,408	65%	26,958
	10-19	11,704	29%	28,480	71%	40,184
	20-44	29,294	25%	89,798	75%	119,092
	45-64	13,094	15%	74,401	85%	87,495
	65+	146	14%	915	86%	1,061
	Overall	**65,572**	**23%**	**213,755**	**77%**	**279,327**
FFY21	**Age**	**Emergency Department**		**Other Outpatient**		**Total**
		N	%Total	N	%Total	N
	<1	1,368	26%	3,934	74%	5,302
	1-9	8,132	20%	33,237	80%	41,369
	10-19	11,836	22%	42,165	78%	54,001
	20-44	32,318	22%	116,196	78%	148,514
	45-64	14,038	13%	96,031	87%	110,069
	65+	207	11%	1,612	89%	1,819
	Overall	**67,899**	**19%**	**293,175**	**81%**	**361,074**

Discussion

In FFY2020, Global Commitment, Medicaid, paid for 13,080 inpatient stays and 361,074 outpatient visits for Vermonters. The total number of inpatient stays stayed the same from FFY20 to FFY21. Outpatient visits increased by 29% during the same period.

Alcohol/substance abuse inpatient stays were somewhat shorter duration, inpatient surgeries were moderately longer, and psychiatric stays were much longer duration than other inpatient medical stays. Psychiatric inpatient medical services constituted 12% of the total inpatient stays and 33% of inpatient days. The average length of stay for alcohol/substance abuse decreased to an average of 3.6 days in FFY21, and inpatient psychiatric medical average length of stay has increased to 16 days. The longest stays for inpatient psychiatric were in the 45+ age group.

Among outpatient visits, emergency department visits constituted roughly 25% of the outpatient visits during

FFY19, and emergency department was 19% of outpatient visits during FFY21.

VII. Policy and Administrative Difficulties

Fiscal & Operational Management:

For all CY2021, AHS paid DVHA 1/12 of the legislative budget for Global Commitment on the first business day of every month. This payment served as the proxy by which to draw down federal funds for Global Commitment.

For each quarter in CY2021, the State prepared the CMS-64 based upon actual allowable Medicaid expenditures (program, investments, and administrative). Administrative costs are claimed outside of GC budget neutrality. After each quarterly submission, AHS reconciled what was claimed on the CMS-64 versus the monthly payments made to DVHA.

CY2021 was notable for several reasons, which are further described throughout this report:

1. It was the final year of the current Global Commitment to Health Waiver, which began on January 1, 2017, and ran through December 31, 2021. While the next waiver is being negotiated, CMS has agreed to extend the terms of the current waiver by six months.

2. It was the second full year of the COVID Public Health Emergency (PHE). Beginning January 1, 2020, and throughout the PHE, Vermont has received a temporary 6.2% enhancement in federal matching funds through H.R. 6021, the Families First Coronavirus Response Act (FFCRA). A condition to receiving these additional funds is that states do not perform redeterminations of eligibility during the PHE. The result has been two years of significantly increased enrollment.

3. It was the first year of an additional 10% enhancement on federal matching funds for home- and community-based services (HCBS) through the American Rescue Plan Act of 2021 (ARPA). These additional matching funds must be used to supplement and not supplant existing state Medicaid HCBS services in effect as of April 1, 2021.

CY 2021 – Annual Expenditures: Budget Neutrality Test

The following paragraphs refer to the chart below.

Overall Budget Neutrality Performance

The overall Budget Neutrality is in a favorable position. For CY2021, total "With Waiver" expenditures resulted in a surplus of $359,242,533 (22.4%) when compared to the total "Without Waiver" amount (caseloads multiplied by the Budget Neutrality PMPMs). CY2021's surplus was a moderate change from CY2020, when "With Waiver" expenditures resulted in a surplus of $234,525,842 (15.9%). For all five years of the waiver, the cumulative savings was $1,004,690,434 (13.8%).

While there have been surpluses each year of the waiver, they have been more pronounced during the Public Health Emergency (PHE), as enrollment has grown while utilization has not increased at the same pace.

Calendar Year	Suplus/(Deficit)	Suplus/(Deficit) Percent
2017	$ 147,421,162	10.6%
2018	$ 120,166,400	8.6%
2019	$ 143,339,249	10.1%
2020	$ 234,525,842	15.9%
2021	$ 359,242,533	22.4%

*Total Without Waiver Expenditure Amount (enrollment * PMPM)*

The total "Without Waiver" amount reflects actual enrollment multiplied by the Budget Neutrality PMPMs. This is compared to actual "With Waiver" expenditures to determine the budget-neutrality performance. This comparison excludes New Adult, which is reported outside of this calculation under the Supplemental Budget Neutrality Tests.

Observations:

- The 8.30% increase in the total "Without Waiver" amount from CY2020 to CY2021 reflects an increased enrollment of 5.6% and the annual increase in the Budget Neutrality PMPMs.
- From CY2019 to CY2021, the cumulative increase in the total "Without Waiver Amount" was 13.06%, while enrollment increased by 6.7%.
- See below for actual enrollment changes, exclusive of New Adult.

Total Actual Expenditures "With Waiver":

Observations:

- From CY2020 to CY2021, "With Waiver" expenditures decreased by 0.16%. From CY2019 to CY2021, they decreased by 2.42%.
- This is notable in comparison to the increase in enrollment over the PHE. Total expenditures reflect the negative effects of the PHE such as decreased utilization, delayed care, workforce challenges, and alternative sources of federal funding.

Budget Neutrality Calculation

ELIGIBILITY GROUP	DY 12 JAN - DEC 2017	DY 13 JAN - DEC 2018	DY 14 JAN - DEC 2019	DY 15 JAN - DEC 2020	DY16 JAN - Dec 2021	Total 2017-2021	Percent Change from CY 2020 - CY2021	Percent Change from CY 2019 - CY2020	Cumulative Percent Change from CY 2019 - CY2021
Without Waiver (Caseload x pmpms)									
ABD - Non-Medicare - Adult	$ 142,860,455	$ 130,050,973	$ 131,976,747	$ 134,423,935	$ 139,208,993	$ 678,521,102	3.56%	1.85%	5.48%
ABD - Non-Medicare - Child	$ 85,359,001	$ 78,434,428	$ 75,860,331	$ 66,152,263	$ 65,101,590	$ 370,907,614	-1.59%	-12.80%	-14.18%
ABD - Dual	$ 664,153,383	$ 693,539,886	$ 720,885,032	$ 755,287,479	$ 798,326,673	$ 3,632,192,452	5.70%	4.77%	10.74%
Non ABD - Non-Medicare - Adult	$ 101,757,250	$ 96,887,008	$ 73,827,769	$ 83,769,514	$ 119,692,483	$ 475,934,024	42.88%	13.47%	62.12%
Non ABD - Non-Medicare - Child	$ 392,665,288	$ 406,444,058	$ 413,877,439	$ 439,075,666	$ 479,148,936	$ 2,131,211,387	9.13%	6.09%	15.77%
Total Expenditures Without Waiver	**$ 1,386,795,376**	**$ 1,405,356,354**	**$ 1,416,427,318**	**$ 1,478,708,857**	**$ 1,601,478,675**	**$ 7,288,766,580**	**8.30%**	**4.40%**	**13.06%**
With Waiver (Actual Expenditures)									
ABD Non Medicare Adult	$ 162,602,152	$ 162,728,372	$ 168,382,861	$ 177,858,509	$ 173,807,393	$ 845,379,287	-2.28%	5.63%	3.22%
ABD - Non-Medicare - Child	$ 66,593,208	$ 60,077,015	$ 58,176,676	$ 55,369,700	$ 46,735,126	$ 286,951,724	-15.59%	-4.82%	-19.67%
ABD - Dual	$ 445,847,909	$ 461,739,496	$ 484,543,363	$ 476,164,427	$ 473,478,125	$ 2,341,773,320	-0.56%	-1.73%	-2.28%
Non ABD - Non-Medicare - Adult	$ 84,040,229	$ 84,275,155	$ 67,221,781	$ 69,967,054	$ 82,724,813	$ 388,229,031	18.23%	4.08%	23.06%
Non ABD - Non-Medicare - Child	$ 305,543,574	$ 335,706,591	$ 350,805,773	$ 334,351,461	$ 346,363,466	$ 1,672,770,866	3.59%	-4.69%	-1.27%
Premium Offsets	$ (655,991)	$ (772,935)	$ (774,152)	$ (413,790)	$ (333,330)	$ (2,950,197)	-19.44%	-46.55%	-56.94%
Moderate Needs Group	$ 1,488,408	$ 1,378,915	$ 1,429,868	$ 703,701	$ 528,428	$ 5,529,320	-24.91%	-50.79%	-63.04%
Marketplace Subsidy	$ 6,355,286	$ 6,242,717	$ 5,915,336	$ 5,862,966	$ 5,315,462	$ 29,691,768	-9.34%	-0.89%	-10.14%
VT Global Rx	$ 13,824,167	$ 15,300,919	$ 10,692,124	$ 3,494,233	$ 5,311,837	$ 48,623,280	52.02%	-67.32%	-50.32%
VT Global Expansion VHAP	$ 414,825	$ (0)	$ 0	$ -	$ -	$ 414,825			
CRT DSHP	$ 10,331,787	$ 9,240,772	$ 6,787,058	$ 5,604,875	$ 4,317,023	$ 36,281,515	-22.98%	-17.42%	-36.39%
Investments	$ 142,332,671	$ 148,500,000	$ 119,133,231	$ 114,806,088	$ 103,659,221	$ 628,431,211	-9.71%	-3.63%	-12.99%
Total Expenditures With Waiver	**$ 1,239,374,215**	**$ 1,285,189,954**	**$ 1,273,088,069**	**$ 1,244,183,015**	**$ 1,242,240,894**	**$ 6,284,076,146**	**-0.16%**	**-2.27%**	**-2.42%**
Hypothetical Test 1: New Adult									
Limit New Adult PMPM*Mem-Mon	$ 370,689,611	$ 375,735,593	$ 369,387,603	$ 422,539,471	$ 523,330,019	$ 2,061,682,298	23.85%	14.39%	41.68%
With Waiver New Adult Total Expenditures	$ 295,620,338	$ 312,104,578	$ 315,240,526	$ 368,166,529	$ 394,240,162	$ 1,685,372,132	7.08%	16.79%	25.06%
Surplus (Deficit)	***$ 75,069,273***	***$ 63,631,015***	***$ 54,147,078***	***$ 54,372,942***	***$ 129,089,857***	***$ 376,310,166***			
Hypothetical Test 2: SUD IMD									
SUD - IMD ABD - Non-Medicare - Adult		$ 268,039	$ 529,433	$ 389,449	$ 269,727	$ 1,456,648	-30.74%	-26.44%	-49.05%
SUD - IMD ABD - Dual		$ 214,495	$ 442,312	$ 387,577	$ 351,037	$ 1,395,420	-9.43%	-12.37%	-20.64%
SUD - IMD Non ABD - Non-Medicare - Adult		$ 533,391	$ 633,224	$ 459,230	$ 413,592	$ 2,039,437	-9.94%	-27.48%	-34.68%
SUD - IMD New Adult		$ 2,704,249	$ 4,842,747	$ 4,130,907	$ 3,623,296	$ 15,301,198	-12.29%	-14.70%	-25.18%
Limit SUD IMD Without Waiver PMPM*Mem-Mon	**$ -**	**$ 3,720,174**	**$ 6,447,715**	**$ 5,367,163**	**$ 4,657,652**	**$ 20,192,704**	**-13.22%**	**-16.76%**	**-27.76%**
SUD - IMD ABD Non Medicare Adult		$ 249,820	$ 646,440	$ 411,251	$ 206,455	$ 1,513,967	-49.80%	-36.38%	-68.06%
SUD - IMD ABD - Dual		$ 199,224	$ 545,837	$ 342,450	$ 213,896	$ 1,301,407	-37.54%	-37.26%	-60.81%
SUD - IMD Non ABD - Non-Medicare - Adult		$ 540,841	$ 803,762	$ 516,507	$ 388,888	$ 2,249,999	-24.71%	-35.74%	-51.62%
SUD - IMD New Adult		$ 2,826,119	$ 5,869,169	$ 4,250,210	$ 3,463,348	$ 16,408,846	-18.51%	-27.58%	-40.99%
Limit SUD IMD With Waiver (Total Expenditures)	**$ -**	**$ 3,816,005**	**$ 7,865,208**	**$ 5,520,418**	**$ 4,272,587**	**$ 21,474,218**	**-22.60%**	**-29.81%**	**-45.68%**
Surplus (Deficit)	***$ -***	***$ (95,830)***	***$ (1,417,494)***	***$ (153,255)***	***$ 385,065***	*$ (1,281,514)*			
Hypothetical Test 3: SMI IMD									
SMI - IMD ABD - Non-Medicare - Adult				$ 1,106,677	$ 1,059,564	$ 2,166,241	-4.26%		
SMI - IMD ABD - Dual				$ 226,752	$ 510,458	$ 737,210	125.12%		
SMI - IMD Non ABD - Non-Medicare - Adult				$ 261,456	$ 250,752	$ 512,208	-4.09%		
SMI - IMD New Adult				$ 2,975,595	$ 3,118,592	$ 6,094,187	4.81%		
Limit SMI IMD Without Waiver PMPM*Mem-Mon	**$ -**	**$ -**	**$ -**	**$ 4,570,480**	**$ 4,939,366**	**$ 9,509,846**	**8.07%**		
SMI - IMD ABD Non Medicare Adult				$ 1,726,684	$ 3,495,784	$ 5,222,468	102.46%		
SMI - IMD ABD - Dual				$ 188,470	$ 884,861	$ 1,073,331	369.50%		
SMI - IMD Non ABD - Non-Medicare - Adult				$ 727,204	$ 825,373	$ 1,552,577	13.50%		
SMI - IMD New Adult				$ 5,348,474	$ 9,785,706	$ 15,134,180	82.96%		
SMI IMD With Waiver (Total Expenditures)	**$ -**	**$ -**	**$ -**	**$ 7,990,832**	**$ 14,991,724**	**$ 22,982,556**	**87.61%**		
Surplus (Deficit)		***$ -***	***$ -***	***$ (3,420,352)***	***$ (10,052,358)***	***$ (13,472,710)***	**193.90%**		
Waiver Savings Summary (Without Waiver - With Waiver Expenditures)									
Annual Savings	**$ 147,421,162**	**$ 120,166,400**	**$ 143,339,249**	**$ 234,525,842**	**$ 359,237,781**	**$ 1,004,690,434**	**53.18%**	**63.62%**	**150.62%**
Percent Savings	**10.6%**	**8.6%**	**10.1%**	**15.9%**	**22.4%**	**13.8%**			

