State of Vermont
Agency of Human Services

Global Commitment to Health
11-W-00194/1

Annual Report
For Demonstration Year 18
July 1, 2022, to December 31, 2022

Submitted via PMDA portal on March 31, 2023

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I. Background and Introduction

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

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

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

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

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

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

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

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

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

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

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

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

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

On July 1, 2018, the Global Commitment to Health demonstration was amended to include authority for Vermont to receive federal Medicaid funding for Substance Use Disorder treatment services 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.

On June 28, 2022, Vermont received approval for a five-and-a-half-year extension of the Global Commitment to Health 1115 waiver, effective July 1, 2022, through December 31, 2027. This extension will enable the state to continue to test, monitor, and evaluate a managed care-like delivery system, home and community-based services, and novel pilot programs, as well as pursue innovations to maintain high-quality services and programs that are cost-effective. Overall,

the demonstration extension will continue to promote health equity by expanding coverage and access to services.

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 eighteenth waiver year, which ended on December 31, 2022. This report encompasses fourth-quarter updates for this demonstration year (10/1/22 - 12/31/22).

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 134 of Vermont's estimated 182 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 2022-Q4 the average monthly number of Medicaid beneficiaries served by Office-Based Opioid Treatment (OBOT/Spoke) programs increased to 3969.

- 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 DY18 and includes the unduplicated count of member months for SUD IMD and SMI IMD stays.

Table 1. Member Month Reporting – Demonstration Year 18 (July 2022 – December 2022), *subject to revision*

Medicaid Eligibility Group	Total DY 2018	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22
ABD - Non-Medicare - Adult	38,362	6,431	6,426	6,386	6,374	6,375	6,370
ABD - Non-Medicare - Child	8,731	1,486	1,470	1,460	1,452	1,440	1,423
ABD - Dual	135,528	22,558	22,610	22,610	22,603	22,588	22,559
Non ABD - Non-Medicare - Adult	112,313	18,730	18,719	18,766	18,693	18,683	18,722
Non ABD - Non-Medicare - Child	378,103	62,783	62,869	62,962	63,073	63,218	63,198
Hypothetical Groups							
New Adult	454,441	74,189	74,973	75,486	75,912	76,604	77,277
SUD - IMD ABD	51	3	4	12	14	9	9
SUD - IMD ABD Dual	70	7	7	17	18	12	9
SUD - IMD Non ABD	121	13	12	23	38	19	16
SUD - IMD New Adult	624	67	50	123	155	114	115
SMI - IMD ABD	55	7	7	10	9	10	12
SMI - IMD ABD Dual	10	4	2	2	1	0	1
SMI - IMD Non ABD	20	4	1	7	1	4	3
SMI - IMD New Adult	156	29	17	28	22	25	35
Housing Pilot	0						
Maternal Health and Treatment Services	114	14	14	33	18	18	17
CRT	1,213	241	223	202	191	165	191
SUD CIT	0						
VT Global RX	55,743	9,380	9,340	9,314	9,279	9,223	9,207
Moderate Needs Group	732	130	125	123	121	116	117
Marketplace Subsidy	60,841	10,574	10,425	10,263	9,963	9,888	9,728

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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:

1. By the end of 2022, more than 229,361 Vermonters were enrolled in Vermont Health Connect (VHC) health plans either through the marketplace or directly through an insurance carrier. This enrollment consisted of 160,548 in Medicaid for Children and Adults (MCA) and 68,813 in Qualified Health Plans (QHPs), with the latter divided between 23,355 enrolled with VHC, 5,191 direct enrolled with their insurance carrier as individuals, and 40,267 enrolled with their small business employer.
2. Vermont Health Connect's tenth open enrollment period launched successfully on November 1, 2022. In October 2022, 99.7% of eligible QHP renewals were handled through a single, clean automated process.
3. Vermonters visited the online Plan Comparison Tool 45,149 times between January 1, 2022, and December 31, 2022. This accounts for a 41% decrease over the prior year.

By the end of 2022, more than 229,361 Vermonters were enrolled in Vermont Health Connect (VHC) health plans either through the marketplace or directly through an insurance carrier. This enrollment consisted of 160,548 in Medicaid for Children and Adults (MCA) and 68,813 in Qualified Health Plans (QHPs), with the latter divided between 23,355 enrolled with VHC, 5,191 direct enrolled with their insurance carrier as individuals, and 40,267 enrolled with their small business employer.

Medicaid Renewals

MCA renewals remained substantially impacted by the Public Health Emergency (PHE) in 2022. 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 pertaining to restarting manual renewals, will be implemented for the Medicaid unwind beginning in April '23.

A total of 36,631 households were successfully renewed via Ex Parte. Ex Parte success rate for the calendar year of 2022 was 40%.

QHP Renewals

DVHA kicked off a series of meetings with its internal stakeholders and Maintenance and Operations vendor in mid-summer 2022 to prepare for the upcoming 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 2022, this step was operated with a single, clean, automated run that took care of 99.7% of eligible cases. The 0.3% 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 2023 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 second year in which QHP premiums are no longer being handled by our previous premium processor, WEX Health. In November 2022, this initial integration run was completed with 99.95% 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 2023 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 66% in December 2022. 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 2022, 98% 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 0.79% error rate and achieved this goal for all months in 2022. DVHA and its partners also acted quickly to resolve errors that did arise. DVHA's goal was to ensure that no more than one-twentieth of one percent of cases sat in error status for more than ten days. That equates to an inventory of 15 or fewer errors open more than ten days.

DVHA also executed monthly reconciliation of the marketplace's enrollment systems in 2022. 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 2022, 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 2022. 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 2022 except in the months of November and December. During these months, the percentage of phone calls answered within 24 seconds was 15% and 10% less than the 75% goal respectively. 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 ten months of 2022 the percentage of phone calls answered within 24 seconds was 75% or higher.

The overall inbound call volume in 2022 was lower (28%) than the corresponding months in 2021.

Additionally, there was a minimal decrease in the percentage of calls that Maximus needed to escalate to DVHA in 2022. In 2021, 8.4% of all calls were transferred to DVHA compared to 7.9% being transferred in 2022.
DVHA's Tier 2 call center maintained prompt service on escalated calls through 2022. In 2017 DVHA set a goal of answering 90% of calls within five minutes. In 2022 they met that goal by 7%. In 2022, 97% of all calls transferred to DVHA were answered within five minutes.

In-person Assisters

DVHA is currently supported by 101 Assisters (91 Certified Application Counselors, 4 Navigators, and 6 Brokers), with 38 Assisters in training, working in 50 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 and organizations continued to provide ongoing in-person and virtual assistance throughout 2022.

Outreach & Education

DVHA used multiple methods to educate and connect to the public and key stakeholders. The department continues to use historical channels of advisory committee meetings, virtual events, social media and website mediums. In 2022, DVHA had strategic focus on improving digital marketing and reengaging community stakeholders.

DVHA has begun to update and modernize its social media and website platforms, specifically by using more, higher quality graphics, more videos and intentional engaging and content development. DVHA also used grant money to leverage paid digital and radio marketing mediums to promote important messaging.

In 2022, DVHA also prepared and began to implement text messaging as a means to enhance communication with customers. This communication medium has now been incorporated as a key method for future communications.

To reengage community Stakeholders, DVHA also restarted a stakeholder newsletter, designed to disseminate important information to key stakeholder as needed. The department continues to recruit and grow the list of organizations on it.

The online Plan Comparison Tool continues to be a core piece of DVHA's health insurance literacy effort. The tool helps Vermonters better assess their choices for health coverage – from potential subsidies, to 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 The Robert Wood Johnson Foundation.

DVHA continued to heavily promote usage of the Plan Comparison Tool in addition to other resources. The Plan Comparison Tool was visited nearly 40,000 times in 2022. During the final quarter of 2022, which included most of the annual open enrollment period, the tool was visited 17,000 times.

Future Development

To allow an additional modality for Vermonters to apply for the Medicaid for the Aged, Blind and Disabled (MABD), a self-service version of the application went live in Spring 2022. This online application allows a Vermonter to apply for MABD 24/7 online as well as over the phone during business hours. This online application includes a save and retrieve function, review before submitting and a digital signature.

IV. Findings

i. External Quality Review

Key updates:

- DVHA received a compliance score of 81.5 % 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 2022 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 seven performance categories (i.e., standards). The seven standards included requirements associated with the federal Medicaid managed care access standards found at CFR §438.206–438.210, enrollment and disenrollment requirements (§438.54–§438.56), and emergency and poststabilization services (§438.114).

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 2022, 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 2022 Controlling High Blood Pressure (CBP) measure and technical specifications. HSAG used CMS' PIP validation protocol as the methodology to validate the PIP. HSAG's validation assessed Steps 7 and 8 (data analysis and interpretation of results and improvement strategies). 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.

DVHA's *Managing Hypertension* PIP received a score of 100 percent for all applicable evaluation elements scored as *Met*, a score of 100 percent for critical evaluation elements scored as *Met*, and an overall validation status of *Met*. The validation results indicate an overall score of 100 percent across all applicable evaluation elements. DVHA initiated the PIP this year and developed the methodology (Design stage). The PIP will progress to reporting baseline results and quality improvement activities and interventions initiated (Implementation phase) during state fiscal year (SFY) 2023–2024. Outcomes will be reported in the next annual EQR technical report.

Validation of Performance Measures

HSAG validated rates for a set of performance measures selected by AHS for 2022 reporting. The validation also determined the extent to which the Medicaid-specific performance measures calculated by DVHA followed the HEDIS 2022 specifications. AHS identified the measurement period for all measures as calendar year (CY) 2021. 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.

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. 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 seven performance categories (i.e., standards). The seven standards included requirements associated with the federal Medicaid managed care access standards found at CFR §438.206–438.210, enrollment and disenrollment requirements (§438.54–§438.56), and emergency and poststabilization services (§438.114).

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 111 elements across the seven standards. Of the 111 elements, DVHA obtained a score of *Met* for 78 elements and a *Partially Met* score for 25 elements. DVHA obtained a *Not Met* score for eight elements. As a result, DVHA obtained a total percentage of compliance score across the 111 requirements of 81.5 percent.

Preparation of the External Quality Review Annual Technical Report

During Q4, 2022, the state supported HSAG as they compiled and analyzed all data from its 2022 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

During this year, the state submitted and received CMS approval for an updated Monitoring Protocol for the SUD programs authorized by the Global Commitment to Health demonstration. The Monitoring Protocol Template was developed in cooperation with CMS and subject to CMS approval. Components of the Monitoring Protocol included: a. An assurance of the state's commitment and ability to report information relevant to each of the program implementation areas listed in STC 9.2 and reporting relevant information to the state's Health IT plan described in STC 9.6; b. 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 12 of the demonstration; and c. A description of baselines and targets to be achieved by the end of the demonstration. Where possible, baselines were informed by state data, and targets benchmarked against performance in best practice settings. After receiving CMS feedback, the state submitted a revised Monitoring Protocol. Progress on the performance measures identified in the Monitoring Protocol were reported via the quarterly and annual monitoring reports.

SUD Mid-Point Assessment

During this year, it was determined that the state must conduct an independent mid-point assessment by June 30, 2025.

SMI/SED Monitoring Protocol

During this year, the state submitted and received approval for an updated SMI/SED Monitoring Protocol for the SMI/SED program authorized by the Global Commitment to Health demonstration that reflected the changes to the

SMI/SED Monitoring Protocol required by STC 10.2(c). The SMI/SED Monitoring Protocol Template was developed in cooperation with CMS and subject to CMS approval. After receiving CMS feedback, the state submitted a revised SMI/SED Monitoring Protocol. Progress on the performance measures identified in the Monitoring Protocol were reported via the quarterly and annual monitoring reports. Components of the Monitoring Protocol included: a. An assurance of the state's commitment and ability to report information relevant to each of the program implementation areas listed in STC 10.2 and STC 10.4, reporting relevant information to the state's SMI/SED Financing Plan described in Attachment L, and reporting relevant information to the state's Health IT plans described in STC 10.3; b. 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 12 of the demonstration; and c. A description of baselines and targets to be achieved by the end of the demonstration. Where possible, baselines were informed by state data, and targets benchmarked against performance in best practice settings.

SMI/SED Mid-Point Assessment

During this year, it was determined that the state must conduct an independent mid-point assessment by June 30, 2024.

ii. Quality Assurance and Performance Improvement Activities

Key updates from QE122022/Annual:
- DVHA continued work on the formal PIP topic of managing hypertension and again met 100% of the PIP protocol standards within its Annual Summary submission.
- Staff from DVHA's Quality, Oversight & Monitoring and Compliance units continued working on a comprehensive risk assessment- for Vermont's Medicaid program.
- The Director of Quality Management lead a Vermont team through the CMS-sponsored Foster Care Learning Collaborative.

The DVHA Quality Improvement unit 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) aswell 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 2022 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)

DVHA's formal PIP topic is the management of hypertension. Intervention strategies have been chosen and continued to be implemented and changes tracked during 2022. Sub-group work focused on activities related to access to blood pressure monitors, provider and patient education, and connecting to community resources. DVHA met 100% of the PIP protocol standards within its Annual EQRO Summary submission.

Other Collaborative Quality Improvement Projects

The Quality Improvement team continued to work with the following groups on collaborative QI projects during 2022:

- 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. QI staff continued to contribute quality of care measures and analysis to ensure that cost and quality incentives are aligned in the APM.

- The Department of Children and Families (DCF), the Vermont Department of Health (VDH), and the Vermont Child Health Improvement Program (VCHIP) on a learning collaborative to improve the timeliness of comprehensive health visits for children and adolescents entering foster care. During 2022 the team established a partnership with a district office, met with them for a process mapping exercise and implemented multiple small tests of change.

Quality Measure Reporting

- CMS Medicaid Quality Core Measure Sets –
  - The Quality Unit and the Data Unit prepared and submitted the Adult and ChildQuality Core Set rates for MY 2020 and MY 2021 into the new CMS reporting platform.

- Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey - the DVHA Quality Unit's Director of Quality Management coordinated the 2022 Consumer Assessment of Healthcare Providers and Systems (CAHPS) Children's and Adults Medicaid 5.1H survey. DVHA continued to include the 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 of2022. The results of the surveys were delivered to DVHA in February 2023 and will be presented by the Director of Quality Management to the PIHP Quality Committee in March 2023.

- HEDIS measure production – In addition to producing administrative (claims-based) measures, the Clinical Services Team produced four (4) HEDIS hybrid measures in 2022. 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.

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 2022 include the following initiatives: Adult Core Set of Health Care Quality Measures, Child Core Set of Health Care Quality Measures, the DVHA Dental Program and the Applied Behavior Analysis (ABA) Program.