Enrollment Excluding New Adult

Demonstrtion Popluation (Without New Adult)	Medicaid Eligibility Groups	Total CY 2021	Total CY 2020	Total CY 2019	Change in Members (2020-2021)	Percent Change from 2020-2021	Change in Members (2019-2021)	Percent Change from 2019-2021
1, 4*, 5*	ABD - Non-Medicare - Adult	79,738	79,846	81,293	-108	-0.14%	-1,555	-1.91%
	SUD - IMD - ABD	71	106	149	-35	-33.02%	-78	-52.35%
	SMI - IMD - ABD	66	71		-5	-7.04%	66	
1	ABD - Non-Medicare - Child	19,037	20,060	23,855	-1,023	-5.10%	-4,818	-20.20%
1, 4*, 5*	ABD - Dual	265,553	260,532	257,866	5,021	1.93%	7,687	2.98%
	SUD - IMD - ABD Dual	121	136	158	-15	-11.03%	-37	-23.42%
	SMI - IMD - ABD Dual	26	12		14	116.67%	26	
2	Non ABD - Non-Medicare - Adult	153,446	112,654	104,150	40,792	36.21%	49,296	47.33%
	SUD - IMD - Non ABD	145	161	222	-16	-9.94%	-77	-34.68%
	SMI - IMD - Non ABD	24	26		-2	-7.69%	24	
2	Non ABD - Non-Medicare - Child	744,876	713,979	703,957	30,897	4.33%	40,919	5.81%
	Medicaid Expansion				0		0	
7	Global RX	77,560	78,064	77,498	-504	-0.65%	62	0.08%
8	Global RX	40,123	41,565	44,169	-1,442	-3.47%	-4,046	-9.16%
6	Moderate Needs	1,697	1,963	2,208	-266	-13.55%	-511	-23.14%
	Total	**1,382,483**	**1,309,175**	**1,295,525**	**73,308**	**5.60%**	**86,958**	**6.71%**
	Average Members	**115,207**	**109,098**	**107,960**	**6,109**		**7,247**	

Supplemental Budget Neutrality Tests:

Supplemental Test: New Adult:

There is a New Adult surplus for CY21 of $129,089,857. The New Adult "Without Waiver" Limit shows a significantly increased enrollment during the PHE:

- From CY2020 to CY21, the New Adult "Without Waiver" amount increased 23.85% as New Adult enrollment increased 18.79%.
- From CY2019 to CY2021, the New Adult "Without Waiver" limit increased 41.68%, while New Adult enrollment increased 30.38%.
- In comparison, New Adult "With Waiver" expenditures increased at a much lower rate.
- Cumulatively, throughout the five years of the waiver, there is a $376,310,166 surplus.

ELIGIBILITY GROUP	DY 12 JAN - DEC 2017	DY 13 JAN - DEC 2018	DY 14 JAN - DEC 2019	DY 15 JAN - DEC 2020	DY16 JAN - Dec 2021	Total 2017-2021	Percent Change from CY 2020 - CY2021	Percent Change from CY 2019 - CY2020	Cumulative Percent Change from CY 2019 - CY2021
Hypothetical Test 1: New Adult									
Limit New Adult PMPM*Mem-Mon	$ 370,689,611	$ 375,735,593	$ 369,387,603	$ 422,539,471	$ 523,330,019	$ 2,061,682,298	23.85%	14.39%	41.68%
With Waiver New Adult Total Expenditures	$ 295,620,338	$ 312,104,578	$ 315,240,526	$ 368,166,529	$ 394,240,162	$ 1,685,372,132	7.08%	16.79%	25.06%
Surplus (Deficit)	***$ 75,069,273***	***$ 63,631,015***	***$ 54,147,078***	***$ 54,372,942***	***$ 129,089,857***	***$ 376,310,166***			

Demonstration Population	Medicaid Eligibility Group	Total CY 2021	Total CY 2020	Total CY 2019	Change in Members (2020-2021)	Percent Change from 2020-2021	Change in Members (2019-2021)	Percent Change from 2019-2021
	New Adults							
3	New Adult without Child	545,896	453,635	423,150	92,261	20.34%	122,746	29.01%
	SUD - IMD New Adult w/o Child	971	1,157	1,352	-186	-16.08%	-381	-28.18%
	SMI - IMD New Adult w/o Child	203	211		-8	-3.79%	203	
3	New Adult with Child	310,660	267,004	233,294	43,656	16.35%	77,366	33.16%
	SUD - IMD New Adult with Child	220	209	259	11	5.26%	-39	-15.06%
	SMI - IMD New Adult with Child	53	44		9	20.45%	53	
	Total	**858,003**	**722,260**	**658,055**	**135,743**	**18.79%**	**199,948**	**30.38%**
	Average Members	**71,500**	**60,188**	**54,838**	**11,312**		**16,662**	

Supplemental Test: SUD IMD:

There is a SUD IMD surplus for the calendar year 2021 of $385,065. Members served and expenditures have decreased significantly throughout the PHE. Cumulatively, there is an overall deficit of $1,281,514 over the five years of the waiver that will be applied to the overall budget neutrality test*.

ELIGIBILITY GROUP	DY 12 JAN - DEC 2017	DY 13 JAN - DEC 2018	DY 14 JAN - DEC 2019	DY 15 JAN - DEC 2020	DY16 JAN - Dec 2021	Total 2017-2021	Percent Change from CY 2020 - CY2021	Percent Change from CY 2019 - CY2020	Cumulative Percent Change from CY 2019 - CY2021
Hypothetical Test 2: SUD IMD									
SUD - IMD ABD - Non-Medicare - Adult		$ 268,039	$ 529,433	$ 389,449	$ 289,727	$ 1,456,648	-30.74%	-26.44%	-49.05%
SUD - IMD ABD - Dual		$ 214,496	$ 442,312	$ 387,577	$ 351,037	$ 1,395,420	-9.43%	-12.37%	-20.64%
SUD - IMD Non ABD - Non-Medicare - Adult		$ 533,391	$ 633,224	$ 459,230	$ 413,592	$ 2,039,437	-9.94%	-27.48%	-34.68%
SUD - IMD New Adult		$ 2,704,249	$ 4,842,747	$ 4,130,907	$ 3,623,296	$ 15,301,198	-12.29%	-14.70%	-25.18%
Limit SUD IMD Without Waiver PMPM*Mem-Mon	$ -	$ 3,720,174	$ 6,447,715	$ 5,367,163	$ 4,657,652	$ 20,192,704	-13.22%	-16.76%	-27.76%
SUD - IMD ABD Non Medicare Adult		$ 249,820	$ 646,440	$ 411,251	$ 206,455	$ 1,513,967	-49.80%	-36.38%	-68.06%
SUD - IMD ABD - Dual		$ 199,224	$ 545,837	$ 342,450	$ 213,896	$ 1,301,407	-37.54%	-37.26%	-60.81%
SUD - IMD Non ABD - Non-Medicare - Adult		$ 540,841	$ 803,762	$ 516,507	$ 388,888	$ 2,249,999	-24.71%	-35.74%	-51.62%
SUD - IMD New Adult		$ 2,826,119	$ 5,869,169	$ 4,250,210	$ 3,463,348	$ 16,408,846	-18.51%	-27.58%	-40.99%
Limit SUD IMD With Waiver (Total Expenditures)	$ -	$ 3,816,005	$ 7,865,208	$ 5,520,418	$ 4,272,587	$ 21,474,218	-22.60%	-29.81%	-45.68%
Surplus (Deficit)	$ -	$ (95,830)	$ (1,417,494)	$ (153,255)	$ 385,065	$ (1,281,514)			

Supplemental Test: SMI IMD:

As shown below, there is an SMI IMD deficit for the calendar year 2021 of $10,052,358. Cumulatively, there is a deficit of $13,472,710 that will be applied to the overall budget neutrality test*.

ELIGIBILITY GROUP	DY 12 JAN - DEC 2017	DY 13 JAN - DEC 2018	DY 14 JAN - DEC 2019	DY 15 JAN - DEC 2020	DY16 JAN - Dec 2021	Total 2017-2021	Percent Change from CY 2020 - CY2021	Percent Change from CY 2019 - CY2020	Cumulative Percent Change from CY 2019 - CY2021
Hypothetical Test 3: SMI IMD									
SMI - IMD ABD - Non-Medicare - Adult				$ 1,106,677	$ 1,059,564	$ 2,166,241	-4.26%		
SMI - IMD ABD - Dual				$ 226,752	$ 510,458	$ 737,210	125.12%		
SMI - IMD Non ABD - Non-Medicare - Adult				$ 261,456	$ 250,752	$ 512,208	-4.09%		
SMI - IMD New Adult				$ 2,975,595	$ 3,118,592	$ 6,094,187	4.81%		
Limit SMI IMD Without Waiver PMPM*Mem-Mon	$ -	$ -	$ -	$ 4,570,480	$ 4,939,366	$ 9,509,846	8.07%		
SMI - IMD ABD Non Medicare Adult				$ 1,726,684	$ 3,495,784	$ 5,222,468	102.46%		
SMI - IMD ABD - Dual				$ 188,470	$ 884,861	$ 1,073,331	369.50%		
SMI - IMD Non ABD - Non-Medicare - Adult				$ 727,204	$ 825,373	$ 1,552,577	13.50%		
SMI - IMD New Adult				$ 5,348,474	$ 9,785,706	$ 15,134,180	82.96%		
SMI IMD With Waiver (Total Expenditures)	$ -	$ -	$ -	$ 7,990,832	$ 14,991,724	$ 22,982,556	87.61%		
Surplus (Deficit)		$ -	$ -	$ (3,420,352)	$ (10,052,358)	$ (13,472,710)	193.90%		

*Any deficits in this supplemental SMI IMD and SUD IMD categories are applied to the overall budget neutrality test. Throughout the term of the waiver (2017-2021), there has been ample room in the overall budget neutrality test to accommodate these deficits.

Home and Community-Based Services:

Vermont has received partial approval for a temporary 10% FMAP increase for qualifying HCBS services under the American Rescue Plan Act of 2021 (ARP), beginning April 1, 2021, through March 31, 2022. Vermont also claimed HCBS reinvestment expenditures, which also receive the enhanced FMAP. There is one remaining quarter to draw down the 10% enhanced FMAP for qualifying HCBS services (QE0322). States have until March 31, 2024, to reinvest the additional earned FMAP in ways that supplement and not supplant existing state funds expended for Medicaid HCBS in effect as of April 1, 2021.

As outlined in its HCBS spending plan, Vermont has increased payment rates for mental health, developmental disabilities, Brain Injury Program, Choices for Care, Assistive Community Care Services (ACCS), and substance use treatment providers. Vermont has experienced challenges in isolating the value of the rate increases to report on the CMS-64 HCBS Reinvestment lines. For example, it is difficult to identify the actual costs of a 3% rate increase due to the various timing of when the rate increases went into effect and the various provider types who receive bundled payments. To date, Vermont has only reported a portion of the 3% rate increase as a reinvestment activity. Vermont welcomes any technical assistance or a methodology on how to best calculate the value of provider rate increases given the noted challenges.

Below are total HCBS expenditures claimed to CMS for the period of April 1, 2021, through December 31, 2021, and the additional 10% federal match that Vermont earned.

Home- and Community-Based Service (HCBS)

Claimed on 64 for QE1221	Gross	Federal	State Share Cash (at HCBS enhanced match)	HCBS enhanced match component
HBCS ARP Sec 9817 enhanced match	$ 167,242,206	$ 121,534,911	45,707,295	$ 16,724,221
VIII New Adult HCBS ARP Sec 9817 match	$ 10,731,266	$ 10,194,703	536,563	$ 536,563
HCBS ARP Sec 9817 reinvest enhanced match	$ 742,743	$ 539,751	202,992	$ 74,274
VIII New Adult HCBS ARP Sec 9817 reinvest enhanced match	$ 141,209	$ 134,149	7,060	$ 7,060
Subtotal Claim	**$ 178,857,424**	**$ 132,403,514**	**$ 46,453,910**	**$ 17,342,119**
Claimed on 64 for QE0921	**Gross**	**Federal**	**State Share Cash**	**HCBS enhanced match**
HBCS ARP Sec 9817 enhanced match	$ 150,190,653	$ 106,289,925	43,900,728	$ 15,019,065
VIII New Adult HCBS ARP Sec 9817 match	$ 10,668,291	$ 10,134,876	533,415	$ 533,414
HCBS ARP Sec 9817 reinvest enhanced match	$ 780,379	$ 552,274	228,105	$ 78,038
VIII New Adult HCBS ARP Sec 9817 reinvest enhanced match	$ 129,299	$ 122,834	6,465	$ 6,465
Subtotal Claim	$ 161,768,622	$ 117,099,909	$ 44,668,713	**$ 15,636,982**
Claimed on 64 for QE0621 (submitted as PQA)	**Gross**	**Federal**	**State Share Cash**	**HCBS enhanced match**
QE 0621 HCBS ARP Sec 9817 (enhanced match)	170,147,853	120,413,636	49,734,217	$ 17,014,786
QE 0621 HCBS ARP Sec 9817 (enhanced match)	49,517	35,043	14,474	$ 4,952
QE 0621 HCBS ARP Sec 9817 (New Adult VIII enhanced)	10,645,408	10,113,138	532,270	$ 532,271
Subtotal Claim	180,842,778	130,561,817	50,280,961	**17,552,008**
Total Claims	**$ 521,468,824**	**$ 380,065,240**	**$ 141,403,584**	**$ 50,531,109**

Investments:

AHS continues to actively monitor Investment spending. The total CY2021 Budget Neutrality Investment Limit was $136,500,000. The State's CY2021 annual investment expenditures of $103,659,221 complies with the STC#84 annual limit. The state completed its scheduled phasedown of IMD service by 25% from DY14 in DY16. From DY14 to DY16, IMD Investment expenses decreased 34%, which is a likely result of the PHE.

State-Funded Marketplace Subsidies

Per STC#41, the State stayed below the CY2021 funding limit of $9,546,869 for state-funded marketplace subsidies with a cumulative total of $5,315,462.

VIII.Capitated Revenue Spending

The PMPM rates as set for 1/1/21-12/31/21 are listed below. AHS submitted the calendar year 2021 PMPM Medicaid rates to CMS in December 2020, which were approved by CMS on September 3, 2021.

PMPM Capitated Rates (Categories include SUD and SMI MEGs)

	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
All MEGs	**$763.43**

Attachments

Attachment 1 – Budget Neutrality Report

State of Vermont Global Commitment to Health
Budget Neutrality PMPM Projection vs 64 Actuals Summary
February 1, 2022

ELIGIBILITY GROUP	DY 12 JAN - DEC 2017	DY 13 JAN - DEC 2018	DY 14 JAN - DEC 2019	DY 15 JAN - DEC 2020	DY 16 JAN - Dec 2021	Total
Without Waiver (Caseload x pmpms)						
ABD - Non-Medicare - Adult	$ 142,860,455	$ 130,050,973	$ 131,976,747	$ 134,423,935	$ 139,208,993	$ 678,521,102
ABD - Non-Medicare - Child	$ 85,359,001	$ 78,434,428	$ 75,860,331	$ 66,152,263	$ 65,101,590	$ 370,907,614
ABD - Dual	$ 664,153,383	$ 693,539,886	$ 720,885,032	$ 755,287,479	$ 798,326,673	$ 3,632,192,452
Non ABD - Non-Medicare - Adult	$ 101,757,250	$ 96,887,008	$ 73,827,769	$ 83,769,514	$ 119,692,483	$ 475,934,024
Non ABD - Non-Medicare - Child	$ 392,665,288	$ 406,444,058	$ 413,877,439	$ 439,075,666	$ 479,148,936	$ 2,131,211,387
Total Expenditures Without Waiver	**$ 1,386,795,376**	**$ 1,405,356,354**	**$ 1,416,427,318**	**$ 1,478,708,857**	**$ 1,601,478,675**	**$ 7,288,766,580**
With Waiver						
ABD Non Medicare Adult	$ 162,602,152	$ 162,728,372	$ 168,382,861	$ 177,858,509	$ 173,807,393	$ 845,379,287
ABD - Non-Medicare - Child	$ 66,593,208	$ 60,077,015	$ 58,176,676	$ 55,369,700	$ 46,735,126	$ 286,951,724
ABD - Dual	$ 445,847,909	$ 461,739,496	$ 484,543,363	$ 476,164,427	$ 473,478,125	$ 2,341,773,320
Non ABD - Non-Medicare - Adult	$ 84,040,229	$ 84,275,155	$ 67,221,781	$ 69,967,054	$ 82,724,813	$ 388,229,031
Non ABD - Non-Medicare - Child	$ 305,543,574	$ 335,706,591	$ 350,805,773	$ 334,351,461	$ 346,363,466	$ 1,672,770,866
Premium Offsets	$ (655,991)	$ (772,935)	$ (774,152)	$ (413,790)	$ (333,330)	$ (2,950,197)
Moderate Needs Group	$ 1,488,408	$ 1,378,915	$ 1,429,868	$ 703,701	$ 528,428	$ 5,529,320
Marketplace Subsidy	$ 6,355,286	$ 6,242,717	$ 5,915,336	$ 5,862,966	$ 5,315,462	$ 29,691,768
VT Global Rx	$ 13,824,167	$ 15,300,919	$ 10,692,124	$ 3,494,233	$ 5,311,837	$ 48,623,280
VT Global Expansion VHAP	$ 414,825	$ (0)	$ 0	$ -	$ -	$ 414,825
CRT DSHP	$ 10,331,787	$ 9,240,772	$ 6,787,058	$ 5,604,875	$ 4,317,023	$ 36,281,515
Investments	$ 142,332,671	$ 148,500,000	$ 119,133,231	$ 114,806,088	$ 103,659,221	$ 628,431,211
Total Expenditures With Waiver	**$ 1,239,374,215**	**$ 1,285,189,954**	**$ 1,273,088,069**	**$ 1,244,183,015**	**$ 1,242,240,894**	**$ 6,284,076,146**
Hypothetical Test 1: New Adult						
Limit New Adult PMPM*Mem-Mon	$ 370,689,611	$ 375,735,593	$ 369,387,603	$ 422,539,471	$ 523,330,019	$2,061,682,298
With Waiver New Adult Total Expenditures	$ 295,620,338	$ 312,104,578	$ 315,240,526	$ 368,166,529	$ 394,240,162	$1,685,372,132
Surplus (Deficit)	*$ 75,069,273*	*$ 63,631,015*	*$ 54,147,078*	*$ 54,372,942*	*$ 129,089,857*	*$ 376,310,166*
Hypothetical Test 2: SUD IMD						
SUD - IMD ABD - Non-Medicare - Adult		$ 268,039	$ 529,433	$ 389,449	$ 269,727	$ 1,456,648
SUD - IMD ABD - Dual		$ 214,495	$ 442,312	$ 387,577	$ 351,037	$ 1,395,420
SUD - IMD Non ABD - Non-Medicare - Adult		$ 533,391	$ 633,224	$ 459,230	$ 413,592	$ 2,039,437
SUD - IMD New Adult		$ 2,704,249	$ 4,842,747	$ 4,130,907	$ 3,623,296	$ 15,301,198
Limit SUD IMD Without Waiver PMPM*Mem-Mon	**$ -**	**$ 3,720,174**	**$ 6,447,715**	**$ 5,367,163**	**$ 4,657,652**	**$ 20,192,704**
SUD - IMD ABD Non Medicare Adult		$ 249,820	$ 646,440	$ 411,251	$ 206,455	$ 1,513,967
SUD - IMD ABD - Dual		$ 199,224	$ 545,837	$ 342,450	$ 213,896	$ 1,301,407
SUD - IMD Non ABD - Non-Medicare - Adult		$ 540,841	$ 803,762	$ 516,507	$ 388,888	$ 2,249,999
SUD - IMD New Adult		$ 2,826,119	$ 5,869,169	$ 4,250,210	$ 3,463,348	$ 16,408,846
Limit SUD IMD With Waiver (Total Expenditures)	**$ -**	**$ 3,816,005**	**$ 7,865,208**	**$ 5,520,418**	**$ 4,272,587**	**$ 21,474,218**
Surplus (Deficit)	*$ -*	*$ (95,830)*	*$ (1,417,494)*	*$ (153,255)*	*$ 385,065*	*$ (1,281,514)*
Hypothetical Test 3: SMI IMD						
SMI - IMD ABD - Non-Medicare - Adult				$ 1,106,677	$ 1,059,564	$ 2,166,241
SMI - IMD ABD - Dual				$ 226,752	$ 510,458	$ 737,210
SMI - IMD Non ABD - Non-Medicare - Adult				$ 261,456	$ 250,752	$ 512,208
SMI - IMD New Adult				$ 2,975,595	$ 3,118,592	$ 6,094,187
Limit SMI IMD Without Waiver PMPM*Mem-Mon	**$ -**	**$ -**	**$ -**	**$ 4,570,480**	**$ 4,939,366**	**$ 9,509,846**
SMI - IMD ABD Non Medicare Adult				$ 1,726,684	$ 3,495,784	$ 5,222,468
SMI - IMD ABD - Dual				$ 188,470	$ 884,861	$ 1,073,331
SMI - IMD Non ABD - Non-Medicare - Adult				$ 727,204	$ 825,373	$ 1,552,577
SMI - IMD New Adult				$ 5,348,474	$ 9,785,706	$ 15,134,180
Limit SMI IMD With Waiver (Total Expenditures)	**$ -**	**$ -**	**$ -**	**$ 7,990,832**	**$ 14,991,724**	**$ 22,982,556**
Surplus (Deficit)		*$ -*	*$ -*	*$ (3,420,352)*	*$ (10,052,358)*	*$ (13,472,710)*
Waiver Savings Summary						
Annual Savings	**$ 147,421,162**	**$ 120,166,400**	**$ 143,339,249**	**$ 234,525,842**	**$ 359,237,781**	**$ 1,004,690,434**
Shared Savings Percentage	30%	25%	25%	25%	25%	
Shared Annual Savings	$ 44,226,348	$ 30,041,600	$ 35,834,812	$ 58,631,460	$ 89,809,445	$ 258,543,666
Hypothetical Test 2 & 3 adjustment	***$ -***	***$ (95,830)***	***$ (1,417,494)***	***$ (3,573,607)***	***$ (10,052,358)***	***$ (15,139,289)***
Total Cumulative Savings		**$ 74,172,118**	**$ 108,589,437**	**$ 163,647,290**	**$ 243,404,378**	**$ 243,404,378**

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	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	76,917	78,509	79,940
(B-2) eligible member months w/o Child	110,736	106,927	103,710	101,777	102,648	110,982	116,878	118,707	129,659	134,078	139,285	142,810
(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	$ 46,993,979.49	$ 47,966,643.73	$ 48,840,941.80
(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	$ 68,530,246.52	$ 69,602,662.38	$ 79,217,759.23	$ 81,917,635.66	$ 85,098,956.45	$ 87,252,625.70
(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%	60.77%	62.67%
(D-2) New Adult FMAP w/o Child	93.00%	93.00%	93.00%	93.00%	90%	90%	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	$ 28,558,241.34	$ 29,149,329.39	$ 30,608,618.23
(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	$ 61,677,221.87	$ 62,642,396.14	$ 71,295,983.31	$ 73,725,872.09	$ 76,589,060.81	$ 78,527,363.13
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	$ 85,081,144.45	$ 86,824,685.36	$ 99,295,809.79	$ 102,284,113.43	$ 105,738,390.20	$ 109,135,981.36
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	$ 83,784,434.33	$ 83,439,260.42	$ 76,989,045.50
Supplemental Budget Neutrality Test 1 over/(under) - report any negative # under main GC budget	$ 7,674,337.60	$ 5,113,127.88	$ 8,770,147.88	$16,655,402.63	$ (6,907,947.32)	$ 13,439,340.51	$ 15,394,677.88	$ 13,018,639.04	$ 25,052,804.62	$ 18,499,679.10	$ 22,299,129.78	$ 32,146,935.86

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: September 1, 2021

VERMONT
AGENCY OF HUMAN SERVICES

VERMONT
AGENCY OF HUMAN SERVICES

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VERMONT
AGENCY OF HUMAN SERVICES

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 Caseload	SFY'21 BAA Budget	SFY'21 BAA PMPM	SFY'21 Actuals Thru June 30, 2021 Caseload	SFY'21 Actuals Thru June 30, 2021 Expenses	SFY'21 Actuals Thru June 30, 2021 PMPM	% of Expenses to Budget Line Item	Ending Enrollment as of June 2021
ABD Adult	6,475	$ 59,467,740	$ 765.35	6,241	$ 55,539,766	$ 741.62	93.39%	6,236
ABD Dual	17,678	$ 48,359,639	$ 227.97	17,921	$ 45,495,222	$ 211.56	94.08%	18,070
General Adult	10,043	$ 60,812,047	$ 504.60	11,121	$ 58,810,030	$ 440.67	96.71%	12,511
New Adult Childless	37,550	$ 204,362,854	$ 453.53	42,029	$ 219,469,261	$ 435.16	107.39%	44,803
New Adult w/Child	22,473	$ 102,062,482	$ 378.46	24,521	$ 114,487,987	$ 389.08	112.17%	25,714
BD Child	1,634	$ 21,562,729	$ 1,099.69	1,624	$ 19,998,435	$ 1,025.98	92.75%	1,578
General Child	59,540	$ 146,388,328	$ 204.89	60,630	$ 155,451,561	$ 213.66	106.19%	61,087
Underinsured Child	549	$ 527,572	$ 80.08	558	$ 542,218	$ 81.01	102.78%	537
CHIP	4,450	$ 8,852,317	$ 165.77	4,338	$ 9,417,889	$ 180.93	106.39%	4,320
Vermont Premium Assistance	15,935	$ 5,625,792	$ 29.42	15,187	$ 5,591,697	$ 30.68	99.39%	14,646
Vermont Cost Sharing	*3,235*	$ 1,076,393	$ 27.73	*3,044*	$ 1,176,262	$ 32.20	109.28%	2,924
Pharmacy Only	9,889	$ 5,630,360	$ 47.45	9,980	$ 4,892,710	$ 40.85	86.90%	9,899
Choices for Care - Traditional	-	$ -	$ -	-	$ -	$ -	0.00%	-
Choices for Care - Acute	4,477	$ 46,175,225	$ 859.49	*4,440*	$ 41,518,289	$ 779.32	89.91%	4,325
Total Medicaid	190,693	$ 710,903,477	$ 310.67	198,589	$ 732,391,326	$ 307.33	103.02%	203,726