The Quality Improvement team also maintained its Green Belt status during 2022 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 Improvement 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 theactivities staff have engaged in. Currently an internal evaluation tool, the dashboard is updated monthlyand made available to all DVHA staff via our intranet. DVHA's Management Team highlights certainmetrics within the dashboard at its regular meetings. This work was maintained throughout 2022.

Vermont Next Generation Medicaid ACO

In 2022 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 and carried this work throughout 2022. 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 informed the DVHA Compliance Committee work plan and updates to DVHA's Intra-Governmental Agreements (IGAs).

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, 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 6.

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: DMH. During this most recent quarter, the performance of the Integrated Family Services and Blueprint payment models are highlighted. The Clear Impact Scorecard for these payment models are included in this report as Attachment 7.

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

During this year, the state worked with its independent evaluator 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 and supporting the calculation of the rates associated with the measures submitted to the evaluator. During quarter four, the state worked with the evaluator to draft the summative evaluation report.

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. CMS has approved the GC Evaluation Design. No work associated with the design was conducted this year/quarter.

GC Summative Evaluation Report

During the year and current quarter, the state worked with its independent evaluator, PHPG, to develop a draft Summative Evaluation Report in accordance with CMS Guidance: *Preparing the Interim and Summative Evaluation Reports*. The state must submit a draft Summative Evaluation Report for the demonstration's approval period within 18months of the end of the approval period represented by these STCs. The Summative Evaluation Report must include the information in the approved Evaluation Design. The state expects to submit the draft report at the end of the next quarter.

Intra-Governmental Agreement (IGA) between AHS and DVHA

During this year, the AHS QIM submitted the 2023 Agency of Human Services (AHS) and the Department of Vermont Health Access (DVHA) IGA to CMS for approval.

iii. Provider and Member Relations (PMR)

Key updates from QE122022:

- 2022 Summary
- Quarter 4 Updates

The Provider and Member Relations (PMR) unit ensures Vermont Medicaid members have access to appropriate health care for their physical health, mental health, and dental health needs. PMR 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 PMR staff for additional information/review. In addition to these responsibilities, the PMR 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.

2022 Summary

The Provider and Member Relations (PMR) unit, like all units within the Department of Vermont Health Access, faced many challenges throughout 2022 due to the ongoing COVID-19 pandemic; however, staff and state partners effectively acted to ensure that standards were met, and services properly delivered. The following programs and projects highlight some of the accomplishments PMR staff lead throughout 2022.

Interoperability and Patient Access: Implementing Daily Exchange for Improved Access

Interoperability & Patient Access Project focused on improving patient access to their health information. Part of this project required states to increase the exchange frequency of enrollee data for individuals dually eligible for Medicare and Medicaid, by requiring MMA and Buy-In files to be exchanged daily. The increased frequency of these file exchanges from monthly to daily improved the dual eligible beneficiary experience by ensuring almost "real-time" access to appropriate programs and ensuring services were billed to the correct payer, eliminating waste and burden. The Department of Vermont Access implemented the MMA daily file exchange on April 1, 2022, as required by the Centers for Medicare and Medicaid

Services (CMS), and implemented the Buy-in daily file exchange on February 1, 2022, in advance of the implementation date required by CMS. The daily file exchanges impacted the following processes:

- Buy-in accretions, deletions, and changes are sent to CMS daily;
- Buy-in accretions, deletions, and changes are almost immediate;
- Notices that result from Buy-in are 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.

Non-Emergency Medical Transportation (NEMT)

For the 2022 calendar year, monthly ride numbers varied marginally from month to month, trending slightly higher toward the latter quarter of the period. The trip numbers remained only 50-60% of what they were pre-Covid, however. The biggest change from pre-Covid times was the marked increase in the number of trips per member per month, with the daily and frequent users of transportation services accounting for a much larger portion of total trips provided in the year.

Payer Initiated Eligibility (PIE) Interface

Federal law requires States to identify and obtain payment from third-party entities that are legally responsible to pay claims primary to Medicaid. To enhance a state's ability to identify legally liable third parties, the Deficit Reduction Act of 2005 (DRA) required States to pass laws imposing requirements on health plans, as a condition of doing business in the State, to provide plan eligibility information to the State. The Payer Initiated Eligibility/Benefit (PIE) Transaction was developed to assist payers in providing the type of health plan eligibility and coverage information to State Medicaid programs that is needed to comply with DRA requirements.

As of January 12, 2023, The PIE project created a successful algorithm to perform the "wash" and data-matching process for all files received from health plans. In addition, this project automated the uploading of the data from these files and will auto populate the data into the legacy eligibility system, ACCESS.

Implementation of this project decreased staff time for manual research and data entry, increased cost avoidance to other health insurance, and increased and afforded a stable amount of savings and recoveries, resulting in a decrease of Medicaid monies paid in error - a savings to the Medicaid program.

The implementation and use of the Payer Initiated Interface strengthens Vermont's ability to identify and collect payments from liable third-party insurers. This will decrease Medicaid payments made in error when Medicaid member/beneficiaries have primary health insurance coverage. The implementation and use of the PIE will reduce the risk of the Vermont Medicaid Program being out of compliance with 42 CFR Subpart D Third-Party Liability.

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.

The current RY2023 PERM audit cycle is reviewing sampled claims with dates of service 7/1/21 – 6/30/22. In 2022 the full PERM sample was selected and medical record requests were sent to Vermont providers for sampled claims.

The PERM sample is broken out by quarter, and reviews for the first 3 quarters of the audit were completed. For those 3 quarters, 310 claims were determined correct, and 8 were found in error for missing records. We are still working with providers to see if these records can be submitted to the auditors and the error findings overturned.

Quarter 4 medical record requests are underway for the remaining 99 claims, and we will continue provider outreach as necessary to ensure the best audit results and reduce errors and recoupments for missing medical records. The PERM review period closes 4/15/23, and medical records can be submitted up until that date.

Quarter 4 Updates:

Non-Emergency Medical Transportation (NEMT)

For the fourth quarter of calendar year 2022, non-emergency medical transportation trip numbers for eligible VT Medicaid members continue to remain fairly steady, with only a slight dip for the month of December. The monthly numbers have stayed somewhat constant, with only minor week to week fluctuations. Program-related complaints still remain mostly constant with the same period last year, with overall complaint numbers continuing to run well below the contracted performance standard of 5% of all rides provided, maintaining a monthly rate of less than 1%.

Coordination of Benefit Activity

Coordination of Benefits (COB) refers to the activities involved in determining Medicaid benefits when an enrollee has coverage through an individual, entity, insurance, or program that is liable to pay for health care services.

Areas of activities:

Casualty: Seek reimbursement when a third-party liability or medical insurance exists during an accident and Medicaid has paid for medical services**.**

- **Estate:** Seek adjustment or recovery from estates of individuals who received long–term care services paid for by the Medicaid program**.**
- **Third Party/Court Ordered Medical: Seek reimbursement** from insurance carriers for Medicaid claims paid as primary.
- **Medicare Prescription Drug Premium/Claims:** - Seek adjustment or recovery when members have Medicare part D plan premium cost and rebilling of Medicare part D pharmacy claims.

- **Over Resource/Hospice/Pt. Share/Credit Balance:** Seek collections that had been determined to be owed for program eligibility.
- **Annuity/Trust/Waiver:** When someone VT Medicaid it is sometimes determined by the eligibility unit to make DVHA the beneficiary of an annuity policy for that person to be eligible for and remain on Medicaid- trust. A Special Needs Trust (SNT)/Pooled Trust is a legal document in which any disabled person can transfer their assistance which is managed and administered by the Trustee for the benefit of the individual. When the assets are placed into the SNT, the beneficiary is still eligible to receive Medicaid benefits.
- **Medicare Recoupment:** Automated recovery process to see collection from providers when Medicare paid for services primary to Medicare, instructing provider to bill primary Medicare.
- **Lamp/Map:** LAMP (Legal Assistance to Medicare Patients)/MAP (Medicare Advocacy Program - Members who were wrongfully denied Medicare coverage, the decision was overturned and the recovery of Medicaid funds for physicians' services, durable medical equipment, home health care, or skilled nursing facility care.
- **Third Party Recoupment:** Seek recovery from providers when Medicaid paid for services as primary and the primary payer requires additional information for recovery.

Member and Provider Services Coordination of Benefit Collection Table:

MPS - Coordination Recovery Activities "Q4"	
Casualty	$293,363.88
Estate	$435,391.08
Third-Party & Court-Ordered Medical	$174,213.79
Medicare Prescription Drug Premium/Claims	$78,234.35
Over Resource/Hospice/Patient Share/Credit Balance	$203,586.67
Annuity/Trust/Waiver	$13,322.55
Lamp/Map, Medicare Claim Recoupment	$228,433.96
Third-Party Claim Recoupment	$134,103.68
Total	**$1,560,649.96**

V. Cost Containment Initiatives

i. Vermont Chronic Care Initiative (VCCI)

Key updates from QE122022:

- Resumption of in person visits
- VCCI Utilization
- New To Medicaid Program Screening Data
- Collaboration on Complex Care Initiative
- Staff Training Initiatives

Workforce Updates

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 2022, VCCI focused on resuming face to face visits with members. Face to face visits are an important way to connect with members that helps to facilitate engagement with all services. Percentages of face-to-face visits steadily increase over the course of the year as seen in Figure 1. Some members continue to prefer a mix of telephonic and face to face visits. Some members prefer home visits while some prefer office-based visits. VCCI works to meet the individual needs and preferences of those served. Enrollment in VCCI has declined since the previous year. In CY 2022, a total of 560 unique members were served which is a reduction of about 140 members from the previous year total number of unique individuals served. The chart below also shows that the total monthly enrollments remain relatively constant despite workforce challenges. Workforce issues and staffing vacancies have been challenges statewide. Also, nine nurses were redeployed in October to help coordinate care for the 1600 households experiencing homelessness statewide. We did contract to backfill these positions while VCCI nurses were temporarily redeployed.

Figure 1. Beneficiary New Enrollment & Face to Face Visits

	SFY22						SFY23					
	Jan-22	**Feb-22**	**Mar-22**	**Apr-22**	**May-22**	**Jun-22**	**Jul-22**	**Aug-22**	**Sep-22**	**Oct-22**	**Nov-22**	**Dec-22**
Measure	2/15/2022	3/15/2022	4/15/2022	5/15/2022	6/15/2022	7/15/2022	8/15/2022	9/15/2022	10/15/2022	11/15/2022	12/15/2022	1/15/2023
# new VCCI eligible members enrolled monthly in care management	33	33	46	24	30	21	34	41	31	43	28	46
Total Open Cases (including newly enrolled - above)	276	280	273	238	245	210	232	213	221	237	213	209
% of VCCI enrolled members with a face to face visit during the month	17.03%	17.86%	25.64%	29.83%	34.29%	41.90%	43.10%	49.30%	46.61%	47.68%	47.42%	58.37%

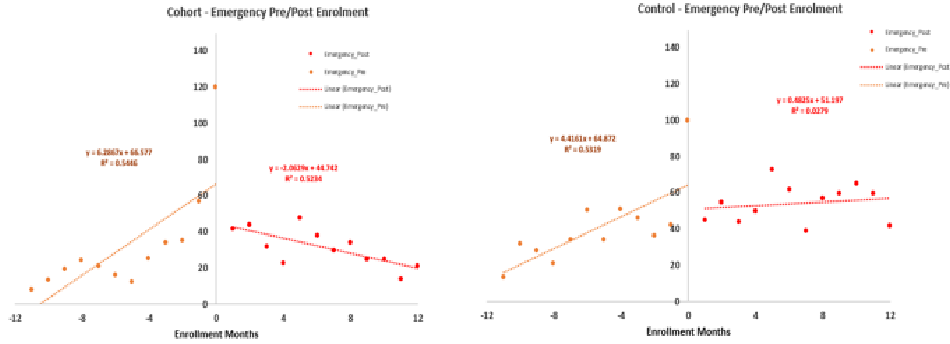
VCCI aims to support appropriate transitions of care, recognizing that beneficiaries may be most vulnerable at this time. These transitions of care (TOC) may be commonly thought of with discharges from either a

medical or psychiatric admission. In the Spring of 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.

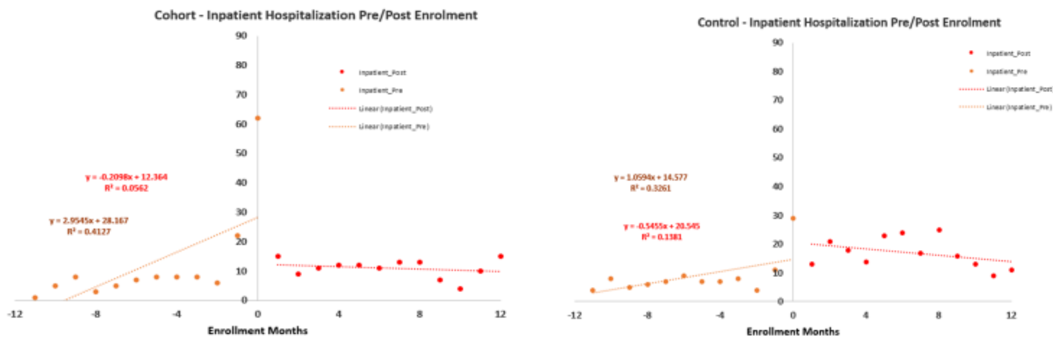
Prevention of readmissions remains a priority of the VCCI; helping members manage their transition from an inpatient stay, back to their communities. The VCCI receives referrals directly from inpatient/facility case managers, as well as from utilization reviews within Vermont Medicaid. The VCCI team strives to facilitate safe transitions of care including medication reconciliation and medical/behavioral health appointment follow-up appointments. CY 2021 report demonstrated a continued reduction in both IP and ED utilization in the VCCI intervened population. Beneficiaries enrolled in VCCI services had a slight decreases in inpatient hospitalizations and emergency room visits, while beneficiaries not enrolled in VCCI services experiences increases in hospitalizations and emergency room visits. In CY 2021, the readmission rate for VCCI involved members went up slightly while the readmission rates for others went up more. VCCI intervention contributes to reduced burdens on the already taxed healthcare systems and cost savings.