All AHS YTD SFY'21

Medicaid Eligibility Group	SFY'21 BAA Caseload	SFY'21 BAA Budget	SFY'21 BAA PMPM	SFY'21 Actuals Thru June 30, 2021 Caseload	SFY'21 Actuals Thru June 30, 2021 Expenses	SFY'21 Actuals Thru June 30, 2021 PMPM	% of Expenses to Budget Line Item	Ending Enrollment as of June 2021
ABD Adult	6,475	$ 149,134,880	$ 1,919.37	6,241	$ 141,631,362	$ 1,891.19	94.97%	6,236
ABD Dual	17,678	$ 227,898,074	$ 1,074.30	17,921	$ 215,994,082	$ 1,004.40	94.78%	18,070
General Adult	10,043	$ 74,194,121	$ 615.64	11,121	$ 73,272,422	$ 549.04	98.76%	12,511
New Adult Childless	37,550	$ 239,454,004	$ 531.41	42,029	$ 256,028,579	$ 507.65	106.92%	44,803
New Adult w/Child	22,473	$ 115,165,886	$ 427.05	24,521	$ 129,675,883	$ 440.70	112.60%	25,714
BD Child	1,634	$ 43,998,441	$ 2,243.90	1,624	$ 39,347,380	$ 2,018.64	89.43%	1,578
General Child	59,540	$ 297,289,260	$ 416.09	60,630	$ 292,350,543	$ 401.82	98.34%	61,087
Underinsured Child	549	$ 989,028	$ 150.13	558	$ 1,073,305	$ 160.36	108.52%	537
CHIP	4,450	$ 11,789,545	$ 220.78	4,338	$ 11,900,937	$ 228.63	100.94%	4,320
Vermont Premium Assistance	15,935	$ 5,625,792	$ 29.42	15,187	$ 5,591,697	$ 30.68	99.39%	14,646
Vermont Cost Sharing	*3,235*	$ 1,076,393	$ 27.73	*3,044*	$ 1,176,262	$ 32.20	109.28%	2,924
Pharmacy Only	9,889	$ 5,630,360	$ 47.45	9,980	$ 4,892,710	$ 40.85	86.90%	9,899
Choices for Care - Traditional	4,605	$ 233,587,557	$ 4,227.06	4,590	$ 208,116,863	$ 3,778.17	89.10%	4,477
Choices for Care - Acute	*4,477*	$ 51,163,140	$ 952.33	*4,440*	$ 46,091,384	$ 865.16	90.09%	4,325
Total Medicaid	190,821	$ 1,456,996,483	$ 636.28	198,740	$ 1,427,143,410	$ 598.41	97.95%	203,878

VERMONT
AGENCY OF HUMAN SERVICES

All AHS and AOE YTD SFY'21

Medicaid Eligibility Group	SFY'21 BAA Caseload	SFY'21 BAA Budget	SFY'21 BAA PMPM	SFY'21 Actuals Thru June 30, 2021 Caseload	SFY'21 Actuals Thru June 30, 2021 Expenses	SFY'21 Actuals Thru June 30, 2021 PMPM	% of Expenses to Budget Line Item	Ending Enrollment as of June 2021
ABD Adult	6,475	$ 150,320,795	$ 1,934.63	6,241	$ 142,468,791	$ 1,902.37	94.78%	6,236
ABD Dual	17,678	$ 228,038,059	$ 1,074.96	17,921	$ 216,054,903	$ 1,004.69	94.75%	18,070
General Adult	10,043	$ 74,401,992	$ 617.36	11,121	$ 73,446,714	$ 550.34	98.72%	12,511
New Adult Childless	37,550	$ 239,552,739	$ 531.63	42,029	$ 256,099,243	$ 507.79	106.91%	44,803
New Adult w/Child	22,473	$ 115,169,071	$ 427.06	24,521	$ 129,686,660	$ 440.73	112.61%	25,714
BD Child	1,634	$ 56,372,188	$ 2,874.96	1,624	$ 46,700,267	$ 2,395.87	82.84%	1,578
General Child	59,540	$ 332,230,166	$ 465.00	60,630	$ 320,232,936	$ 440.15	96.39%	61,087
Underinsured Child	549	$ 1,240,306	$ 188.27	558	$ 1,296,652	$ 193.73	104.54%	537
CHIP	4,450	$ 13,318,106	$ 249.40	4,338	$ 13,125,827	$ 252.16	98.56%	4,320
Vermont Premium Assistance	15,935	$ 5,625,792	$ 29.42	15,187	$ 5,591,697	$ 30.68	99.39%	14,646
Vermont Cost Sharing	*3,235*	$ 1,076,393	$ 27.73	*3,044*	$ 1,176,262	$ 32.20	109.28%	2,924
Pharmacy Only	9,889	$ 5,630,360	$ 47.45	9,980	$ 4,892,710	$ 40.85	86.90%	9,899
Choices for Care - Traditional	4,605	$ 233,587,557	$ 4,227.06	4,590	$ 208,116,863	$ 3,778.17	89.10%	4,477
Choices for Care - Acute	*4,477*	$ 51,192,959	$ 952.89	*4,440*	$ 46,103,720	$ 865.39	90.06%	4,325
Total Medicaid	190,821	$ 1,507,756,483	$ 658.45	198,740	$ 1,464,993,245	$ 614.28	97.16%	203,878

The Vermont Cost Sharing Reduction (VCSR) population are also eligble 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
October 1, 2021 – December 31, 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.

October 2021:

- Member called to submit negative feedback regarding their medical provider. The member calls the office for information and requests a call back from the doctor regarding their personal health. When they received a call back it is hours or days later. The member stated that they understand that the doctor is busy, but they are uncomfortable with discussing their health needs with the front desk receptionists. CSR apologized for the inconvenience, documented the member's feedback, and offered to mail out a Provider Complaint Form.
- Member requested to submit negative feedback regarding Durable Medical Equipment. Member states that the process to get all pieces of a machine covered through DME is very inconvenient. This has resulted in many calls to multiple companies and they think that the DME Vendor should carry all pieces to the equipment. CSR apologized for the inconvenience, documented their feedback and transferred to DVHA.
- Member states that the DVHA website for Green Mountain Care Covered Services conflicts with the information that they are given over the phone when they call Member Services to review Covered Services. CSR apologized for the inconvenience, documented their feedback and reviewed the Medicaid/Dr.D Covered Services Chart with them. DVHA MPS staff actively review and address where miscommunication may occur.

- Member requested to speak with a supervisor about recent care at a provider's office. Customer states that providers are not providing correct care and have given incorrect information. Supervisor apologized for the inconvenience, documented their feedback and mailed out a Provider Complaint form.

November 2021:

- Member was transferred to a supervisor per their request regarding the interactions they have had over the past few months with their providers. They are dissatisfied with their medical determinations. Supervisor documented their feedback and offered to mail a Provider Complaint Form along with referring them to VT Legal Aid and Area on Aging.

December 2021:

- Member requested to submit Negative Feedback with a supervisor. Member states that their providers will not do what the member wants them to do. VT Legal Aid has mailed the member paperwork to fill out but the member does not want to fill it out due to their hand writing being so bad. Supervisor apologized for the inconvenience, documented the feedback and advised to contact VT Legal Aid again to explain the situation.
- Member requested to document negative feedback as they are currently on VPharm-3 and only pay $0.03 for their Prescription Drug Plan through Humana. Member states that this is a waste of money and paperwork having to pay for such a low premium but having to pay for the VPharm-3 coverage through GMC. Member is also upset that there are no online options to pay for any GMC Programs. CSR apologized for the inconvenience and explained that GMC pays up to the benchmark so that their PDP is only a couple cents a month and went over their options on how they can pay for the VPharm-3 premium. They also documented the customers feedback request.

2021 Annual Summary (January 1, 2021 – December 31, 2021)

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

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

Green Mountain Care members continued to receive timely and accurate information throughout 2021. The Green Mountain Care Customer Support Center (MAXIMUS) captures member requests to file formal complaints on behalf of DVHA on a daily basis. MAXIMUS documents these actions in the Siebel CRM and escalates the Service Request to the appropriate Resolver Group for review and actions. Additionally, MPS receives monthly reports from MAXIMUS that highlight negative feedback. In most cases, the member received resolution through the Green Mountain Care Customer Support Center representative, and the actions were documented within the monthly report.

MPS staff worked to ensure that Green Mountain Care members' questions, concerns, and complaints were addressed in a timely manner. Member complaint topics covered in 2021 included:

- access to care concerns;
- covered services;

- payment issues; and
- provider complaints;

MPS staff worked across DVHA and the Agency of Human Services in order to provide Green Mountain Care members with information that provided timely resolution. Of particular note was the efforts of DVHA's MPS and Pharmacy units' collaboration with MAXIMUS to reduce the number of complaints regarding pharmacy benefits. DVHA staff noticed confusion when calls regarding durable medical equipment (DME) purchased at a pharmacy were accidentally assigned to Pharmacy Unit staff for resolution. DVHA staff provided MAXIMUS with updated job aides and business processes in order to ensure that members' pharmacy questions received first call resolution whenever possible. The number of customer complaints regarding misguided call transfers reduced sharply from when the problem was identified in September 2021 to the time when updated resources were implemented shortly thereafter. MPS staff continues to work closely with MAXIMUS to monitor trends and improve our customer support resources and response.

Attachment 4 – Grievance and Appeal Report

Grievance and Appeal Quarterly Report
Medicaid Managed Care Model
All Departments Combined Data
November 1, 2021 – January 31, 2022

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 November 1, 2021, through January 31, 2022.

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 19 grievances filed; twelve 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, 95% were filed by the beneficiary, and 5% were filed by a representative. DMH had 68%, DAIL had 11%, DVHA had 16%, and VDH had 5% of the grievances filed. There were no grievances filed for DCF during this quarter.

Grievances were filed for service categories case management, , community social supports, quality of service, staff/contractor issues, 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 17 appeals filed. Of these 17 appeals, 15 were resolved (88%).

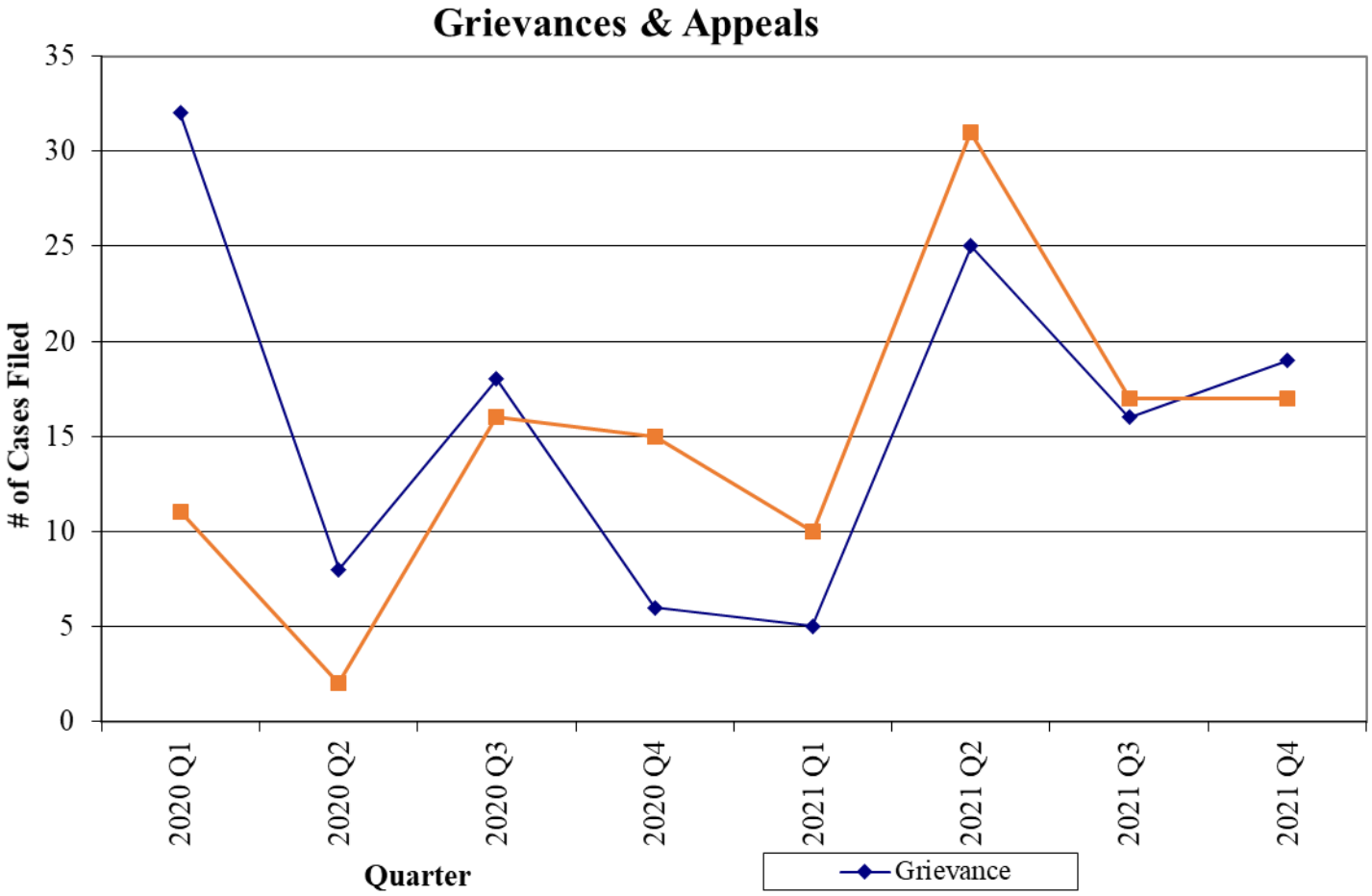
Of the 15 appeals that were resolved this quarter, 100% were resolved within the statutory time frame of 30 days. The average number of days it took to resolve these cases was 19 days. Acknowledgement letters of the receipt of an appeal must be sent within five days; the average was two days.