Figure 2. VCCI Utilization Data

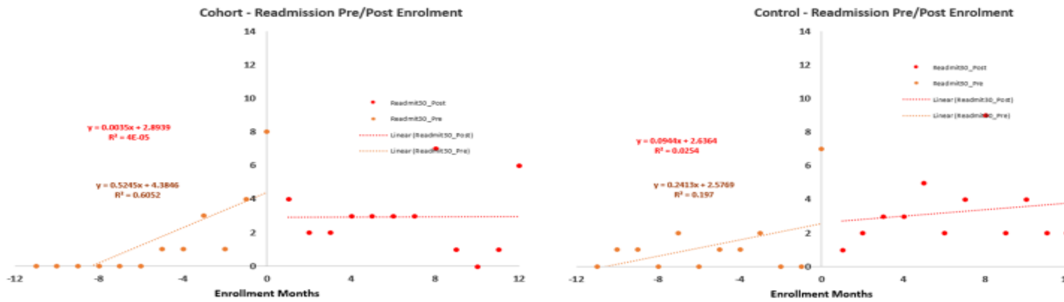
Utilization: Emergency Visits



Utilization: Inpatient Hospitalization



Utilization: Readmission



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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 4).** 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. In the past year, several primary health care offices closed in the State which made it even harder to help members attain PCP care. In addition, most dental practices that accept Medicaid are not taking new patients so dental care is rarely accessible. New To Medicaid screening tool assessed that less than half of those screened had seen a dentist in the past year, and that 84% of those screened would like to see a dentist.

Figure 3. New To Medicaid Members Screened

Updated Dates - month reported	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
received from data unit	2/15/2022	3/15/2022	4/15/2022	5/15/2022	6/15/2022	7/15/2022	8/15/2022	9/15/2022	10/15/2022
# of new to Medicaid members (Adults 18+)	566	358	327	301	343	423	491	395	439
# of new to Medicaid members reached	107	66	72	71	83	101	84	83	85
# of new to Medicaid members screened	150	111	105	97	104	158	162	142	159
% of new to Medicaid members screened	26.50%	31.01%	32.11%	32.23%	30.32%	37.35%	32.99%	35.95%	36.22%

Figure 4. Number of New Medicaid Beneficiaries Screened & Successfully Established Care

% of New to Medicaid members who accepted help with PCP establishment and who successfully established care with practice/medical home	CY		2022	
	Q1	Q2	Q3	Q4
# of "New to Medicaid" members who already had a PCP they saw regularly (of those screened)	483	361	466	474
# who didn't have a PCP and declined help	13	6	29	36
# who didn't have a PCP and accepted help	155	87	164	173
# of members who successfully established care	8	2	17	25
% of members who successfully established care	5.16%	2.30%	10.37%	14.45%

Successful facilitation of access to PCP appointments to establish new patient care presented as a challenge the past few years, with barriers including long wait times for new patient appointments, the requirement for former health records, and practices closed to new patients. However, as Figure 3 shows that the number of members who are connecting successfully to PCP care is increasing. VCCI has seen shorter wait periods for care around the State for Primary Care.

VCCI continues to engage is several projects with various departments at the Agency of Human Services. The pilot project with the Department of Corrections continues. The focus is on providing team-based care to people coming out of incarceration who are experiencing complex medical and social issues. The program is voluntary.

VCCI are working on a Complex Care Initiative that engages all departments within AHS to reinvigorate the work the State did in 2015 on the Complex Care model. Due to workforce turnover, there is a need to develop a sustainable training model and work with local ecosystems of care to adopt principles and practices of the complex care model to create efficiencies within their system and improve engagement of people experiencing complex health and social needs.

VCCI has been working with Keypro, VITL and the Healthcare Information Exchange to begin idnetifying what data will transfer from eQHealth into the Healthcare Information Exchange. VCCI team members worked diligently with Keypro and VITL in the development and initiation of the new VITL platform and integrated sign on button in the eQHealth database.

VCCI has worked with our medical director and pharmacy team to implement a medication reconciliation process/protocol for all RN case managers to do with every beneficiary served. The team is working with people to gather all information of prescribed medications and is communicating that to all providers and prescribers. They have also been helping beneficiaries appropriately dispose of unused medications. This is initiative is aimed at improving health and safety of beneficiaries.

VCCI nurses were also involved in the initiative to help reduce blood pressure. They outreached to pharmacies to encourage them stocking blood pressure cuffs that members could get to monitor their blood pressure at home.

Workforce shortages continued throughout 2022 due three staff leaving VCCI in the past year. VCCI has had success

recruiting Registered Nurses; however, we still have two vacancies. In CY 2022, six new staff were onboarded.

Goals CY 2023:

1. Increase in the resumption of face-to-face visits with beneficiaries enrolled in VCCI.
2. Increase the percentage of members who successfully establish primary care with VCCI intervention.
3. Develop and monitor data that speaks to the quality-of-service VCCI provides.
4. Work with all departments to improve our we all work together providing team-based care.
5. Participate in Agency Learning Collaborative that focuses on staff retention efforts.

ii. Mental Health, Substance Use Disorder and Behavioral Health

Key updates from QE122022:

- Inpatient psychiatric placements
- Applied Behavior Analysis

The Clinical Integrity Unit (CIU) is responsible for concurrent review and authorization of inpatient psychiatric and detoxification services for members with Medicaid as a primary insurer. . The CIU works 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 CIU 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 a psychiatric facility. Before implementation Department of Vermont Health Access & Department of Mental Health reimbursed the facility 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 facility
- Projected utilization in the coming year
- Recent cost per day values incurred by the facility 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 facility have agreed upon performance measures and a monitoring platform for the model was built by the DVHA Quality and Clinical Integrity units. Year one reconciliation was completed on 05/31/22. Year two reconciliation is projected to be completed by April 2023.

The CIU manages the Team Care program. Team Care is a care management program and a federally mandated prescription lock-in program. The program is to prevent misuse, abuse and diversion of medications on the FDA Controlled Substance Schedule such as opioid pain medications and sedatives. 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 annual 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. Outreach and education with providers and pharmacies is ongoing. 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.

Effective 07/01/2022, the DVHA began reimbursement for extended Emergency Department (ED) stays in which a Vermont Medicaid member was meeting clinical criteria for inpatient psychiatric level of care (LOC) AND there were no inpatient beds available for placement. Requesting hospitals may submit request after a Vermont Medicaid member meeting inpatient psychiatric LOC has had an initial 24 hour stay in an ED. The CIU is reviewing and making authorization determinations for these requests.

CIU 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.

The CIU also manages the Applied Behavior Analysis (ABA) benefit. In 2021, DVHA changed the timing of the ABA 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. . 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 steady during the past three years. . The intensity of service has also increased; there have been substantial increases each year in the average service hours per member per month.

The DVHA ABA team is working with the Payment Reform Unit on a valued based payment project. Beginning with Calendar Year 2023, DVHA's ABA Tiered Payment Model will incorporate provider results on three performance measures into the reconciliation process and calculations. This value-based payment proposal will allow providers to earn up to 10 points and up to 1% of their total earned service level tier payments (the 1% is anticipated to be an added payment for services provided in calendar year 2023 and a withhold thereafter). The measures include, amount of service provided in member months, percentage of total billed hours that are direct therapeutic service hours and timely claims submissions. The Senior Autism Specialist worked with the payment reform and policy teams on provider outreach to ensure information was thoroughly and accurately discussed. The Policy Unit posted a GCR that will require a 30-day public comment period prior to implementation in CY '23. CMS posed several questions regarding the value-based payment project which the DVHA Policy Unit hopes to have answered by 1/12/23.

The DVHA Senior Autism Specialist conducts annual site visits/audits with Vermont Medicaid enrolled ABA providers

who provide services to Vermont Medicaid members. The purpose of these visits/audits is to ensure that members were receiving quality care, that providers are accurately reimbursed for provided services, to verify that required documentation is included in members' charts and that clinical documentation follows ABA Policy and Clinical Guideline standards.

Site visits/audits are completed in a virtual format. The process includes 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 Senior Autism Specialist or designee. Eighteen site visits were completed in 2022.

iii. Mental Health System of Care

Key updates from QE12/2022

- 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 serious mental illnesses (SMI). Funding is provided through the Vermont Agency of Human Services (AHS) Provider Agreements (formerly termed Master Grants/Agreements) to ten (10) Designated Agencies and two (2) 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 serious 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, Specialized Services 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 (1) of six (6) 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 had to adapt to continued 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, some of which are still in place. Providers have had to manage severe staffing shortages and retention of staff as this workforce deals with shifting domestic responsibilities or financial stressors all while adapting to hybrid (virtual and in person) workspace environments. Overall, the system has suffered from the long-term impacts of the pandemic that continue to present challenges both statewide and at the local levels.

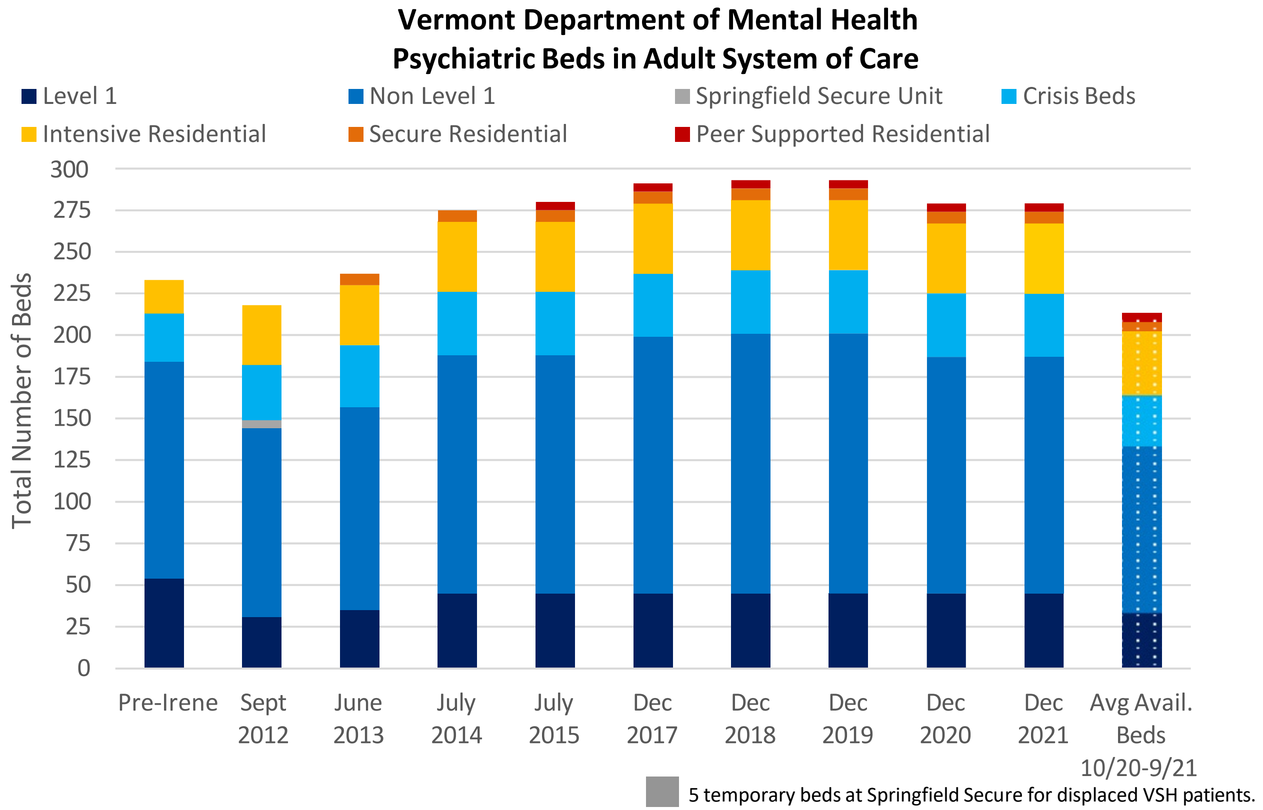
Enhancements of the Mental Health System of Care:

Hospital Services

Level One (1) 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 One (1) beds and a total of 229 total194 psychiatric inpatient beds (194 adult beds; 35 youth 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.

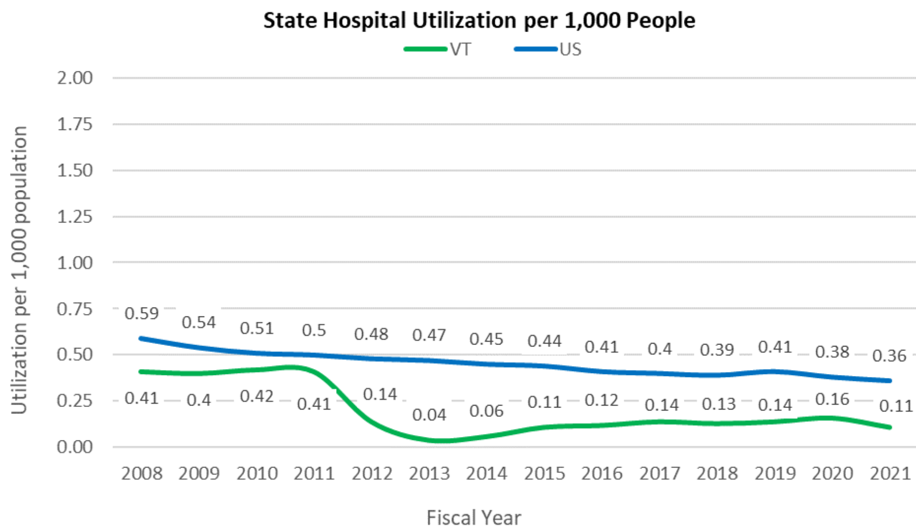
In addition to this temporary loss of adult beds, the Covid-19 pandemic had a ripple effect across the adult psychiatric system of care during this same period. In the below table, a bar illustrating Average Available Beds reflects a system-wide impact across inpatient and community-based crisis beds 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 2021 is the most recent analysis available.

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



The national rate of state hospital utilization continues to decline year over year. Vermont Psychiatric Care Hospital opened in FY 2015 with 25 beds and Vermont's rate of inpatient utilization continues to be lower than the national average in the United States. The significant decrease from FY 2011 to FY 2012 represents the closure of Vermont State Hospital due to flooding from Tropical Storm Irene in August 2011. The Vermont hospital utilization data had been showing a slowly progressing upward trend since 2012 but has decreased from FY 2020 to 2021.

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)

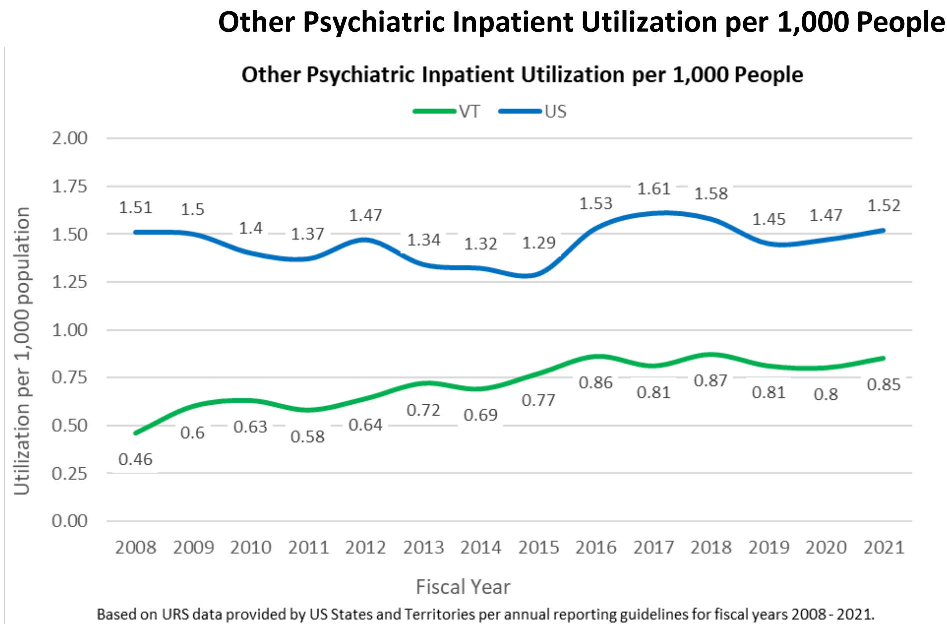
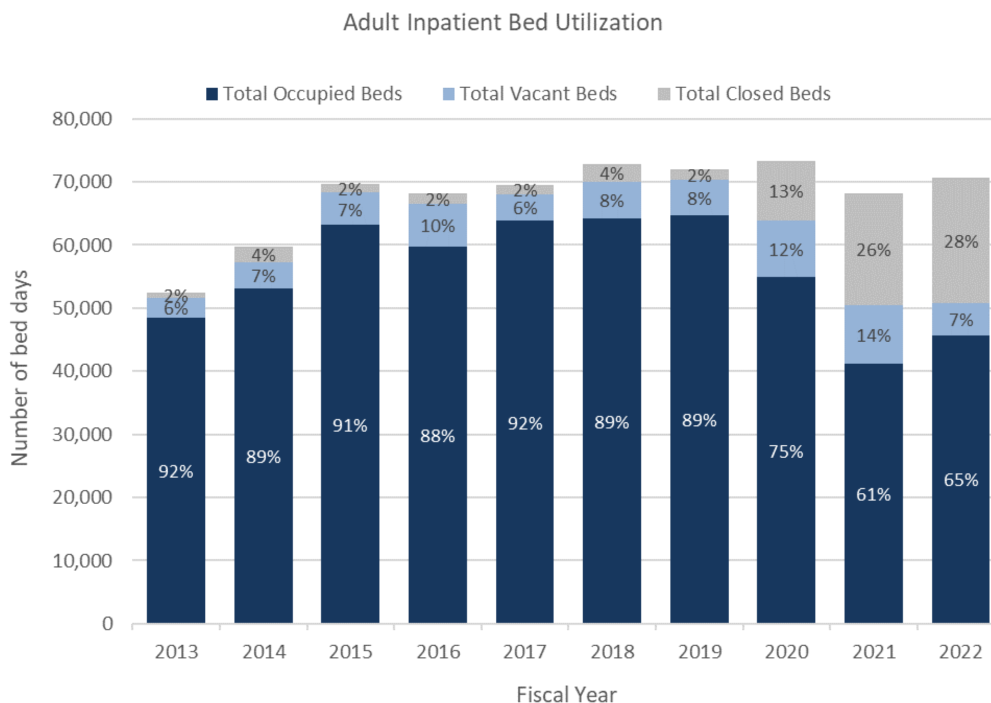


Figure 6. Adult Inpatient Utilization and Bed Closures



The Adult Inpatient Utilization and Bed Closures chart depicts the total bed day capacity across the Vermont Designated Hospital system through FY 2022. The total bed day availability across the system had remained relatively constant from 2015-2019, but bed day utilization decreased 14% from 2019 to 2020 and decreased another 14% from 2020 to 2021 followed by a 4% increase from 2021 to 2022. The impact of the Covid-19

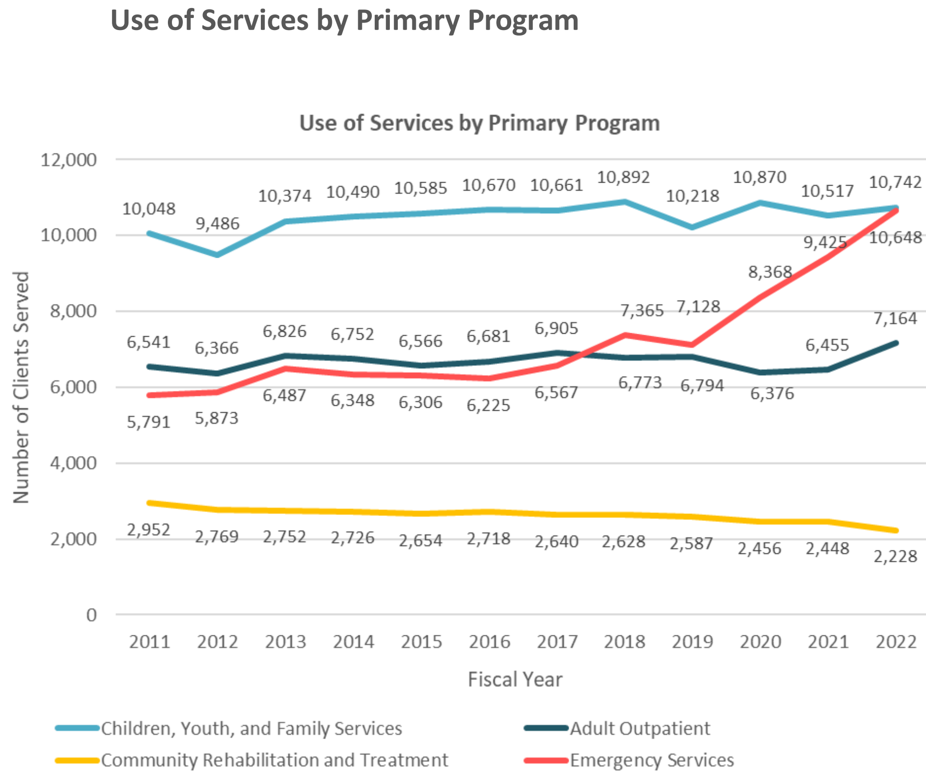
pandemic has contributed to a variable increase in bed vacancies from 2019 through 2022 with a 26% increase in beds closed through FY 2021. Over these ten years, 2021 had seen the lowest level of adult inpatient bed utilization, although the inpatient system of care slightly rebounded during FY 2022 to 65% total bed occupancy.

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 9-8-8 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 continued 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

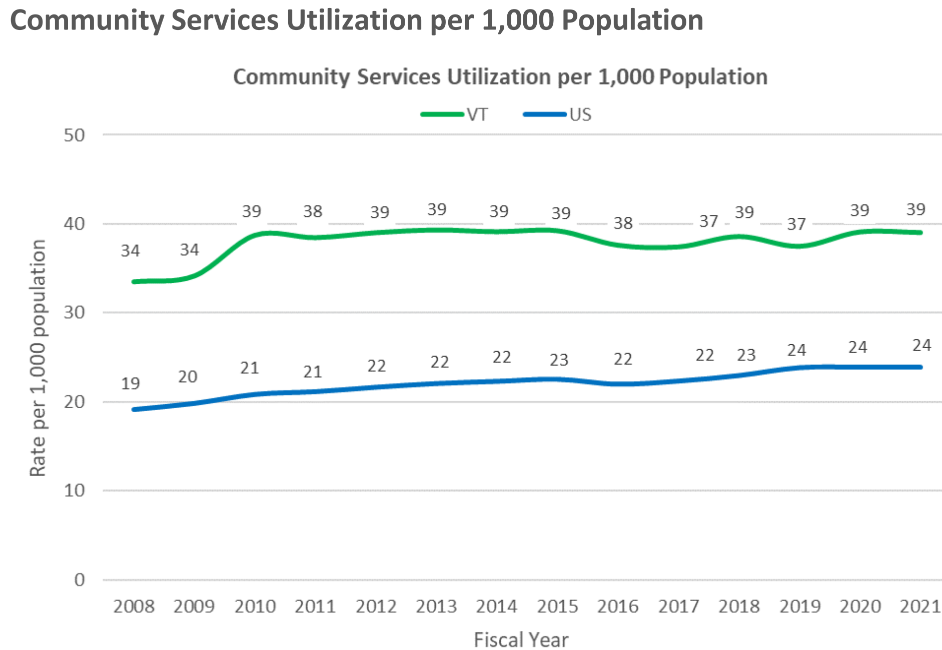
Enhanced community services funding provided by the legislature through increased appropriations to key mental health programs in the community over the last several years has helped, but staff recruitment and retention necessary to meet and expand these service capacities continues to be a struggle.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



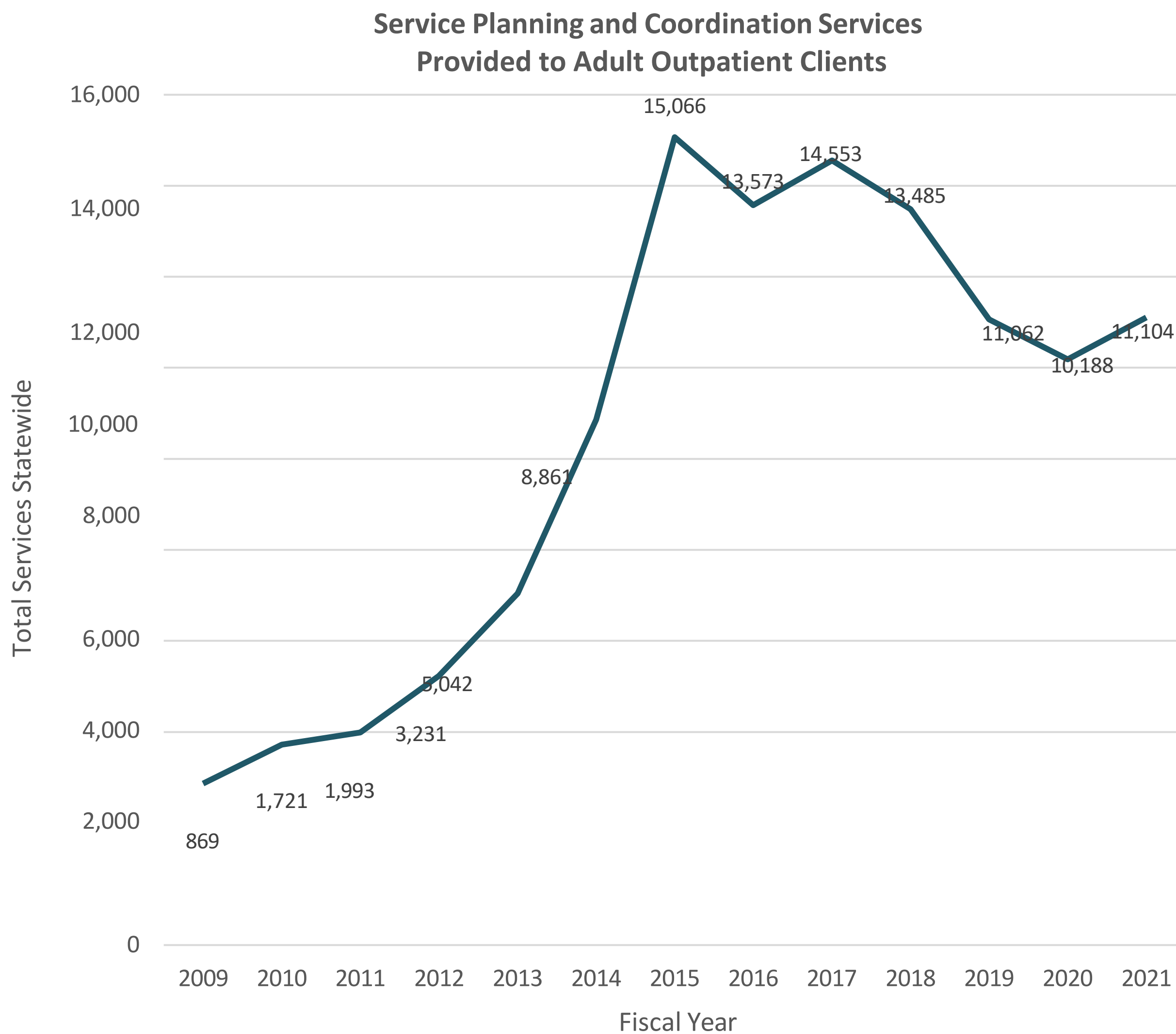
The highest number of persons served by programs offered by the Designated Agencies (DAs) continues to be in services for children, youth, and families, although emergency services has continued to increase that reflects the needs associated with the impacts of Covid-19.. The 6% decrease noted in 2019 appears to have self-corrected and closely approximates the previous average utilization. In FY 2022, Adult Outpatient programs saw an increase in utilization while the CRT programs continued a steady decline that started in FY 2016.

Figure 8. Community Utilization per 1,000 Populations



The Vermont community mental health system serves 39 out of every 1,000 Vermonters for FY 2021, which is higher than the national utilization rate of 24 out of every 1,000 people. The most recent national data available through FY 2021 shows that Vermont continues 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.