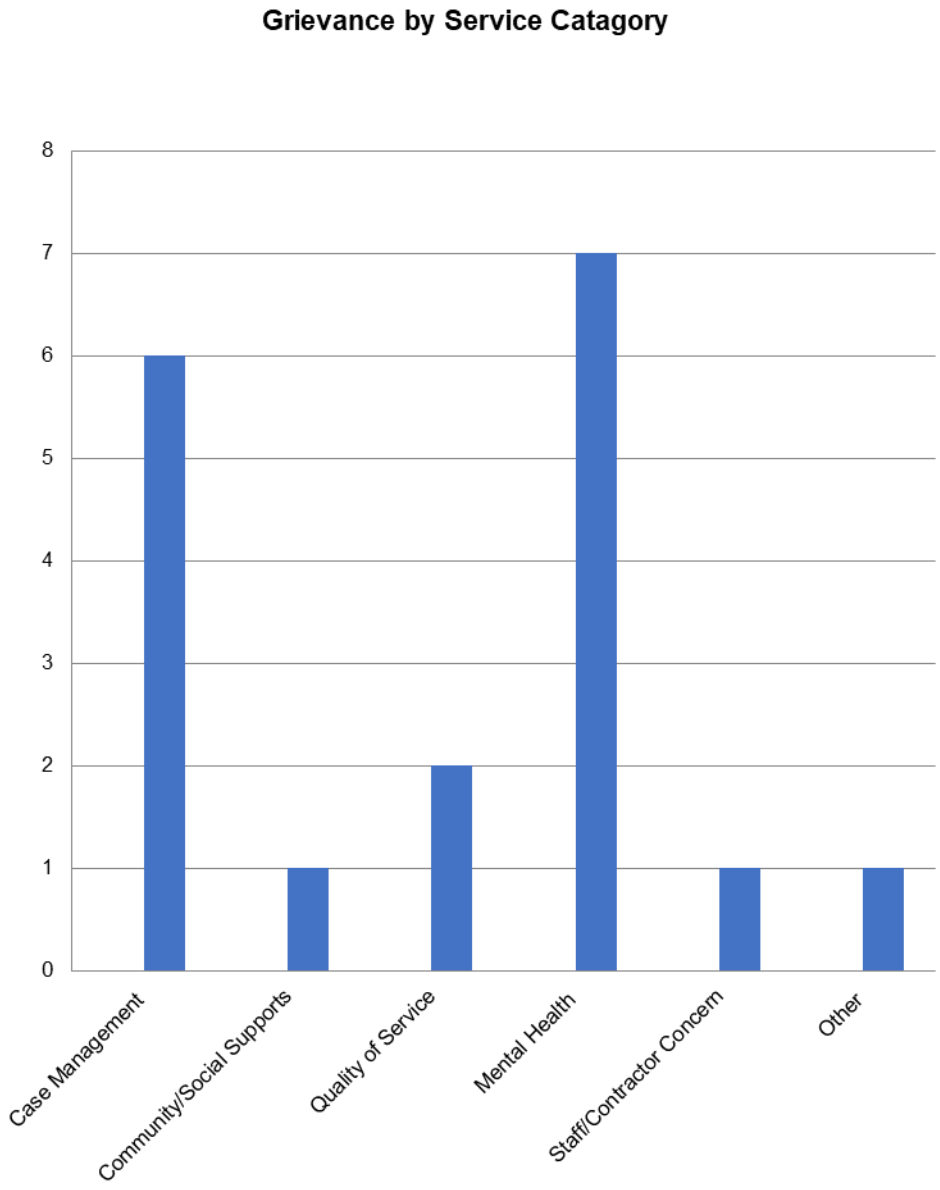
Of the 17 appeals filed, DVHA had 11 appeals filed (64%), DAIL had 3 (18%), DMH had 3 (18%) and VDH had none.

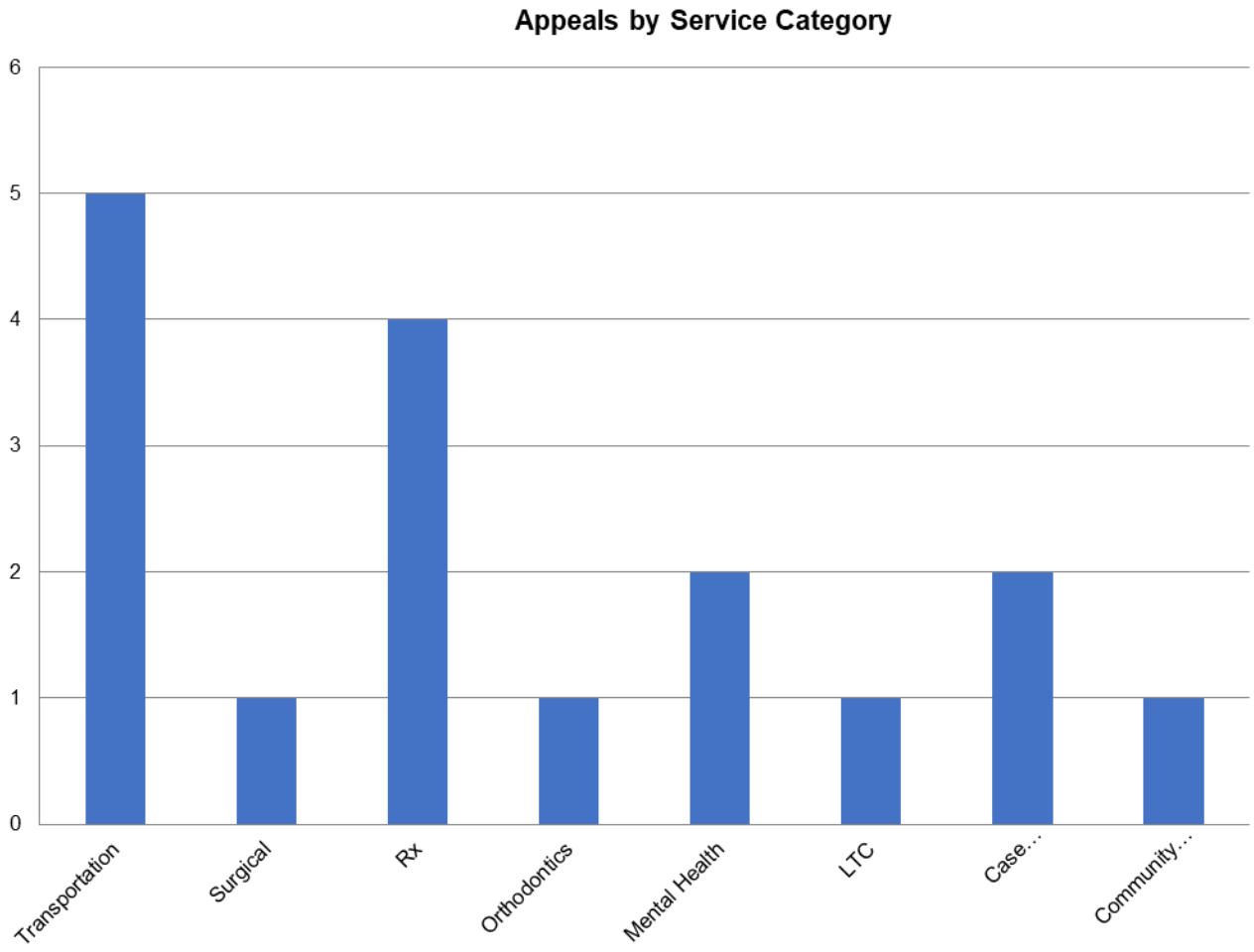
The appeals filed were for service categories, community/social supports, transportation, prescriptions, case management, counseling, metal health services, personal care services and Long-Term Care.

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

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


Grievances & Appeals
35
30
25
20
15
10
5
0
# of Cases Filed
2020 Q1
2020 Q2
2020 Q3
2020 Q4
2021 Q1
2021 Q2
2021 Q3
2021 Q4
Quarter
Grievance


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


Appeals by Service Category
6
5
4
3
2
1
0
Transportation
Surgical
Rx
Orthodontics
Mental Health
LTC
Case…
Community…

2021 Summary

Grievances:

There were 70 Grievances filed in 2021. Of those 70 grievances filed, DAIL had 19%, DMH had 54%, DVHA had 21% and VDH had 6%. The top service categories for grievances filed were for mental health, community/social supports and case management.

Appeals:

There were 70 appeals filed in 202. Of those appeals filed, DAIL had 27%, DMH had 9%, DVHA had 63%, and VDH had 1%. The top reasons for appeal were, prescriptions, transportation services, and long-term care services.

Attachment 5 - HCA Report

Vermont Legal Aid

Office of the Health Care Advocate

Quarterly Report

October 1, 2021 - December 31, 2021

to the

Agency of Administration

submitted by

Michael Fisher, Chief Health Care Advocate

Office of the Health Care Advocate

January 21, 2022

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 (GMCB), 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 until the spring of 2022. The HCA Helpline now has eight advocates working to resolve issues.

This past quarter, the HCA focused on Vermont Health Connect (VHC) Open Enrollment and Medicare Part D Open Enrollment. We talked to 77 households about how Medicare works and what it covers (54 the previous quarter). Our calls about Premium Tax Credit eligibility also doubled this past quarter (60 this quarter vs. 31 the previous quarter), and we had a significant increase in cases of consumers interested in buying plans on VHC (43 this quarter vs. 23 the previous quarter). Medicaid eligibility remains the top issue with over 1500 webpages views and 180 calls about all types of Medicaid eligibility. Overall, the HCA helpline had 756 calls this quarter.

We did significant outreach and consumer education about Open Enrollment, and about the increased subsidies available on VHC because of American Rescue Plan Act (ARPA). We talked to 30 households about ARPA and their eligibility for increased subsidies. We also had two news articles about ARPA on our website, which were viewed 143 times this quarter.

Starting in 2022, VHC enrollees will start to pay their premiums directly to the insurance carrier, instead of to VHC. The HCA has been working with VHC on consumer education and outreach about the transition. We received some calls from consumers about this issue, and we plan on continuing to do outreach and education to consumers during this transition.

The HCA is also working with other stakeholders to consider changes to the Vermont Essential Health Benchmark plan on VCA. The group is considering whether the plan can be updated and expanded within the regulatory framework to cover items such as dental care for adults, fertility services, or hearing aids. During this quarter, we continued to meet and hear from stakeholders about possible changes.

Kristi's Story:

Kristi lost her insurance and needed to see a dentist. Previously, she had been on her spouse's plan, but they were now divorced. She did not think that she could afford to pay for her insurance. She had delayed her dental work for several years, and she was now having pain whenever she ate. The HCA advocate quickly discovered that Kristi would be eligible for Medicaid for Children and Adults. Medicaid for Children and Adults has $1000 worth of dental coverage, plus two preventive visits per year. The advocate helped Kristi apply, and she was approved. The next hurdle was finding a dentist who accepted Medicaid *and* was taking new patients. The HCA contacted Department of Vermont Health Access, and a dental access specialist helped Kristi find a dentist who was accepting new patients, and she was able to schedule an appointment.

The HCA helpline continues collaborating with other projects within Vermont Legal Aid and community stakeholders to make sure the community understands the impact on health care programs of 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 will again advocate for the use of one-time Federal funds to improve access to dental care and dentures for lower income Vermonters and plans to continue to advocate for increased dental access. We had 32 calls about dental access this past quarter. Our dental pages service webpage was viewed 762 times, which was the third highest of all our webpages.

As we enter another winter of the COVID-19 pandemic, we know that Vermonters and our health care system are under a great deal of stress. Many Vermonters face the challenges of medical debt or the fear of such debt. In addition, we continue to hear from many Vermonters who cannot access healthcare because of the long wait times for appointments. We are working with other stakeholders to address accessibility and affordability issues as the state moves forward, so that Vermonters will be able to get in and see their providers. The HCA will continue to work to make healthcare more accessible for all Vermonters, and to make the system more equitable, responsive, and affordable.

Cecily's Story:

Cecily called the HCA because she wanted help understanding her eligibility for Premium Tax Credit (PTC) to help pay for a plan on Vermont Health Connect (VHC) Cecily was over 65 years old, and most people over 65 lose their eligibility for PTC when they become eligible for premium free Medicare Part A. Cecily, however, was not eligible for Premium free Medicare Part A, and this meant that she could stay on a VHC plan and continue to get PTC to help pay for her plan. With the passage of American Rescue Plan Act (ARPA) in 2021, many Vermont households were eligible for increased subsidies to help pay for VHC plans. When the HCA advocate reviewed Cecily's income, she discovered that VHC did not have the correct income listed. When the HCA advocate reported the new income, and Cecily was found eligible for more PTC because of ARPA, her monthly premium was reduced to less than $5. She was also now eligible for more cost-sharing assistance, which meant that her deductible and maximum out-of-pocket also decreased.

Zach's Story:

Zach found a new doctor, but he had no way to get to any appointments. He did not have a car or anyone who could drive him. The HCA advocate investigated and found that Zach was on Medicare. Medicare does not have non-emergency transportation benefits, but Medicaid does. The advocate discovered that Zach would qualify for Medicaid for the Aged, Blind and Disabled (MABD) with a small spend down. If you are slightly above the MABD limit, you can request a spenddown. The spenddown is calculated by taking the amount your monthly income is over the monthly limit for MABD and multiplying it by six. Basically, your spenddown amount acts like a deductible. You need to spend that amount or owe that amount in healthcare before your MABD can become active. Zach was only slightly above the MABD limit, so he had small spenddown. He was able to meet the spenddown with what he was spending for over-the-counter medications. Once he met the spenddown, his MABD was active. Zach was then able to access Medicaid transportation and get rides to his medical appointments.

Rosie's Story:

Rosie called the HCA because she had received a bill for over $15,000 from a recent hospital stay and could not pay for it. When the HCA advocate spoke to Rosie, she found that Rosie had been on Medicaid when she was hospitalized. The HCA advocate investigated and found that Rosie had given her insurance information to the hospital. The hospital had submitted the bill to Vermont Medicaid. Medicaid providers are subject to balance billing provisions, and once they have billed Medicaid, they cannot bill the patient for the service. The HCA advocate pointed this out to the hospital, and it agreed that the bill had been sent in error and Rosie was able to disregard it. When talking to Rosie, the HCA advocates learned that she was turning 65 in the next month and was worried about the costs of Medicare. The HCA advocates advised Rosie she would be eligible for a program called the Medicare Savings Program which would help pay for Medicare premiums and showed her how to apply for it. This meant Rosie would be able to afford her premiums when she turned 65 and went onto Medicare.