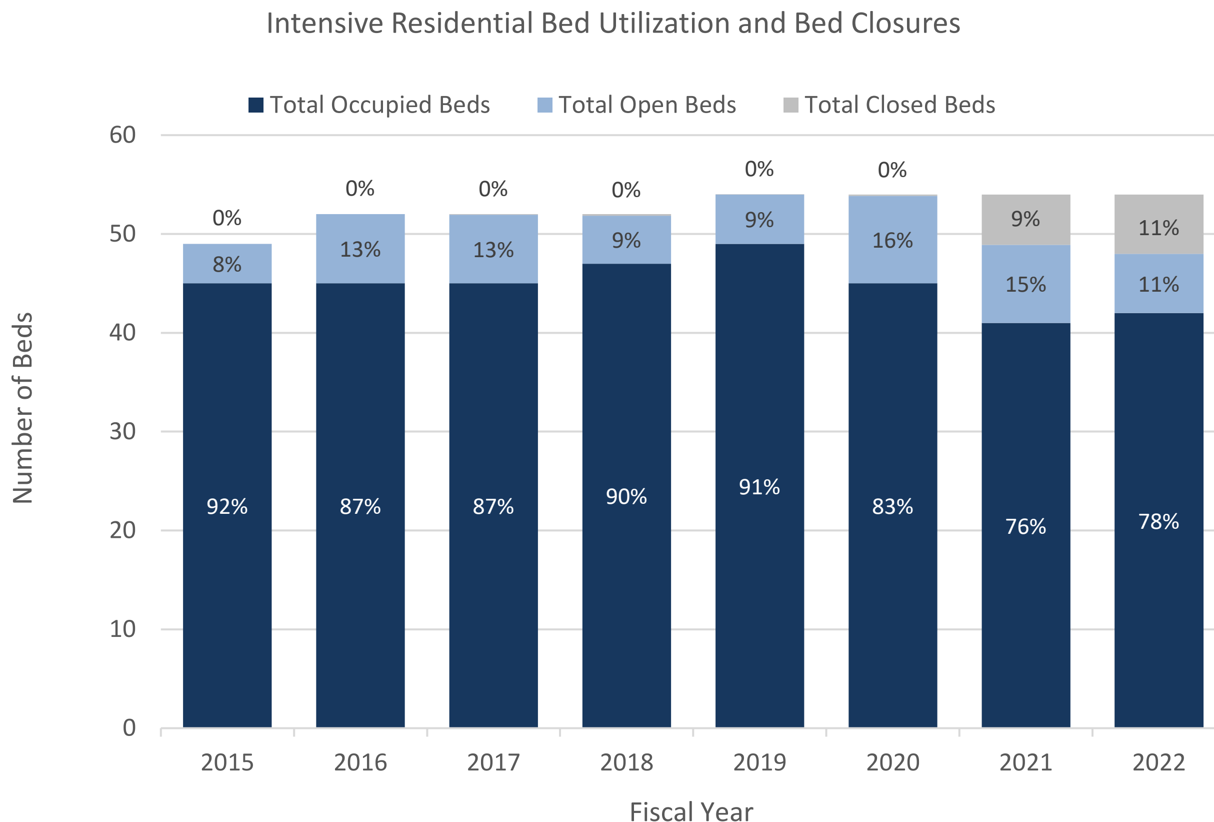
Figure 9. Service Delivery: Planning and Coordination



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.

Residential and Transitional Services

Figure 10. Intensive Residential Bed Utilization



The Intensive Residential Recovery Programs (IRRs) continue to meet a key need for a significant number of individuals who are ready to leave higher levels of care, but who still require intensive supervision and support before taking steps toward integrating back into their communities. 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. The chart above illustrates the utilization of beds in these programs. FY 2018 and FY 2019 reflect a plateauing of utilization with a high at 91%, although the impacts of the Covid-19 pandemic being reflected starting in FY 2020 with a decrease in occupancy and closed beds. FY 2021 saw the greatest decrease in utilization over the 8-year period reported in the above graph to 76%. The influence of the pandemic and the changing capacities of programs to safely transfer and introduce new residents into programs likely contributed to this drop.

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 RBA performance scorecards to assess the performance of value-based payment measures focusing on access to and quality of care provided in the state's community mental health centers
- DMH continues to use RBA scorecards to communicate payment reform service utilization data to DAs to ensure transparent accounting of service reporting.

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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 continues to use 2 case rates: 1) children/youth mental health services, and 2) adult mental health services. The goal of this work is to move toward a simple, accountable system that reduces the complexities of payment, provides flexibility to providers in their delivery of mental health services, 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 this time, the Department of Mental Health submitted their most recent payment model with the IFS regions included to end additional and duplicative reporting that has been occurring over the past two years.

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.

The toll the pandemic has taken on everyone is being profoundly felt by the mental health staff in Vermont as they respond to others while managing their own experience of trauma. Vacancy rates were at 22% in FY18 and they are now at 33.6%. This is impacting service delivery for individuals, children, and families.

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

Mental Health Integration Council

DMH convened the state's Mental Health Integration Council in July 2021. This council meets every other month, with subcommittee work occurring both outside and during these regularly scheduled meetings. Its work focuses on opportunities to integrate mental health into a holistic health care system and facilitate the necessary discussions with key stakeholders to further this integration. Additionally, both national and state experts have provided 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 enact more focused integration on the following targeted areas:

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

In January of this year, the Council submitted an interim report to the State General Assembly with recommendations from each workgroup. Between now and when the Council dissolves in July, the workgroups continue to pursue projects and build relationship with a view toward maintaining progress going forward.

iv. Blueprint for Health

Key updates from QE 12/2022:

- The majority of Vermont's primary care practices are now Blueprint-participating Patient-Centered Medical Homes, as 134 of Vermont's estimated 182 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 2022-Q4 the average monthly number of Medicaid beneficiaries served by Office-Based Opioid Treatment (OBOT/Spoke) programs increased to 3,969.
- Vermont Continues to increase access to enhanced preventative health, psychosocial screening, and comprehensive family planning services, as evidenced by the commitment of 44 practices and all 6 Planned Parenthood sites to participate in the Women's Health Initiative as of October 2022

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 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 (HSAs). These teams, called Community Health Teams (CHTs), provide supplemental services that allow Blueprint-participating primary care practices to focus on promoting prevention, wellness, and coordinated care 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 Health Service Area, 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. 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)
- 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

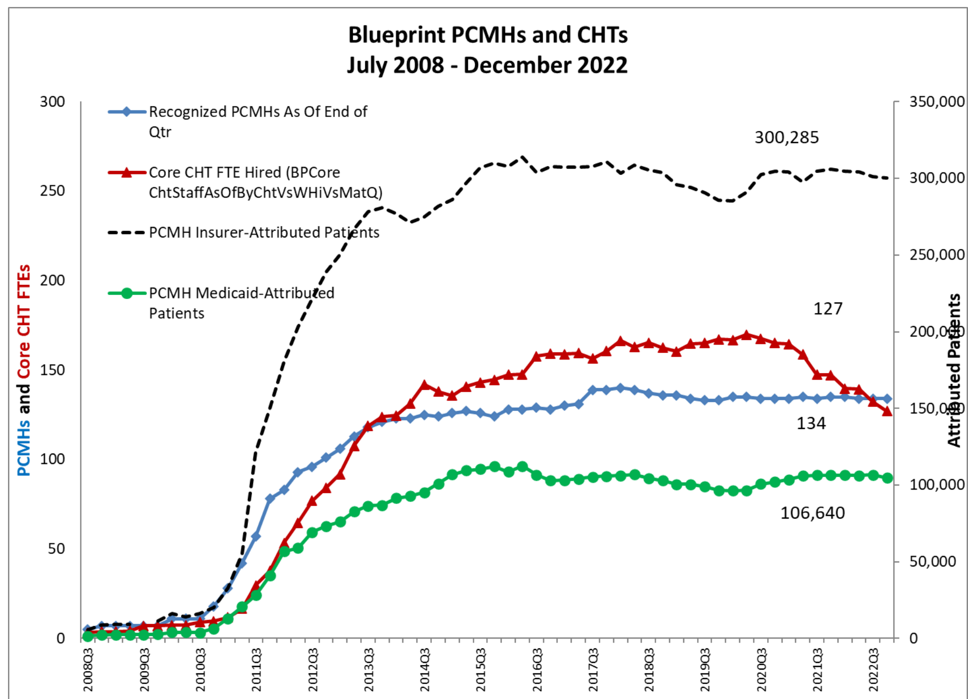
Quality Improvement

Facilitators worked with interested practices to request PCMH annual submission extensions to NCQA in order for practices to better utilize State sponsored CAHPS results for reporting on Patient Experience of Care measures. As part of ongoing work of patient centered medical homes, thirty four (34) practices across the State successfully completed their National Committee for Quality Assurance annual recognition process in this period, demonstrating their ongoing commitment to the model and continuous quality improvement. The QI facilitation network received and further disseminated education/resources to practices and community collaboratives on food security screening, Health Information Exchange efforts through VITL (Access Clinical Portal, vaccination data and lab data connections) , CDC Opioid and Pain Guideline Updates, Care Management Best Practices, and the 2023 Quality Measures Crosswalk, a resource for practices involved in various quality reporting/payment programs across the state and nationally.

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. Practices in collaboration with CHT teams are reaching out to patients who have missed annual visits such as physicals and key annual screenings for preventative care. When reaching out to patients, they would also inquire about other social determinants of health, such as access to food, medication, housing, mental health and substance abuse disorders and other factors that could impact health and well-being. While in-person visits have increased substantially telehealth continues to be an option for some primary care appointments and screenings. The network continues to work diligently to ensure excellent patient care and care coordination supporting whole-person health including intervention and referral to higher level of care if needed. The community collaboratives have brought key partners in the community to discuss needs of each health service areas. Team based care and collaboration is key to improve and understand root cause of population health.

In Quarter 4 (October- December 2022), 134 Vermont practices were operating as Patient- Centered Medical Homes, thanks to the commitment of providers and staff, the support of Program Managers, and the technical assistance of Quality Improvement Facilitators. The number of practices participating in the Blueprint for Health program is a key performance measure; the Blueprint estimates that there are about 182 total primary care practices operating in the state. Blueprint-participating Patient-Centered Medical Homes currently serve 300,285 insurer-attributed patients, of which 106,640 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 127 full- time equivalents of Community Health Team staff.

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

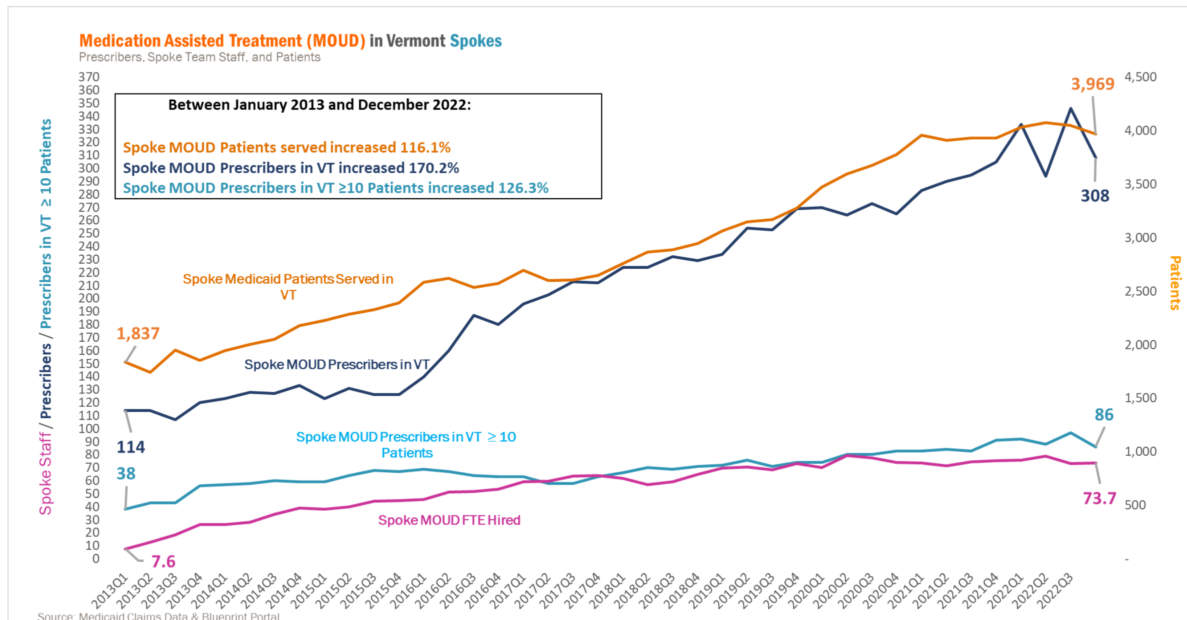
Hub & Spoke is Vermont's system of medication for opioid use disorder (MOUD) supporting people in recovery from opioid use disorder. The Blueprint administers the Spoke part of the Hub & Spoke system. Vermont continues to demonstrate substantial access to medication-assisted treatment for Vermonters with opioid use disorder 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. The Blueprint contract with Dartmouth College provides learning sessions with expert-led, peer-supported training in best practices for providing team-and evidence-based medication-assisted treatment for opioid use disorder. Five webinars, three virtual workshops, and a virtual two day conference was held from January through October of 2022. Sessions alternated between didactic care management webinars and multidisciplinary care management workshops.

The average participant attendance at these ten event dates was • The average number of attendees at a session in 2022 was 74 professionals. 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.

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 69 different Spoke settings (as of December 2022). The capacity to serve Vermonters continued to increase, as evidenced by a monthly average of 3969 Medicaid beneficiaries served by Office-Based Opioid Treatment (OBOT/Spoke) programs. There are 308 medical doctors, nurse practitioners, and physician assistants who work with 73.7 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 2022



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 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 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 2022 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. However, we did lose a few sites with the PPNNE closing some of their sites for many reasons. There was great concern about a few areas access to pregnancy termination, gender affirming care and the potential for bad debt to lack of sliding fee scales that match PPNNE fee scale. We worked with UVM/AHEC and they supported a learning series on gender affirming care which will began in January 2023. PPNNE has a robust telehealth program and felt confident they could continue to serve folks in this way. As of this report and inquiring with our health service areas, I have not heard any concerns on debt at this time. We continue to have a monthly call with WHI leadership. We have discussed a name change in the next year that is more representative of people who can become pregnant and supports non binary and transgender population. We have sent two surveys out to the field to get their input on a name change.