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

- **28.44%** about **Access to Care**
- **10.58%** about **Billing/Coverage**
- **6.61%** about **Buying Insurance**
- **14.15%** about **Complaints**
- **9.79%** about **Consumer Education**
- **19.31%** about **Eligibility** for state and federal programs
- **9.79**% 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 146 of our cases had eligibility for state and federal healthcare programs listed as the primary issue, an additional 482 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 VHC and Medicaid programs fell into all three insurance status categories.

The full quarterly report for October – December 2021 includes:

- This narrative
- Five data reports, including three based on the caller's insurance status:
  - **All Calls/All Coverages**: 756
  - **Department of Vermont Health Access (DVHA) beneficiaries**: 221

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

- **Commercial Plan Beneficiaries**: 147
- **Uninsured Vermonters**: 50
- **Vermont Health Connect (VHC)**: 126

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 756 (vs. 737 last quarter)

1. Complaints about Providers 111 (101)
2. MAGI Medicaid Eligibility 82 (90)
3. Medicare Consumer Education 77 (54)
4. Premium Tax Credit Eligibility 60 (33)
5. Medicaid Eligibility (non-MAGI) 56 (54)
6. Buy-in Programs/Medicare Savings Programs 55 (52)
7. Information/Applying for DVHA Programs 45 (50)
8. Access to Prescription Drugs/Pharmacy 45 (48)
9. Buying Insurance – QHP – VHC 43 (14)
10. Other issues (Not Health-related) 41 (36)
11. Medicare Eligibility 40 (1)
12. Access to Nursing Home & Home Health 37 (0)
13. Complaints about Hospital 36 (1)
14. Hospital Billing & Financial Assistance 33 (11)
15. Buying Medicare Supplement Insurance 31 (0)

Vermont Health Connect Calls 126 (109)

1. Premium Tax Credit Eligibility 60 (31)
2. Medicaid Eligibility – MAGI 45 (43)
3. Buying QHPs through VHC 43 (23)
4. Information about ACA 23 (5)
5. ACA Tax Issues 17 (16)
6. IRS Reconciliation Education 17 (12)
7. ARPA (American Rescue Plan Act) Consumer Education 16 (16)
8. Information about DVHA 15 (16)
9. Nonfinancial Eligibility Requirements 15 (13)
10. Medicare Consumer Education 14 (6)
11. ARPA Eligibility 14 (14)
12. Special Enrollment Period Eligibility 14 (14)

DVHA Beneficiary Calls 221 (vs. 258 last quarter)

1. MAGI Medicaid Eligibility 35 (50)
2. Non-MAGI Medicaid Eligibility 35 (38)
3. Complaints about Providers 32 (38)
4. Eligibility for MSPs/Buy-In Programs 32 (26)
5. Information about Medicare 26 (26)
6. Information about DVHA 21 (28)
7. Access to Dental Care 18 (15)
8. Medicare Eligibility (non-MAGI) 26 (38)
9. Access to Prescription Drugs/Pharmacy 15 (18)
10. Part D Plan Eligibility 13 (9)

Commercial Plan Beneficiary Calls 147 (vs. 107 last quarter)

1. Premium Tax Credit Eligibility 40 (20)
2. Buying QHPs through VHC 29 (14)
3. Medicare Consumer Education 17 (3)
4. Information about ACA 15 (4)
5. ARPA Consumer Education 14 (12)
6. Eligibility for MAGI Medicaid 14 (16)
7. Carrier Complaints 13 (3)
8. IRS Reconciliation Consumer Education 13 (8)
9. ARPA Eligibility 13 (12)
10. Billing - Coverage &Contract Questions 12 (9)
11. Billing - Premiums 12 (14)

The HCA received **756** 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"): 29.23% (221 calls)
- **Medicare**[2] **beneficiaries (**Medicare only, Medicare Advantage Plans, Medicare and a Medicare Supplemental Plan aka Medigap, Medicare and Medicaid also known as "dual eligible," Medicare and Medicare Savings Program also called Buy-In program, Medicare and Part D, or Medicare and VPharm): 16.66% (126 calls)
- **Commercial plan beneficiaries** (employer-sponsored insurance, small group plans, or individual plans) 19.44% (147 calls)
- **Uninsured:** 6.61 % (50 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 776 cases this quarter. Overall, 325 were resolved by brief analysis and advice. Another 266 were resolved by brief analysis and referral. There were 100 complex interventions involving complex analysis and more than two hours of an advocate's time, and 42 cases that involved at least one direct intervention on behalf of a consumer. The HCA provided consumer education in 498 cases. We also estimated eligibility for insurance coverage and helped enroll people onto coverage in 60 cases. We saved consumers $69,527.66 this quarter.

Consumer Protection Activities

Rate Review

The HCA monitors all commercial insurance carrier requests to the Green Mountain Care Board (Board) for changes to premium rates. These are usually requests for rate increases.

On August 5, 2021, the Board issued a Decision and Order related to Blue Cross Blue Shield of Vermont (BCBSTV) 2022 insurance premiums for the individual and small group markets (Order). On August 18, 2021, BCBSVT filed a Motion to Reconsider (Motion) with the Board challenging the Order. BCBSVT argued, in the Motion that the Board should have used the affordability statutory factor rather than the word "excessive," which BCBSVT argues is an actuarial term, when it reduced BCBSVT's allowed profit. The HCA filed a response to the Motion and argued that the Board properly reduced BCBSVT's proposed rate. On August 24, 2021, the Board denied the BCBSVT Motion.

On September 3, 2021, BCBSVT filed notice that it would appeal the Order to the Vermont Supreme Court arguing that the Board should not have used the word "excessive" when it reduced its proposed profit. The parties to the suit are BCBSVT, represented by Stris and Maher, the Board, represented by the Attorney General, and the HCA. BCBSVT filed their initial brief on January 3, 2022. The Attorney General and the HCA will file their initial briefs on February 14, 2022, after which BCBSVT will file a reply brief. After BCBSTVT's reply brief, the Vermont Supreme Court may schedule that case for oral argument.

Hospital Budgets

The HCA is currently assessing the findings of the GMCB's hospital sustainability process and its potential impact on Vermonters.

Certificate of Need Review Process

The GMCB currently has an unusually large number of open certificate of need applications. In the last quarter, the HCA monitored ongoing and new applications and filed several notices of appearance (NOA) requests to best monitor processes and raise consumer-related concerns, when necessary.

Oversight of Accountable Care Organizations

The HCA participated in the GMCB's annual ACO budget review process of OneCare Vermont (OCV). During the public hearing, we argued against proposed cuts to population health related investments and called for an increased commitment to health equity and organizational transparency. We continue to advocate for the right of the public to view and comment on required disclosures of current and future budgetary activities of non-certified 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, and weekly Prescription Drug Technical Advisory subgroup meetings (which includes the Out-of-Pocket Costs and Pharmacy Benefit Manager subgroups).

Act 140 Workgroups

The HCA participated in two workgroups convened as part of Act No. 140 (H.960) – An act relating to miscellaneous health care provisions. These workgroups are led by the GMCB and the Department of Financial Regulation. Our recommendations to build on the shared goal of simplifying and streamlining the PA process and focus on improving Vermonters' ability to access the right care at the right time were incorporated into the final report.

Interstate Telehealth Working Group

The HCA participated in a working group formed out of Act 21 of 2021 that was created to assess the landscape of telehealth practice and its current and potential future impacts on Vermont.

The Medicaid and Exchange Advisory Committee

The Advisory Committee met two times this quarter. The content of this quarter's meetings included a focus on this year's open enrollment, budget priorities from the advisory committee, the Essential Health Benefit (EHB) analysis, the 1115 waiver renegotiation as well as the Act 48 implementation process.

Mental Health Integration Council

The HCA is a member of the Mental Health Integration Council. The Chief advocate attended all meetings of the full council as well as the Pediatric integration subgroup. The council spent meeting time understanding the integration work successes already underway in Vermont including the efforts our Blueprint for Health. In addition, the effort to organizing the subgroups and developing a process for how the subgroups work on overlapping issues have been a significant focus.

EHB Benchmark Plan Workgroup: October 20th, October 27th; November 3rd, and December 29th

The HCA participated in two meetings of the Essential Health Benefits Plan Workgroup. During this quarter we defined the service areas that should be costed out in consideration of updating our EHB.

The workgroup also started to take testimony from stakeholders and advocates about these service areas.

Legislative Advocacy

This quarter saw significant increases in activities by Legislative study committees as we draw closer to the session. The HCA attended the meetings of the Health Reform Oversight Committee as well as the Legislative Task Force on Access and Affordability. The HCA also met with various legislators in response to their requests for information and continued the process of legislative outreach for the coming legislative year.

Medical Debt Story Telling Project

The HCA has long recognized the impact of medical debt on Vermonters. This year, in addition to the ongoing casework and the regulatory work, we engaged in a proactive outreach project with specific goals in mind.

First, we want to help diminish the stigma that people experience when they owe medical debts beyond their ability to pay. Vermonters and their policymakers must understand that these debts are related to structural problems in our healthcare system. Many families, even those with insurance, are exposed to unreasonable medical charges for preventive, routine, and emergency medical care, given their income.

Second, the HCA wanted to learn more about how medical debt impacts Vermonters. We heard directly from Vermont families whose medical debt prevents them from seeking medical care.

This quarter's activities included a significant amount of outreach to Vermonters through paid media, social media, community organizations, and legislators. We engaged Vermonters first through a simple survey. The main goal of this survey tool was to engage a broader set of Vermonters and to hear directly from them in their own words.

This quarter, the project continued with more in-depth discussions with a smaller set of people to help us deepen our understanding of how Vermont households experience medical debt. We plan to share our findings publicly with Vermonters and the Legislature, as well as other major stakeholders in the health policy arena.

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
- Bridges to Health
- Blue Cross Blue Shield of Vermont
- Department of Financial Regulation
- Families USA
- IRS Taxpayer Advocate Service
- Let's Grow Kids
- Mexican Consulate
- 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
- Rights and Democracy (RAD)
- RISPnet Group
- Rural Vermont
- South Royalton Legal Clinic
- Spectrum Youth and Family Services
- SHIP, State Health Insurance Assistance Program
- U.S. Based Committee for Refugees and Immigrants Vermont
- 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 Health Care for All
- Vermont Interfaith Action (VIA)
- Vermont Medical Society
- Vermont - NEA
- Vermont Workers' Center
- VPIRG
- 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. *Health* - section home page – 1,683 pageviews
2. *Income Limits - Medicaid* – 1,577
3. *Dental Services* – 762
4. *Medicaid* – 476
5. *Services Covered – Medicaid* – 453
6. *Long-Term Care* – 406
7. *Medicare Savings Programs* – 405
8. *Medicaid, Dr. Dinosaur & Vermont Health Connect* – 400
9. *Vermont Health Connect* – 360
10. *HCA Help Request Form* – 323 pageviews and 118 online help requests
11. *Resource Limits - Medicaid* – 282
12. *Medical Decisions: Advance Directives* – 277
13. *Choices for Care* – 238
14. *Prescription Help – State Pharmacy Programs* – 229
15. *News: Coronavirus and Long-Term Care* – 208
16. *Dr. Dynasaur* – 203
17. *Choices for Care Income Limits* – 191
18. *Vermont Long-Term Care Ombudsman Project* – 188
19. *Transportation for Health Care* – 187
20. *Medicare* – 193 *

This quarter we had these additional news items:

- *News item 1: Coronavirus SEP for Vermont Health Connect* – 115 pageviews
- *News item 2: More Financial Help Available for Vermont Health Connect Plans for 2022; Enroll Now!* – 100
- *News item 3: You May Be Eligible for New Financial Help for Health Insurance (ARPA)* – 43
- *News item 4: Public Listening Sessions Gather Vermonters' Stories of Long Wait Times for Health Services* – 30

Outreach and Education:

This quarter the HCA focused on connecting Vermonters with information about the Vermont Health Connect Open Enrollment Period and the increased financial help that is available because of the American Rescue Plan Act (ARPA).

We collaborated with 16 organizations and participated in 10 outreach presentations to provide Vermonters and direct service providers with accessible information on insurance eligibility health care policy.

The HCA utilized social media platforms Facebook and Youtube to produce interactive educational resources to inform Vermonters about the Open Enrollment Period and the increased financial assistance that is available through Vermont Health Connect (VHC). On December 10th, the HCA published an outreach video event on YouTube and Facebook. Viewers learned about the extended Open Enrollment Period, premium process changes, and the extra benefits that are available because of the American Rescue Plan Act (ARPA). Over 300 Vermonters viewed this recording.

In addition to publishing these digital educational resources, the HCA also co-hosted education events in collaboration with partner organizations. On November 19th our office partnered with the Family Room and the U.S. Based Committee for Refugees and Immigrants (USCRI) to host an educational event on the services that the HCA can provide to Vermonters. The HCA's Communication Coordinator hosted 8 more presentations on these subjects during this quarter in collaboration with Working Bridges, the Mexican Consulate, Let's Grow Kids, the Old North End Senior Center, and indigenous community leaders. These education meetings and presentations were attended by 27 direct service providers. These collaborations have led to referrals that have helped our office connect with an array of Vermonters who often have urgent access to care questions.

The HCA also developed digital outreach materials that were distributed on Facebook and Front Porch Forum. These materials provided Vermonters with information on the Medicare and Vermont Health Connect Open Enrollment Periods. We used targeted ads on Facebook to connect to over 700 Vermonters with this information.

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 letter**:**

- **Letter to Vermonter Taxpayers without insurance**

Department	Final Receiver Suffix	Investment Description	QE 0321	QE 0621	QE 0921	QE 1221	CY 2021 Total
AHSCO	9091	Investments (STC-79) - 2-1-1 Grant (41)	113,250	10,235	140,765		**264,250**
AHSCO	9090	Investments (STC-79) - Designated Agency Underinsured Services (54)	1,575,984	4,996,257	1,575,984	1,704,648	**9,852,873**
AOE	n/a	Non-state plan Related Education Fund Investments					**-**
DCF	9402	Investments (STC-79) - Medical Services (55)	41,263	14,021	48,271	47,906	**151,461**
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	1,010,121	972,668	**4,014,579**
DCF	9406	Investments (STC-79) - Aid to the Aged, Blind and Disabled Res Care Level III (57)	26,243	26,431	26,538	25,976	**105,188**
DCF	9407	Investments (STC-79) - Aid to the Aged, Blind and Disabled Res Care Level IV (58)	61,115	58,539	56,817	57,774	**234,245**
DCF	9408	Investments (STC-79) - Essential Person Program (59)	191,025	184,639	186,115	184,007	**745,786**
DCF	9409	Investments (STC-79) - GA Medical Expenses (60)	42,555	20,511	49,202	52,233	**164,501**
DCF	9411	Investments (STC-79) - Therapeutic Child Care (61)	287,305	279,190	311,274	261,445	**1,139,215**
DCF	9412	Investments (STC-79) - Lund Home (2)	693,053	720,143	612,428	481,815	**2,507,438**
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	17,665	30,153	**98,403**
DCF	9415	Investments (STC-79) - Challenges for Change: DCF (9)	36,083	23,333	23,157	79,898	**162,471**
DCF	9416	Investments (STC-79) - Strengthening Families (26)	198,336	304,099	202,563	303,907	**1,008,906**
DCF	9417	Investments (STC-79) - Lamoille Valley Community Justice Project (62)	54,594	58,253	56,430		**169,277**
DCF	9418	Investments (STC-79) - Building Bright Futures (35)	129,876	112,290	99,002	77,798	**418,966**
DCF	9419	Investments (STC-79) - United Ways 2-1-1 (41)			75,475	75,468	**150,944**
DDAIL	9602	Investments (STC-79) - Mobility Training/Other Svcs.-Elderly Visually Impaired (63)	148,054	90,774	87,554	34,966	**361,347**
DDAIL	9603	Investments (STC-79) - DS Special Payments for Medical Services (64)	1,119,839	374,476	940,239	145,091	**2,579,646**
DDAIL	9604	Investments (STC-79) - Flexible Family/Respite Funding (27)	289,286	267,578	570,909		**1,127,772**
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	245,009	245,966	**981,969**
DDAIL	9607	Investments (STC-79) - HomeSharing (77)	69,670	69,459	73,451	69,697	**282,276**
DDAIL	9608	Investments (STC-79) - Self-Neglect Initiative (78)	130,202		135,411		**265,613**
DDAIL	9609	Investments (STC-79) - Seriously Functionally Impaired: DAIL (65)		29,990			**29,990**
DMH	9501	Investments (STC-79) - Special Payments for Treatment Plan Services (28)	23,353	39,545	26,789	20,461	**110,149**
DMH	9502	Investments (STC-79) - MH Outpatient Services for Adults (66)	827,220	774,685	804,889	626,059	**3,032,852**
DMH	9504	Investments (STC-79) - Mental Health Consumer Support Programs (79)	98,319	113,715	147,083	100,153	**459,270**
DMH	9505	Investments (STC-79) - Mental Health CRT Community Support Services (16)	(697,469)	1,436,960	2,026,730	1,622,525	**4,388,746**
DMH	9506	Investments (STC-79) - Mental Health Children's Community Services (12)	597,557	559,399	799,397	493,344	**2,449,697**
DMH	9507	Investments (STC-79) - Emergency Mental Health for Children and Adults (29)	2,332,038	2,304,917	3,141,077	2,343,722	**10,121,753**
DMH	9508	Investments (STC-79) - Respite Services for Youth with SED and their Families (67)	311,549	267,100	465,994	313,103	**1,357,746**
DMH	9510	Investments (STC-79) - Emergency Support Fund (22)	131,863	105,167	263,468	94,211	**594,710**
DMH	9511	Investments (STC-79) - Institution for Mental Disease Services: DMH (3) - VPCH	3,154,313	3,069,979	5,232,837	3,890,749	**15,347,878**
DMH	9512	Investments (STC-79) - Institution for Mental Disease Services: DMH (3) - BR	2,607,983	2,161,055	495,118	44,101	**5,308,256**
DMH	9514	Investments (STC-79) - Seriously Functionally Impaired: DMH (68)	28,956	27,630	44,177	38,519	**139,282**
DMH	9516	Investments (STC-79) - Acute Psychiatric Inpatient Services (13)	156,906	194,642	425,526	35,460	**812,534**
DOC	n/a	Return House	74,551	187,218	48,853	68,677	**379,299**
DOC	n/a	Northern Lights	79,633	152,252			**231,885**
DOC	n/a	Pathways to Housing - Transitional Housing	176,666	159,478	181,700	263,069	**780,913**
DOC	n/a	St. Albans and United Counseling Service Transitional Housing (Challenges for Change)	68,677	125,682	-	58,938	**253,297**
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	-	868,087	**3,039,831**
DOC	n/a	Intensive Sexual Abuse Program					**-**
DOC	n/a	Vermont Achievment 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	687,057	451,477	**2,500,750**
DVHA	9103	Investments (STC-79) - Buy-In (52)	15,276	10,701	891	934	**27,802**
DVHA	9104	Investments (STC-79) - HIV Drug Coverage (53)	1,438		605		**2,043**
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	1,175,335	1,206,952	**4,400,251**
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)				2,863,208	**2,863,208**
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				**108,212**
VAAFM	n/a	Agriculture Public Health Initiatives					**-**
VDH	9201	Investments (STC-79) - Emergency Medical Services (19)	84,423	143,874	105,463	111,749	**445,508**
VDH	9203	Investments (STC-79) - TB Medical Services (74)	487	309	1,695	34	**2,525**
VDH	9204	Investments (STC-79) - Epidemiology (40)	27,503	27,340	57,856	54,014	**166,713**
VDH	9205	Investments (STC-79) - Health Research and Statistics (39)	140,741	207,756	276,900	411,781	**1,037,178**
VDH	9206	Investments (STC-79) - Health Laboratory (31)	454,147	584,377	702,215	800,189	**2,540,927**
VDH	9207	Investments (STC-79) - Tobacco Cessation: Community Coalitions (50)	582,170	588,892	392,920	276,861	**1,840,843**
VDH	9208	Investments (STC-79) - Statewide Tobacco Cessation (76)					**-**
VDH	9209	Investments (STC-79) - Family Planning (75)	296,039	274,108	165,257	462,459	**1,197,863**
VDH	9210	Investments (STC-79) - Physician/Dentist Loan Repayment Program (25)	144,000	455,000	504,000	497,111	**1,600,111**
VDH	9211	Investments (STC-79) - Renal Disease (73)					**-**
VDH	9213	Investments (STC-79) - WIC Coverage (37)		1,983		834,021	**836,003**
VDH	9214	Investments (STC-79) - Area Health Education Centers (AHEC) (21)	166,717		393,568		**560,285**
VDH	9217	Investments (STC-79) - Patient Safety - Adverse Events (47)	8,582	10,082	547	5,766	**24,977**
VDH	9219	Investments (STC-79) - Substance Use Disorder Treatment (30)	1,009,910	623,086	974,923	1,009,216	**3,617,135**
VDH	9220	Investments (STC-79) - Recovery Centers (17)	478,134	313,439	359,915	310,154	**1,461,643**
VDH	9221	Investments (STC-79) - Enhanced Immunization (46)	17,426	22,648	17,238	37,902	**95,214**
VDH	9222	Investments (STC-79) - Poison Control (48)	37,010	31,765	32,316	39,039	**140,130**
VDH	9223	Investments (STC-79) - Public Inebriate Services, C for C (23)	561,415	421,582	269,348	327,155	**1,579,500**
VDH	9224	Investments (STC-79) - Fluoride Treatment (38)	6,196	5,179	8,162	15,745	**35,282**
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	20,937	18,672	**74,485**
VDH	9228	Investments (STC-79) - VT Blueprint for Health (44)	110,032	66,834	171,539	117,550	**465,955**
VSC	n/a	Health Professional Training	-		409,461		**409,461**
VVH	n/a	Vermont Veterans Home					**-**
			22,664,232	**28,034,242**	**27,376,164**	**25,584,583**	**103,659,221**

Institution for Mental Disease (IMD)

Investment IMD

Budget Information

CY 2021 (DVHA only) = $3,193,299

What We Do

The Brattleboro Retreat is considered an Institute for Mental Disease (IMD) and is a key provider for psychiatric and detoxification inpatient care in the state. DVHA purchases services identified as cost-effective alternatives to traditional state plan services.

- In SFY 2019, there were a total of 1730 (ACO and non-ACO) adult psychiatric hospital admissions across the state. Of those 1730 admissions, 881 of them (or 50.7%) were at the Brattleboro Retreat.
- In SFY 2020, there were a total of 1488 (ACO and non-ACO) adult psychiatric hospital admissions across the state. Of those 1488 admissions, 636 of them (or 42.7%) were at the Brattleboro Retreat.
- In SFY 2021, there were a total of 1259 (ACO and non-ACO) adult psychiatric hospital admissions across the state. Of those 1259 admissions, 419 of them (or 33.3%) were at the Brattleboro Retreat.
- Continued funding is necessary to ensure access to needed care.

Who We Serve

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

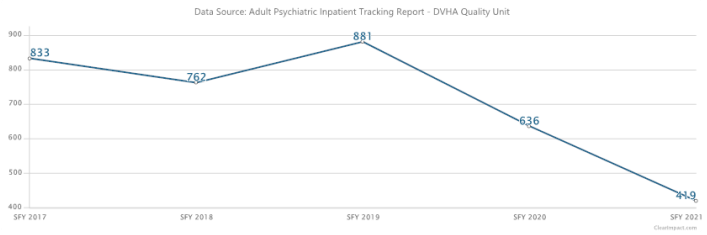
How We Impact

Investment Objective:

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

Measures

Measures	Most Recent Period	Current Actual Value	Current Target Value	True	Current Trend	Baseline % Change
PM DVHA # of adult psychiatric admissions to the Brattleboro Retreat	SFY 2021	419			2	-50%



SFY 2020	636	1	-24%
SFY 2019	881	1	6%
SFY 2018	762	1	-9%
SFY 2017	833	0	0%

Notes on Methodology

Institution for Mental Disease (IMD)					
Adult psychiatric admissions to the Brattleboro Retreat					
	SFY17	**SFY18**	**SFY19**	**SFY20**	**SFY21**
ACO	33	152	254	312	215
Non-ACO	800	610	627	324	204
Total	**833**	**762**	**881**	**636**	**419**

Please note that:

- *The ACO data is pulled from MMIS in a BOBJ report and the non-ACO data comes from internal clinical tracking spreadsheets.*
- *The non-ACO data has had the Level 1 admissions removed from it; we do not have sufficient detail to remove the Level 1 admissions from the ACO data.*

Story Behind the Curve

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

Please note that the non-ACO admissions are authorized by both the Department of Vermont Health Access (DVHA) and the Department of Mental Health (DMH) utilization review clinicians but DO NOT include DMH Level 1 admissions. The UR Teams review all admission notifications within 1 business day of receipt. The UR Teams did not provide utilization review for ACO members in SFY17, SFY18, SFY19, or the first half of SFY20.

DVHA participates in an Accountable Care Organization program as part of Vermont's All Payer Model Agreement with CMS. Through the procurement process, in 2017 DVHA contracted with an ACO, OneCare Vermont, to participate in the Vermont Medicaid Next Generation (VMNG) program. The number of Medicaid members attributed to the VMNG has increased year-to-year as the ACO has expanded its provider network and more members become eligible for attribution. Attribution increased over time as follows:

- 28,593 members in 2017
- 42,342 members in 2018
- 79,004 members in 2019
- 114,335 members in 2020
- 111,532 members in 2021

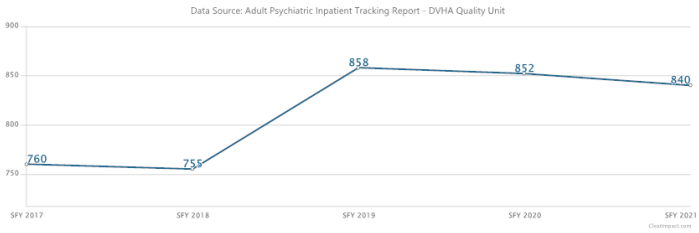
The Brattleboro Retreat Inpatient Services Alternative Payment Model Project represents one component of a larger effort to achieve long term stability and sustainability for the Brattleboro Retreat (the Retreat). The Retreat provides essential capacity and Medicaid services in Vermont's mental health system of care – serving children, adolescents, and adults in need of treatment. In addition to substance use disorder treatment, the Retreat supplies 100% of Vermont's children's mental health inpatient capacity and over 50% of Vermont's adult mental health inpatient capacity.

Vermont's mental health system was rendered even more fragile due to the PHE. The impact of COVID-19 significantly threatened the Retreat's ability to provide mental health care to Vermonters. In 2020, a payment reform initiative was implemented to meet the goals of ensuring ongoing capacity for inpatient days for Medicaid child, adolescent, and adult stays where Medicaid is the primary payer, while providing stable and predictable monthly prospective payments to the Retreat.

In addition to supporting the goals of stability and sustainability, the model seeks to streamline both financial and administrative processes for the AHS and the Retreat by combining payment and reporting requirements for multiple AHS services into a single payment model. The adoption of the APM eliminated the need for prior authorization but the utilization review teams for DVHA and DMH continue to use criteria to ensure appropriate level of care. There will be a shift in the Scorecard reporting based on the new model.

Last updated: March 2022

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



SFY 2021	840		2	11%
SFY 2020	852		1	12%
SFY 2019	858		1	13%
SFY 2018	755		1	-1%
SFY 2017	760		0	0%

Notes on Methodology

Institution for Mental Disease (IMD)					
Adult psychiatric admissions to all other VT facilities					
	SFY17	**SFY18**	**SFY19**	**SFY20**	**SFY21**
ACO	38	147	217	441	550
Non-ACO	722	608	641	411	290
Total	**760**	**755**	**858**	**852**	**840**

Please note that:

- *The ACO data is pulled from MMIS in a BOBJ report and the non-ACO data comes from internal clinical tracking spreadsheets.*
- *The non-ACO data has had the Level 1 admissions removed from it; we do not have sufficient detail to remove the Level 1 admissions from the ACO data.*

The VT facilities included in the measure are:

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

Story Behind the Curve

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

Please note that the non-ACO admissions are authorized by both the Department of Vermont Health Access (DVHA) and the Department of Mental Health (DMH) utilization review clinicians but DO NOT include DMH Level 1 admissions. The UR Teams review all admission notifications within 1 business day of receipt. The UR Teams did not provide utilization review for ACO members in SFY17, SFY18, SFY19, or the first half of SFY20.