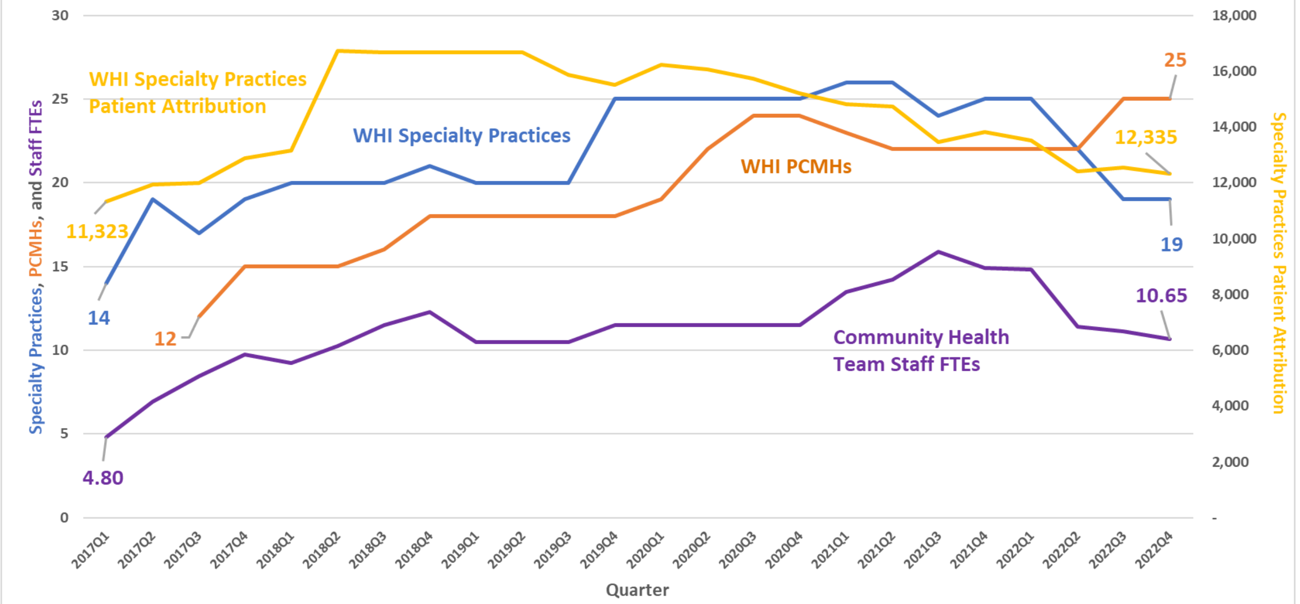
The Blueprint provided several lunch and learn sessions on best practices regarding same-day LARC and patient engagement. Also, 2 in person LARC insertion training for providers by Dr. Lauren MacAfee from UVM medical center. The filed was so appreciative to meet in person again for this essential training.

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.

Rutland Health Service was the hiring entity for PPNNE staff and they decided to transition their position to the PPNNE team as the hiring entity. At this time, all PPNNE positions are hired through that entity.

Figure 3 below shows WHI enrollment and staffing over time. By the end of 2022, the number of practices enrolled was 44. 19 women's specialty health care sites and 26 PCMHs participate in the Women's Health Initiative as of December 2022.

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



Women's Health Initiative (WHI):
Patients Attributed to Specialists, Specialty Practices, Patient Centered Medical Homes (PCMHs), and Community Health Team Staff
WHI Specialty Practices Patient Attribution
WHI Specialty Practices
WHI PCMHs
Community Health Team Staff FTEs
11,323
14
12
4.80
25
12,335
19
10.65
Specialty Practices, PCMHs, and Staff FTEs
Specialty Practices Patient Attribution
Quarter

Table 4. Women's Health Implementation by Region

Health Service Area / Team	WHI Specialist Practices as of Q4 2022	WHI PCMH Practices as of Q4 2022	WHI CHT Staff FTE Hired as of Q4 2022	WHI Specialist Quarterly Attributed** Medicaid Beneficiaries as of Q4 2022	WHI PCMH Quarterly Attributed** Medicaid Beneficiaries as of Q4 2022
Barre	1	1	0.75	632	467
Bennington	1	2	0.30	831	232
Brattleboro	1	0	.7	900	0
Burlington	2	9	1.	1922	4894
Middlebury	1	0	0.75	622	0
Morrisville	1	3	0.50	296	1294
Newport	1	0	1	914	0
Randolph	2	0	0.50	278	0
Rutland	2	0	1	1953	0
Springfield	0	5	0	0	1721
St. Albans	0	0	0.00		0
St. Johnsbury	1	2	0.75	836	668
Windsor*	0	3	0.00	0	87
Planned Parenthood (Statewide)	6	0	3.2	3301	0
Total	19	25	10.65	12485	9363

*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 CY2022

- Operational Activities
  1. Prior Authorization (PA) Data
  2. Paid Claims and Drug Spend
  3. Provider Communications

- Clinical Activities
  1. 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 for pharmacies and prescribers. The Pharmacy Unit is also responsible for overseeing the contract with CHC. The Pharmacy Unit manages approximately $266 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, Division of Substance Use Program (formerly 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 Special Investigation 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	501,894	90	20,323	181	84	6,394	17,117	546,083
	92%	<1%	4%	<1%	<1%	1%	4%	100%
Quarter 3	500,641	85	13,149	210	78	6,690	16,7832	537,636
	93%	<1%	2%	<1%	<1%	1%	3%	100%
Quarter 2	508,626	93	10,228	243	94	6,872	16,651	542,807
	94 %	<1%	2%	<1%	<1%	1%	3%	100%
Quarter 1	488,631	92	19,851	190	98	7,260	15,777	531,899
	92%	<1%	4%	<1%	<1%	1%	3%	100%

- Total claim count does not include compounded drugs.

Paid Claims and Drug Spend

MEDICAID

Period	# Claims	# Of Members	State Paid Amounts
4Q2022	494,745	87,541	$71,649,905.12
3Q2022	482,749	83,701	$69,548,297.74
2Q2022	484,772	87,713	$68,602,012.81
1Q2022	471,462	80,819	$65,686,201.08

VPHARM

Period	# Claims	# Of Members	State Paid Amounts
4Q2022	60,231	6,637	$1,060,163.00
3Q2022	63,956	6,857	$1,226,688.17
2Q2022	7 66,979	7,031	$1,390,713.66
1Q2022	67,154	7,157	$2,038,496.04

COVID-19 Communications

Information for Treatment Related to COVID-19	To ensure that Vermont Medicaid members continue to have access to the medications they need and in response to evolving conditions related to COVID-19, the Department of Vermont Health Access (DVHA) is implementing the following changes to its prescription drug benefits programs: Copayments do not apply to any treatments of underlying conditions that may complicate the treatment of COVID-19 including treatments long-COVID/long haul, copayments for treatments while a Vermont Medicaid beneficiary is diagnosed with or presumed to have COVID-19, effective October 22, 2021. The prescribers shall write a memo/note on the prescription indicating it is being prescribed for treatment of COVID-19 or a COVID-19-related diagnosis.
Update on Pharmacy COVID-19 Antigen Test Coverage	Vermont enrolled pharmacies can bill for select over-the-counter COVID-19 test for use by Medicaid members in a hoe setting when prescribed by a Vermont Medicaid enrolled provider effective 12/1/2021. Reminder that members may only receive test kits (at no cost) when pharmacies bill them directly to Medicaid with a valid prescription. Reminder that pharmacies must follow the NCPDP standard and use the NDC or UPC products codes found on the package. Copayments will not apply, and the coverage limit is no more than 4 test kits (8 test) every 30 days.

Provider Communications

Updates to Buprenorphine Prior Authorization Form	Effective 1/1/23, Vermont Medicaid is updating the prior authorization (PA) requirements for SPOKE/OBOT Buprenorphine prescribing for opioid use disorder (OUD). Prior authorization is required for all doses of non-preferred formulations (e.g., buprenorphine mono tablets) and preferred formulations (e.g., buprenorphine/naloxone combination tablets, Suboxone® films) if the daily dose exceeds 16 mg. The complete list of preferred and non-preferred formulations along with PA criteria can be found on the DVHA 01/01/2023 PDL.
Point of Sale (POS) Blackout Period	Due to the need to perform system maintenance, the DVHA POS system will unavailable for approximately 3 hours starting at 10:00 PM on Friday, December 16,2022.
Change Healthcare Holiday Observation	Change Healthcare, in observance for Christmas and New Year's were closed on Saturday 12/24/22 and Saturday 12/31/22.
Preferred Drug List (PDL) changes	A communication was sent in December 2022 for changes effective on 1/1/23 for drugs on the Preferred Drug List (PDL) either moving to preferred status or moving to non-preferred status.

Changes to Select Specialty Pharmacy Medication Dispensing	Dispensing restrictions have been removed for a select number of medications that no longer meet the requirements for inclusion on the specialty drug list for Vermont Medicaid. Effective 1/13/23, DVHA no longer requires dispensing by an accredited specialty pharmacy. Prescriptions for Enbrel®, Humia®, Jatenzo®, Praluent®, Repatha®, Tlando®, and Veltassa® can be filled at any VT Medicaid enrolled pharmacy.
Changes to Coverage for Diabetic Supplies	Becton Dickinson & CO will no longer be the preferred manufacturer for pen needles effective 1/1/23. Pharmacies need to choose for a wide selection of pen needles/pen tis from Arkray USA, Inc. or Owen Mumford USA, Inc.
Changes to Coverage for Select Outpatient Infusions	Effective 1/1/2023 there was changes to the preferred formulations of infliximab, epoetin alpha, rituximab, and pegfilgrastim on the Department of Vermont Health Access (DVHA) Preferred Drug List (PDL).
Pharmacy Newsletter	A pharmacy newsletter went out in October 2022 giving updates on changes to Synagis® Season 2022, Influenza 22/23 flue season, ProAir HFA inhalation aerosol discontinuation, changes in coverage for Naloxone nasal spray, Buprenorphine products covered list, Drug Utilization Review Board and meeting schedule.
Synagis Season	As of 10/10/22 started to allow Synagis® shipments. This is due to a shift in seasonality noted in 2021 and current variability in RSV cases, The American Academy of Pediatrics (AAP) supports the use of Synagis® in eligible patients in any region experiencing rates of RSV activity at any time in 2022 similar to a typical fall-winter season.
Changes to Coverage for Naloxone Nasal Spray	Effective 10/7/22, generic formulation of naloxone HCI nasal spray (4mg/0.1mL) will be moved to non-preferred status on the Department of Vermont Health Access (DVHA) Preferred Drug Lis (PDL).
Buprenorphine Products Covered List	HUB (OTP) covered Buprenorphine products list was updated on 10/1/2022.
ProAir® HFA (albuterol sulfate) inhalation Aerosol Discontinuation	Effective 10/1/22, Change Healthcare discontinued the manufacturing of ProAir® HFA (albuterol sulfate) inhalation. Providers may continue to dispense ProAir® HFA until supply is exhausted. Alternatives that are preferred with no prior authorization are ProAir Respiclick® inhalation powder, Preventil® HFA inhalation aerosol, and Ventolin® HFA inhalation aerosol.
Influenza (Flu) 2022/2023 season	DVHA enrolled pharmacies may be reimbursed for injectable influenza vaccines administered by pharmacist to adults 19years and older who are enrolled in Vermont's publicly funded programs. Pharmacist must be enrolled with Vermont Medicaid, certified to administer vaccines in the State of Vermont and must be compliant with all Vermont laws governing vaccine administration.

Changes to VPharm 2 and VPharm 3 Coverage	Effective 7/1/2022 expansion of drug coverage under VPharm 2 and VPharm 3 is now equivalent to drug coverage available under VPharm 1. Changes are a result from Vermont's new Global Commitment to Health 1115 waiver allowing for lower cost out-of-pocket for VPharm members.
Pharmacy Newsletter	A pharmacy newsletter went out in June2022 giving updates on changes to VPharm2/VPharm 3 coverage, 802 Quits supports pharmacist in helping patients quit smoking, Drug Utilization Review Board (DRUB) meeting, blood glucose test strip quality limits, Point of Sale (POS) blackout period, and change to coverage for Estonogestrel/Ethinyl Estradiol vaginal ring.
Blood Glucose Test Strip Quantity Limit	Effective 6/10/2022 prior authorization will be required for members using more than 200 strips per 30 days to control quantity limits. This change came from the Drug Utilization Review Board (DURB) after a review of utilization and identifying members using a significant number of strips upwards of 10 strips per day.
Important Changes to Coverage for Etonogestrel/Ethinyl/Estradiol Vaginal Ring	As of June 10, 2022, generic formulations of estonogestrel/ethinyl estradiol vaginal ring moved to a non-preferred status on the Preferred Drug List (PDL). Brand Nuvaring®, has a significantly lower net cost to Vermont Medicaid compared to currently available generics and will remain preferred on the PDL. We continually monitor the net costs of these medications and periodically adjust the PDL if new cost-effective products become available.
Point of Sale (POS) Blackout Period	On Wednesday June 8,2022 the Department of Vermont Health Access POS system will be unavailable for approximately 8 hours starting at 8:00 PM, due to the need to perform system maintenance, the on Wednesday, June 8, 2022. Pharmacy claims will not be adjudicated during this time.
Updated Letrozole Prior Authorization Request	Effective 6/17/22, a prior authorization request for Letrozole will be required to ensure medication is being used for a covered diagnosis for patients under 50 years of age. This came from a review of pharmacy dispensing data identified members were being prescribed letrozole for treatment of infertility. Pursuant to Social Security Law, Sec. 1927. [42 U.S.C. 1396r–8], agents when used to promote fertility are excluded from Medicaid coverage.
Point of Sale (POS) Blackout Period	Due to the need to perform system maintenance, the DVHA POS system will have intermittent outages beginning 12:01 a.m. and 7 a.m. Saturday, May 21, 2022; and then again (if needed) from 12:01 a.m. to 7 a.m. Sunday, May 22, 2022. Pharmacy claim adjudication may be impacted during this time.
Important Changes to Coverage for Isotretinoin Capsules	April 29, 2022, generic formulations of Isotretinoin capsules (manufactured by Actavis, Amneal Pharmaceuticals, Mayne Pharma, Sun Pharmaceuticals, and Upsher-Smith) will be moving to a non-preferred status on the Preferred Drug List (PDL). Amnesteem, Claravis, Myorisan, and Zenatane (commonly referred to as "branded generics") have a significantly lower net cost to Vermont Medicaid compared to currently available generics and will remain preferred on the PDL.

Buprenorphine Products Covered List	Hub (OTP) Covered Buprenorphine Products list as updated on March 18, 2022
Update on Synagis® (palivizumab) Dispensing	DVHA continued to monitor RSV activity through their Pharmacy Benefit Manager, Change Healthcare, data from the National Respiratory and Enteric Virus Surveillance System (NREVSS) and has determined that the Synagis® "season" has ended since the percent positives on antigen tests is ≤ 10% for 2 weeks or the percent positives on PCR tests is ≤ 3% for 2 consecutive weeks. Therefore, no further shipments will be authorized after 3/11/2.
Pharmacy Newsletter	A pharmacy newsletter went out in March 2022 giving updates on hypertension management initiative, Team Care program, changes to administration fees for vaccines, pharmacy COVID-19 antigen test coverage, the preferred drug list, new Drug Utilization Review Board (DURB) board member, DURB meeting, website updates and information on how to take the pharmacy satisfaction survey.
Pharmacy Benefit Provider Satisfaction Survey for Prescribers and Pharmacies	On February 14, 2022, a Pharmacy Benefit Provider Satisfaction Survey was distributed to Vermont Medicaid enrolled Prescribers and Pharmacies. The Department of Vermont Health Access (DVHA) contracts with Change Healthcare to support Vermont's publicly funded pharmacy benefit programs. The Change Healthcare Help Desk supports all pharmacies and prescribers enrolled in Vermont's pharmacy benefit programs such as Medicaid and Dr. Dynasaur and is the first point of contact for pharmacy and medical providers for drug prior authorization requests, drug claims processing issues, and other drug-related questions, concerns, and complaints. This survey is required annually by DVHA to assure that enrolled providers are receiving the highest quality of service possible from its contracted vendors.
Changes to Administration Fees for Vaccines	Effective 1/1/2022, pharmacy administration fee for vaccines will be changing from $13.97 to $13.87. This does not apply to COVID-19 vaccination administration rates. This adjustment is being made to align with changes to the physician fee schedule (CPT code 90471) for adult vaccinations by primary care practitioners. DVHA enrolled pharmacies may be reimbursed for vaccinations administered by pharmacists to adults 19 years and older who are enrolled in Vermont's publicly funded programs. Pharmacists must be compliant with all Vermont laws governing vaccine administration. Failure to comply with all Vermont immunization regulations will subject these claims to recoupment.