DVHA participates in an Accountable Care Organization program as part of Vermont's All Payer Model Agreement with CMS. Through the procurement process, in 2017 DVHA contracted with an ACO, OneCare Vermont, to participate in the Vermont Medicaid Next Generation (VMNG) program. The number of Medicaid members attributed to the VMNG has increased year-to-year as the ACO has expanded its provider network and more members become eligible for attribution. Attribution increased over time as follows:

- 28,593 members in 2017
- 42,342 members in 2018
- 79,004 members in 2019
- 114,335 members in 2020
- 111,532 members in 2021

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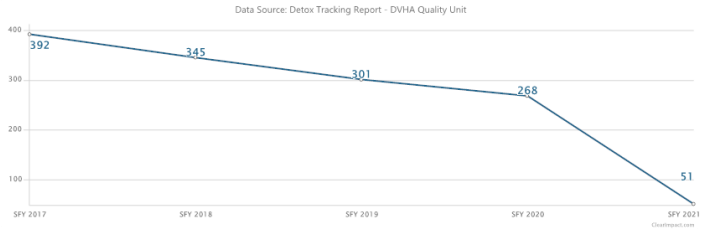
Last updated: March 2022

PM DVHA # detoxificiation admissions to the Brattleboro Retreat



SFY 2021	51	4	-87%	
SFY 2020	268	3	-32%	
SFY 2019	301	2	-23%	
SFY 2018	345	1	-12%	
SFY 2017	392	0	0%	

Notes on Methodology

Institution for Mental Disease (IMD)					
Detoxification admissions to the Brattleboro Retreat					
	SFY17	**SFY18**	**SFY19**	**SFY20**	**SFY21**
ACO	17	75	122	152	35
Non-ACO	375	270	179	116	16
Total	**392**	**345**	**301**	**268**	**51**

- *Please note that the ACO data is pulled from MMIS in a BOBJ report and the non-ACO data comes from internal clinical tracking spreadsheets.*

Story Behind the Curve

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

Please note that the non-ACO admissions are authorized by both the Department of Vermont Health Access (DVHA) and the Department of Mental Health (DMH) utilization review clinicians but DO NOT include DMH Level 1 admissions. The UR Teams review all admission notifications within 1 business day of receipt. The UR Teams did not provide utilization review for ACO members in SFY17, SFY18, SFY19, or the first half of SFY20.

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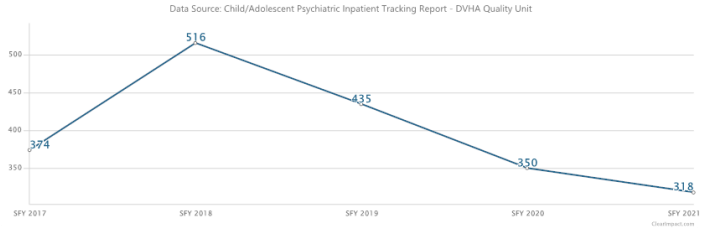
Last updated: March 2022

PM DVHA # of child psychiatric admissions to the Brattleboro Retreat



SFY 2021	318	3	-15%
SFY 2020	350	2	-6%
SFY 2019	435	1	16%
SFY 2018	516	1	38%
SFY 2017	374	0	0%

Notes on Methodology

Institution for Mental Disease (IMD)					
Child psychiatric admissions to the Brattleboro Retreat					
	SFY17	**SFY18**	**SFY19**	**SFY20**	**SFY21**
ACO	33	132	225	266	243
Non-ACO	341	384	210	84	75
Total	**374**	**516**	**435**	**350**	**318**

- *Please note that the ACO data is pulled from MMIS in a BOBJ report and the non-ACO data comes from internal clinical tracking spreadsheets.*

Story Behind the Curve

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Actions

Name	Assigned To	Status	Due Date	Progress

IFS Performance Measures for CMS- FY21

***Due to ongoing issues with transition to Electronic Health Records are IFS agencies the data available for reporting is based on fiscal year.**

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

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

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

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

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

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

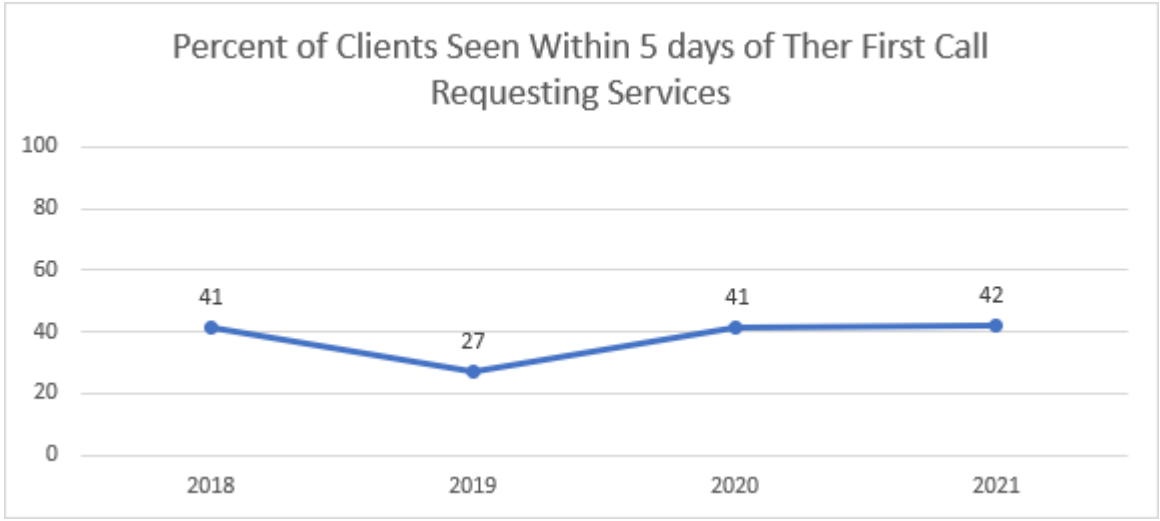
IFS providers are expected to serve a minimum caseload for the target population each year.

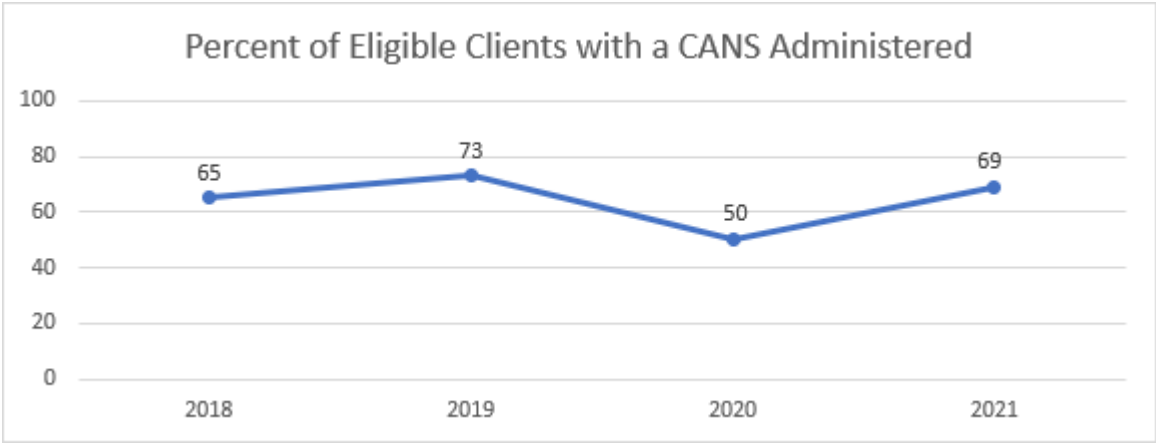
Should the IFS provider incur verifiable service costs that, because of the pilot, are not reimbursable, but would be reimbursable under practices in place for non-pilot sites at the time the services were provided, they may request a review and payment by the State. The request must be accompanied by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

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

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

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

Measure	Data	Story behind the curve
Target: IFS grantees will demonstrate a 2% decrease in the average wait time (in days) between first call requesting services and first appointment offered. *The definition of first call is when contact with the client/family themselves has been made and they have stated they would like or need services.*	**% of clients seen within 5 days of their first call requesting services.** **FY18:** NCSS: 7.3% CSAC: 74.6% Average: 40.95% **FY19:** NCSS: 17% CSAC: 36.8% Average: 26.9% **FY20** NCSS: 34% CSAC: 48% Average: 41% **FY21:** NCSS: 43% CSAC: 40% Average: 42%	This measure is used to monitor from an access perspective. When a family calls requesting services, IFS regions are looking to provide them supports and services as quickly as possible. Important to note is that while we are looking for quick access, families are also being asked when they would like services which may impact the timeline for services beginning. For NCSS, their intake team was comprised of 5 individuals, and they are now down to a screener. As they have improvised to ensure that clients are getting screened, training around data entry has been simplified due to strain on workforce. This has impacted the numbers, as interim staff were unaware of some reporting requirements. This has since been rectified and screener is completing Access to Care portion of screening. Another important factor to consider with this performance measure is that the majority of services provided to families are home and community-based which can also impact how quickly clients are seen upon their first call. Families are often provided support by phone and that does not get counted in this measure. For both of these agencies, as is true for the entire mental health system in Vermont and nationwide the COVID pandemic and workforce shortages has put tremendous stress on the system. Due to that fact, DMH is not surprised by fluctuations in data which is being experienced in all agencies.
Methodology: Numerator: Time in days between first call requesting services and appointment offered. Denominator: Total number of inactive clients requesting services.		 Data source: NCSS and CSAC

Measure	Data	Story behind the curve
Target: IFS grantees will demonstrate a 2% increase of children who have the CANS administered per the eligibility guidelines in the IFS Procedures Manual	**% of eligible clients with a CANS administered** **FY18:** NCSS: 67% CSAC: 62.1% Average: 64.55% **FY19:** NCSS: 72% CSAC: 74.7% Average: 73.35% **FY20:** NCSS: 49.7% CSAC: 49.5% Average: 49.6% **FY21:** NCSS: 66% CSAC: 72% Average: 69%	The CANS is a comprehensive tool that integrates client-level data in one place, while revealing areas that need intense or immediate action, moderate action, or watchful waiting. The simple scoring and clear visual representations help to inform treatment plans and services, by allowing children and caregivers to identify and envision their needs and strengths and communicate them easily to multiple providers. One unique feature of the CANS is that it also focuses on the strengths of children and their caregivers; this positive lens can prove instrumental in a personalized treatment plan. Vermont began implementation of the CANS in 2015 with the IFS regions being early adopters. This meant the regions have had to invest time and resources in training their staff in the CANS, tracking data and embedding the CANS information in their EHR systems. These regions have begun utilizing the data to track individual's progress over time and to look at program data to assess if children are better off as a result of interventions provided by their interdisciplinary teams. For both of these agencies, as is true for the entire mental health system in Vermont and nationwide the COVID pandemic has put tremendous stress on the system. Due to that fact, DMH is not surprised by fluctuations in data which is being experienced in all mental health agencies across the state.  Data Source: NCSS and CSAC
Methodology: Numerator: All children with a first CANS administered Denominator: All children eligible for a CANS receiving services		

<table>
<tr><th>Measure</th><th>Data</th><th>Story behind the curve</th></tr>
<tr><td>Target: IFS grantees will demonstrate a 2% increase in the percent of clients that have a plan completed within 45 days of referral during the measurement period.</td><td>% of clients who have a plan of care completed within 45 days of referral

FY18:
NCSS: 28.3%
CSAC: 31.5%
Average: 44.05%

FY19:
NCSS: 69%
CSAC: 59.7%
Average: 64.35%

FY20:
NCSS: 49%
CSAC: 42%
Average: 45.5%

FY21:
NCSS: 52%
CSAC: 29%
Average: 41%</td><td rowspan="2">This measurement is a Medicaid standard which indicates access to care.

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

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 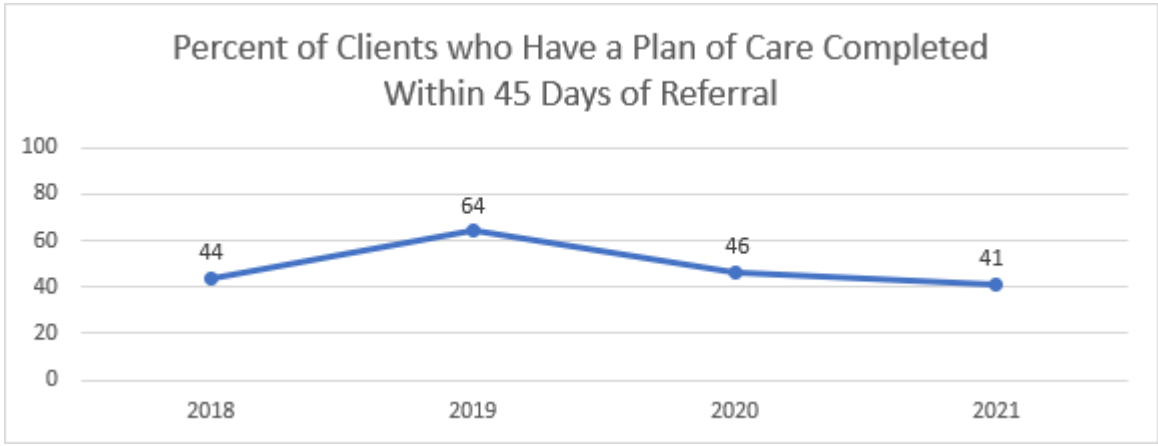

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Numerator: All children who have a plan of care completed within 45 days
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</table>