Clinical Activities

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 by ensuring that the full value of these medications in improving patient outcomes 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 2022. 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.

Vermont PCM Progress Report– 12/31/2022

Program-to-Date (through 12/31/2022):
Total Members Enrolled: **3185**
Total Medications covered: **179**

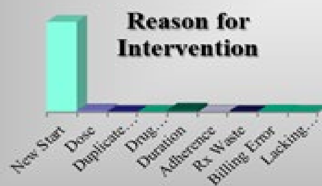
Fiscal Year 2023, Quarter 2:
Current Active Enrollments: **495**[1]
Newly Enrolled: **157**
Initial claim/Prior Authorization reviews: **157**
Follow-up reviews: **394**
Patient Contact
- Phone call attempts[2]: **209**
  - Answered/Member Counseled: **103**
- Phone calls received from member: **0**

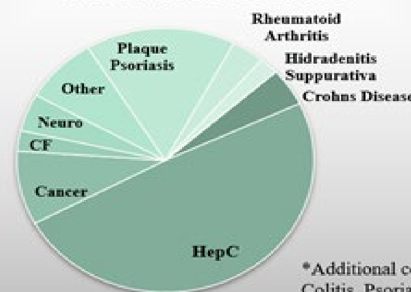
Provider Contact
- Phone calls: **8**

Chart notes
- Requested: **113**
- Received: **58**

Prescription Images
- Requested: **1**
- Received: **0**

Interventions with Direct Cost Avoidance: **3**





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

Quick Summary

✓ ***Promacta***

Member's platelets failed to increase after 4 weeks at the maximum daily dose

- Worked with provider and member to discontinue treatment that was ineffective
- *$130,142.52 (cost extrapolated)*

✓ ***Fasenra***

Pharmacy continued loading dose frequency of every 4-week fills, when should have moved to the 8-week dosing of maintenance phase

- Worked with pharmacy and member to correct the dosing frequency
- *$31,290.54 (cost extrapolated)*

1. Exclusive of members that are no longer being monitored (closed) and those that have lost eligibility (inactive)

Change Healthcare (January 1, 2022, through December 31, 2022). Change Healthcare Pharmacy Management Reporting Suite by a collection of reports recording the process and progress of PCM.

In the fourth quarter of 2022, the PCM program enrolled an additional 157 members for a total of 3,185 members on 179 unique medications. The program is actively monitoring 495 enrollees. A total of 209 outgoing telephone calls were placed to members, 103 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 $623,402 so far in SFY2023. More than $4.94 million in unnecessary drug spend in total avoided for the program.

vi. Choices for Care and Traumatic Brain Injury Programs

Key updates from YE122022:

- DAIL implemented the CBA minimum wage increase, as well as a 8% rate increase for HCBS services, impacting all consumer surrogate self-directed programs.
- DAIL began implementation of a 5-million-dollar Capacity Building supplemental grant

Summary of Individuals served through CFC and BIP in SFY2022:

Choices for Care (CFC)	**SFY 2022**
Unique People Served by CFC	**6783**
High/Highest	**5711**
Moderate Needs	**1198**
Money Follows the Person	**72**
HCBS High/Highest	
Total Unique People Served	**2805**
Percentage of High/Highest CFC	**4%**
ERC	
Total Unique People Served	**762**
Percentage of High/Highest CFC	**13%**
Nursing Facility High/Highest	
Total Unique People	**2745**
Percentage of High/Highest CFC	**48%**
Brain Injury Program (BIP)	**SFY 2022**
Total Unique People Served	**86**

Brain Injury Program:

In 2022, the Brain Injury Program:

- Had 46 individuals enrolled in the Long-Term Program
- Had 34 individuals enrolled in the Rehab Program
- The BIP program had 26 applications, 1 graduation, 1 transfer to CFC.
- 19 individuals clinically approved, but not served by an agency due to workforce capacity DAIL worked closely with the Brain Injury Alliance of Vermont for the roll out of the Neuro Resource Facilitation and joined the re-established the VT Brain Injury Alliance Advisory

Council.
DAIL increased our brain injury program provider list to include Lamoille County Mental Health.

- We have initiated an update on the Brain Injury Program manual to align with current program guidance.
- Continues to implement the program name change of Brain Injury Program (BIP) formerly Traumatic Brain Injury Program to more accurately reflect the scope of individuals served.

Choices for Care:

Money follows the Person Grant:

In 2022 the Money Follows the Person Grant

- Transitioned 72 participants
- For CY2022 MFP transitioned 72 CFC participants, 101% of the approved target of 71 individuals for the year.
- At the end of CY2021, MFP had 65 active enrollees.
- For, CY2023 Vermont is requesting funds to support approximately 62 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
- In CY2022 all the Capacity Grant Initiatives were begun with the exception of the CAPABLE program for falls prevention. The contract for that initiative will begin April 2023. In CY 2022, CMS also approved one additional Capacity Grant initiative that will improve hospital discharge planning protocols and processes for discharging individuals will complex care needs who have been unable to discharge despite no longer needing acute care. This initiative will begin in May 2023.

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 delayed until2025.

Adult Day Services

Adult Day Centers have resumed operations at a reduced capacity. Operational capacity across all Adult Day Centers varies from 30-100% of pre-pandemic capacity. Barriers to full census include workforce shortage and ongoing concern regarding COVID restrictions.

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 to $13.44/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 an 8% increase in rates for HCBS services.

Quality Management Unit – The Adult Services Division Quality Management Unit initiated quarterly provider meetings to provide education and technical support to all provider networks.

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. Workforce shortage continues to be the main driver for the waitlist. . There is currently no wait list for the Brain Injury Program.

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vii. Developmental Disabilities Services Division (DDSD)

DDSD Clinical and Crisis Continuum of Care

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.

- In November 2022, ITS supports officially admitted the first individual to receive these supports. DDSD continues to explore opportunities to expand the system's clinical and crisis framework to increase capacity to support individuals. This includes exploring opportunities related to prevention and early intervention, as well as community crisis beds.

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) (SFY2023-SFY2025)

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. (See previous updates). Throughout this quarter, DDSD created and presented a draft SSOCP to the Developmental Disabilities State Program Standing Committee, integrated feedback and input, and finalized the Plan. The Vermont State System of Care Plan for Developmental Services will be implemented effective January 1, 2023.

Regulations Implementing the Developmental Disabilities Act of 1996

During the 2022 Legislative session, Act 186 was passed which amended the DD Act was amended to no longer require changes in the SSOCP to be adopted through the rulemaking process. This amendment allows the Division to act more nimbly with updates and renewals of the SSOCP. It does not, however, remove the requirement for stakeholder involvement and input. 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. Over the summer, the Division held public input sessions to solicit feedback on the proposed rule. DDSD reviewed the input, responded to the points, and incorporated feedback as appropriate. The updated Rule was submitted to the Legislative

Committee on Administrative Rules in December for consideration after the turn of the year.

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

Key updates from QE122022:

- Executed a contract extension with OneCare for a 2023 performance year of the program.
- Continue to support Vermont's broader efforts to develop an integrated healthcare delivery system under an All-Payer Model through future program planning and implementation.

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

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

DVHA issues a prospective Per-Member-Per-Month (PMPM) payment to the ACO; the ACO distributes payments to providers participating in the program per contractual arrangements between the ACO and providers. The ACO is paid for each attributed beneficiary according to their Medicaid Eligibility Group, and the ACO is accountable for the cost and quality of care of each attributed beneficiary. Payments for services not included in the ACO contract continue to be paid fee-for-service, as are payments made to Medicaid providers not participating in the ACO's network.
DVHA and OneCare executed a contract amendment for a 2023 performance year of the VMNG program in Q4 of 2022. Programmatic changes to the model were minor in many areas, with more significant changes around OneCare's care model and care management requirements and minor 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 2022 and 2023 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 2023 performance year. The number of attributed lives for the 2023 performance year increased from approximately 126,291 lives (95,727 through the traditional attribution methodology and 30,564 lives through the expanded attribution methodology) to 142,101(105,101 through the traditional attribution methodology and 37,000 through the expanded attribution methodology).

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

x. *Global Commitment Register*

Key updates from 2022:

- 97 policies were posted to the GCR in 2022.
- Since the Global Commitment Register (GCR) launched in November 2015, 352 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 continued to impact the state budget and Medicaid operations in 2022, which is reflected in the number and type of policies being posted to the GCR. There were 48 proposed policies posted in 2022, including 21 in the 4th quarter of the year. A total of 43 final policies were posted in 2022, including 9 final policies in Q4. Six policy clarifications, none in Q4, were posted to the GCR in 2022. 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.

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.

In 2022, the Clinical Utilization Review Board made the following recommendations:

1. Increase the limit of individual psychotherapy services from 24 to 260 sessions per calendar year prior to requirement of prior authorization
2. Allow Non-invasive Prenatal Testing (NIPT) screening to all pregnant members, regardless of age or baseline risk
3. Adoption of position statement for PA changes related to hysterectomy services for gender dysphoria related diagnoses that; 1. Removes PA requirement for hysterectomy requests for members 18 years of age or older with gender dysphoria related diagnoses and 2. Requires PA for hysterectomy requests for members less than 18 years of age with gender related diagnoses
4. Approval of adding seven codes to the current Imminent Harm Code list (two surgical codes, two speech generating device codes, and three wheelchair codes)

In addition, the Board examined the following topics through the lens of medical necessity and utilization:
• Telemedicine and Remote Patient Monitoring
• Changes to Clinical Prior Authorization Requirements
• Consumer Assessment of Healthcare Provider & Systems Reporting
• Alignment of ACO and DVHA Quality Measures
• Identification of Preventive Clinical Guidelines; and
• COVID-19 Flexibilities

The Clinical Utilization Review Board is required to meet at least quarterly. In response to the pandemic, the Board met virtually while maintaining required access for members of the public. Duties and responsibilities of the Board include identification and recommendation of opportunities to improve quality, efficiencies, and adherence to relevant evidence-based clinical practice guidelines in the Department's clinical programs. The Board completes this function through review of claims data and information provided by the Clinical Services Team.

Telemedicine and Remote Patient Monitoring

The Board was asked to review telemedicine data compiled by the Department of Vermont Health Access ("Department"). The Department has supported continued access to, and provision of, medically necessary health care services via telemedicine at parity with in-person visits. Monitoring and modification to alternate delivery methods continues to ensure clinically appropriate delivery of services.

Telemedicine Utilization

Data show that telemedicine utilization peaked in April 2020. Since then, telemedicine utilization has decreased and in-person visits have increased (Appendix II). This includes telemedicine provided via audio and visual connection as well as audio-only telemedicine. The Board reviewed data and offered the following:
• Recommended empowering providers to use clinical judgement to determine best use of audio-only telemedicine services;
• Encouraged the Department to develop exclusionary (versus inclusionary) guidelines for audio-only services; and
• Endorsed audio-only monitoring for chronic conditions

Prior Authorization (PA) Requirements

Per requirement of legislative bill H.960 (Act 140) of 20203, "a health plan shall review the list of medical procedures and medical tests for which it requires prior authorization at least annually and eliminate the prior authorization requests for those procedures and tests for which such a requirement is no longer justified or for which requests are routinely approved with such frequency as to demonstrate that the prior authorization requirement does not promote health care quality or reduce health care spending to a degree of sufficient to justify the administrative costs to the plan." The Department has convened a work group to gather and analyze prior authorization (PA) data to inform proposals. The information is shared with the Board.
Board recommended the following to the Commissioner of the Department of Vermont Health Access (see board minutes for rational and detail):
• Removal of prior authorization requirement for hysterectomy for members 18 years of age or older regardless of diagnosis;
• Increase the individual outpatient psychotherapy limit from 24 sessions to 260 sessions per calendar year;
• Align and expand criteria coverage to allow non-invasive prenatal testing regardless of maternal age and baseline risk; and
• Adoption of seven additional codes (Durable Medical Equipment & Surgical) to the Imminent Harm list.

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 2021/2022 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

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 program (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

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 2022, the PI reviewed approximately 89 cases related to potential provider fraud, waste, and abuse allegations. In total, PI successfully settled and cost-avoided a collective $3,465,980.

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 2022 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 2022 O&M:

- Facilitated five 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. Twenty new SOPs were created and approved in 2022.

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 the medical records to substantiate the claim. The previous RY2020 PERM audit cycle was suspended early due to the PHE, and there were no state-level findings identified, only national error trends.

The current RY2023 PERM audit cycle is reviewing 550 sampled claims with dates of service between 7/1/21 – 6/30/22 and CMS has required that auditors have remote system access to conduct reviews remotely instead of coming on site.

Outcomes

The close of the PERM review cycle, 4/15/23, is approaching. Data processing reviews are 97% complete, medical record reviews 96%, and eligibility reviews are 95% complete. We continue to address additional document requests and any findings as they come in, with the goal of providing the auditors the documentation they need and reduce error findings where possible. At this time there is only 1 data processing error finding, 1 eligibility error finding, and we continue to outreach providers with outstanding record requests to assist them with submitting requested documentation for the medical record reviews.

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 our third quarterly implementation monitoring call with CMS is scheduled for March 6th.

Healthcare Quality Control Unit (HCQC)

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

Outcomes

- RY2017 Internal: **180** cases reviewed.
    - Audit Period: Nov-Dec 2017
- RY2018 Internal: **1031** cases reviewed.
    - Audit Period: Jan 1 to Dec 31, 2018
- RY2019 Internal: **978** cases reviewed.
    - Audit Period: Jan 1 to Dec 31, 2019
- **RY2020 MEQC** & Internal: **846** cases reviewed.
    - **MEQC: 213** Cases (Medicaid, CHIP)
        - **Audit period:** Jan 1-Mar 31,2020
        - 3/18/2020: Reduced due to COVID to 200.
        - 8/17/2020 CMS issued an MEQC COVID-19 Supplemental guidance outlining the relaxed policy regarding auditing activities
    - Internal: **633** Cases (VPharm & Non-MEQC)-Continued to keep in training for the rest of the year.
        - Audit period: Apr 1-Dec 31, 2020
- RY2021 Internal: **598** cases reviewed.
    - Audit Period: Jan 1-Dec 31, 2021
    - Caseload reduced due to COVID
- RY2022 Internal: **801** cases reviewed.
    - Audit Period: Jan 1-Dec 31, 2022
    - Started reviewing IHIP cases for training purposes in August 2022
- **RY2023 MEQC & Internal: Current Year**
    - MEQC Audit**: (Medicaid, CHIP)**
        - **Audit period: Jan 1-Dec 31, 2023, currently under review.**
        - **Plan Proposal was submitted and accepted 10/28/2022**

    - **Case level details and CAPS due 8/1/2024.**
    - **No relaxed policy. CMS expects full review of 800 minimum cases.**
- **Internal Audit: (VPharm, IHIP(Training))**
    - **Audit Period: Jan 1-Dec 31, 2023**
    - **Will officially begin auditing IHIP cases 7/1/2023.**

Promoting Interoperability & Medicaid Data Aggregation and Access 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 was 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 pos-payment audit function of the program resides under the Oversight & Monitoring Unit and the pre-payment review function resides under the HIE Unit.
- As part of the Global Commitment to Health Demonstration Waiver, a new incentive program titled Medicaid Data Aggregation and Access Program (MDAAP) is being created that will provide health information technology infrastructure support to Medicaid providers to increase health information technology use and connectivity to the state's health information exchange. Eligible providers will include mental health providers, substance use disorder treatment providers, and long-term services and supports providers. The HIT auditor is working closely with the HIE program on the development of the MDAAP, using her expertise from the HITECH incentive program for the development of MDAAP program rules and audit functions. This involves engagement with stakeholders, including AHS, DVHA, the HIE Steering Committee, and our fiscal agent.

Outcomes

- Audits are performed following an Audit Plan, annually approved by CMS to accommodate rule changes. 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-one individual audits have been completed.
- 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 continue through 2023 to allow for audits to occur and to process adjustments.
- For the MDAAP, outcomes include an RFP for consultative services for market analysis and program design, determining Medicaid provider type and specialty codes for MDAAP eligibility and provider survey, and defining technical and functional needs for an application for provider attestations.

v. Inpatient, Outpatient, and Emergency Department Utilization

Methods

Utilization statistics for inpatient, outpatient, and emergency department services provided under Global Commitment during FFY 2020-22 were compiled by the DVHA's Data Unit in February 2023 using paid claims data. The scope of analysis included institutional services provided under the Medicaid program

between 10/1/2019 and 9/30/2022, excluding crossover claims.[1] 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 2020-22.

Table 5. Inpatient Utilization by Fiscal Year and Age Group

Total Inpatient:									
	Sum LOS Days			**Discharges**			**Average LOS Days**		
Age	**2020**	**2021**	**2022**	**2020**	**2021**	**2022**	**2020**	**2021**	**2022**
<1	9,984	9,534	10,063	2,565	2,467	2,426	3.9	3.9	4.2
1-9	2,740	1,721	2,225	439	365	477	6.2	4.7	4.7
10-19	7,378	9,675	7,985	930	984	914	7.9	9.8	8.7
20-44	27,376	27,513	30,399	5,344	5,421	5,464	5.1	5.9	5.6
45-64	27,534	27,037	25,784	3,593	3,726	3,652	7.7	7.3	7.0
65+	1,027	2,306	1,652	73	117	121	14.1	19.7	13.7
Overall	**76,039**	**77,786**	**78,108**	**12,944**	**13,080**	**13,054**	**5.9**	**5.9**	**6.0**

1 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):

Age	Sum LOS Days 2020	Sum LOS Days 2021	Sum LOS Days 2022	Discharges 2020	Discharges 2021	Discharges 2022	Average LOS Days 2020	Average LOS Days 2021	Average LOS Days 2022
<1	9,734	9,195	9,979	2,530	2,431	2,409	3.8	3.8	4.1
1-9	2,506	1,394	1,948	375	295	416	6.7	4.7	4.7
10-19	6,857	9,130	7,245	819	859	797	8.4	10.6	9.1
20-44	22,043	20,810	22,481	4,199	4,253	4,295	5.2	4.9	5.2
45-64	21,265	19,671	18,285	2,715	2,754	2,753	7.8	7.14	6.6
65+	855	2,060	1,447	59	90	102	14.5	22.9	14.2
Overall	**63,260**	**62,260**	**61,385**	**10,697**	**10,682**	**10,772**	**5.9**	**5.8**	**5.7**

A1) Alcohol/Substance Inpatient Medical:

Age	Sum LOS Days 2020	Sum LOS Days 2021	Sum LOS Days 2022	Discharges 2020	Discharges 2021	Discharges 2022	Average LOS Days 2020	Average LOS Days 2021	Average LOS Days 2022
<1	-	-	-	-	-	-	-	-	-
1-9	-	-	-	-	-	-	-	-	-
10-19	49	14	44	5	6	6	9.8	2.3	7.3
20-44	1,583	1,049	1,158	356	326	332	4.4	3.2	3.5
45-64	1,411	893	973	322	216	242	4.4	4.1	4.0
65+	25	4.00	104	1	1	5	25.0	4.0	20.8
Overall	**3,068**	**1,960**	**2,279**	**684**	**549**	**585**	**4.5**	**3.6**	**3.9**

A2) Mental Health Inpatient Medical:

Age	Sum LOS Days 2020	Sum LOS Days 2021	Sum LOS Days 2022	Discharges 2020	Discharges 2021	Discharges 2022	Average LOS Days 2020	Average LOS Days 2021	Average LOS Days 2022
<1	25	5	-	1	1	-	25.0	5.0	-
1-9	991	427	424	54	34	37	18.4	12.6	11.5
10-19	5,277	7,575	5,465	401	446	366	13.2	17.0	14.9
20-44	10,330	9,726	11,299	911	810	908	11.3	12.0	12.4
45-64	9,212	6,643	4,494	331	302	311	27.8	22.0	14.5
65+	120	1,384	504	4	8	11	30.0	173.0	45.8
Overall	**25,955**	**25,760**	**22,186**	**1,702**	**1,601**	**1,633**	**15.2**	**16.1**	**13.6**

A3) Other Inpatient Medical:

Age	Sum LOS Days 2020	Sum LOS Days 2021	Sum LOS Days 2022	Discharges 2020	Discharges 2021	Discharges 2022	Average LOS Days 2020	Average LOS Days 2021	Average LOS Days 2022
<1	9,709	9,190	9,979	2,529	2,430	2,409	3.8	3.8	4.14
1-9	1,515	967	1,524	321	261	379	4.7	3.7	4.02
10-19	1,531	1,541	1,736	413	407	425	3.7	3.8	4.08
20-44	10,130	10,035	10,024	2,932	3,117	3,055	3.5	3.2	3.28
45-64	10,642	12,135	12,818	2,062	2,236	2,200	5.2	5.4	5.83
65+	710	672	839	54	81	86	13.1	8.3	9.76
Overall	**34,237**	**34,540**	**36,920**	**8,311**	**8,532**	**8,554**	**4.1**	**4.0**	**4.32**

B) Inpatient Surgery:

Age	Sum LOS Days 2020	Sum LOS Days 2021	Sum LOS Days 2022	Discharges 2020	Discharges 2021	Discharges 2022	Average LOS Days 2020	Average LOS Days 2021	Average LOS Days 2022
<1	250	338	81	35	35	15	7.1	9.7	5.4
1-9	234	314	267	64	64	57	3.7	4.9	4.7
10-19	521	531	728	111	118	111	4.7	4.5	6.6
20-44	5,333	6,658	7,868	1,145	1,161	1,158	4.7	5.7	6.8
45-64	6,269	7,296	7,396	878	962	884	7.1	7.6	8.4
65+	172	239	204	14	26	18	12.3	9.2	11.3
Overall	**12,779**	**15,376**	**16,544**	**2,247**	**2,366**	**2,243**	**5.7**	**6.5**	**7.4**

The following table (Table 6) presents visit counts by age for outpatient services provided in FFY2020-22; first emergency department services, next other outpatient services, and then the combination of ED and other outpatient services.

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**
FFY22	**Age**	**Emergency Department**		**Other Outpatient**		**Total**
		N	%Total	N	%Total	N
	<1	2,300	31%	5,016	69%	7,316
	1-9	11,777	23%	39,897	77%	51,674
	10-19	14,496	24%	45,657	76%	60,153
	20-44	35,693	23%	120,974	77%	156,667
	45-64	15,612	14%	99,406	86%	115,018
	65+	226	10%	2,052	90%	2,278
	Overall	**80,104**	**20%**	**313,002**	**80%**	**393,106**

Discussion

In FFY2022, Global Commitment, Medicaid, paid for 13,054 inpatient stays and 393,106 outpatient visits for Vermonters. The total number of inpatient stays was similar from FFY21 to FFY22. Outpatient visits increased by 9% during the same period.

Alcohol/substance-abuse inpatient stays were somewhat shorter in duration, inpatient surgeries were moderately longer, and psychiatric stays were much longer than other inpatient medical stays. Psychiatric inpatient medical services constituted 13% of the total inpatient stays and 28% of inpatient days. Average length of stay alcohol/substance abuse increased slightly to an average of 3.9 days in FFY22, and inpatient psychiatric medical average length of stay decreased to 13.6 days. The longest stays for all measured categories were in the 65+ age group.

Among outpatient visits, emergency department visits constituted 19% of the outpatient visits during FFY21 and 20% of outpatient visits during FFY22.

VII. Policy and Administrative Difficulties

Fiscal & Operational Management:

DY18 marks the renewal of the Global Commitment to Health Waiver. Due to the timing of the renewal negotiations, this DY represents only a six-month period (July 2022-December 2022). For DY18, 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 the two quarters in DY18, 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.

For the first time in the history of the GC Waiver, Vermont reported on all applicable category of service rows on the CMS-64 report. Previously, Vermont reported all expenditures on the CMS-64 "Other" row. Vermont used an internal report received from the MMIS fiscal agent, Gainwell, to assist with claiming on all applicable rows, but it was a very manual, labor-intensive process. Vermont is working with Gainwell to develop an automated CMS-64 report that will fully align with all categories of service reporting lines.

The new Budget Neutrality construct is a combination of Without Waiver vs With Waiver expenditures, as well as 10 Hypothetical Tests. The Investments are included in the With Waiver expenditures. As of QE1222, Vermont had an initial surplus of $8.4M in Waiver Savings. However, there were three Hypothetical tests (SUD IMD, Maternal Health and Treatment Services, and Global Rx) in a deficit position which reduced the Waiver savings by $1.1M, to $7.3M. Upon further guidance from CMS, Vermont fully intends to recalculate Budget Neutrality pmpms given the recent CMS policy update and Vermont's STCs. Vermont anticipates the carryforward savings from the previous demonstration (DY12-17) to be slightly over $1B which will be used towards the current demonstration's activities.

There are a few areas of reporting that will need to be corrected in the next quarter:

- Expenditures for the CFC population were reported in the ABD Non-Medicare Adult MEG. These expenditures should have been split between ABD Non-Medicare Adult and ABD-Dual.
- Expenditures for Brattleboro Retreat and Vermont Psychiatric Care Hospital were reported on the regular Investments form. These expenditures should have been reported on the IMD Investments form.
    - In addition, Vermont exceeded the IMD Investments cap and will be making an adjustment to reduce the claim as a prior quarter adjustment next quarter.
    - Once this adjustment occurs, Vermont will have approximately $8.5M remaining on the DY18 cap for Investments to be carried forward into subsequent DYs.

Vermont claimed a prior quarter adjustment for the temporary 10% FMAP increase for qualifying HCBS services under the American Rescue Plan of 2021 (ARPA). This brings the total 10% FMAP drawn to $71.8M which will be re-invested as match into $158M of total spending on new and approved HCBS spending plan activities. To date, Vermont has spent $41M (~25%) of its HCBS spending plan.

VIII. Capitated Rate Setting

The PMPM rates as set for 1/1/22-12/31/22 are listed below. AHS submitted the calendar year 2022 PMPM Medicaid rates to CMS in February 2022.

Medicaid Eligibility Group (MEG)	CY 2023 PMPM
ABD Dual	$2,105.97
ABD Non-Dual Adult	$2,763.84
ABD Non-Dual Child	$3,330.95
Non - ABD Adult	$800.57
Non - ABD Child	$604.59
Moderate Needs Group	$884.48
New Adult	$600.96
Global Rx	$135.26

Attachment 1 - Budget Neutrality Report

ELIGIBILITY GROUP		DY 18 Jul 2022 - Dec 2022
Without Waiver (Caseload x pmpms)		
ABD - Non-Medicare - Adult	$	92,251,341
ABD - Non-Medicare - Child	$	23,299,596
ABD - Dual	$	287,210,954
Non ABD - Non-Medicare - Adult	$	88,412,542
Non ABD - Non-Medicare - Child	$	226,312,813
Total Expenditures Without Waiver	**$**	**717,487,246**
With Waiver		
ABD - Non-Medicare - Adult	$	233,353,544
ABD - Non-Medicare - Child	$	20,360,439
ABD - Dual	$	145,706,415
Non ABD - Non-Medicare - Adult	$	56,470,924
Non ABD - Non-Medicare - Child	$	180,085,944
Individual Cost Effective	$	-
Community Transition Services	$	-
HIE	$	-
Investments	$	73,022,505
Total Expenditures With Waiver	**$**	**708,999,771**
Waiver Savings Summary		
Subtotal Annual Savings	$	8,487,475
Hypothetical Test Deficits	$	(1,150,493)
Cumulative Savings	$	7,336,982
HYPOTHETICAL TESTS		
Hypothetical Test 1: New Adult		
Limit New Adult PMPM*MM	$	261,315,743
New Adult Total Expenditures	$	222,857,284
Surplus (Deficit)	$	38,458,459
Hypothetical Test 2: SUD IMD		
SUD - IMD ABD - Non-Medicare - Adult	$	156,312
SUD - IMD ABD - Dual	$	129,959
SUD - IMD Non ABD - Non-Medicare - Adult	$	342,876
SUD - IMD New Adult	$	1,944,745
Limit SUD IMD PMPM*MM	**$**	**2,573,893**
SUD - IMD ABD Non Medicare Adult	$	156,753
SUD - IMD ABD - Dual	$	236,032
SUD - IMD Non ABD - Non-Medicare - Adult	$	380,720
SUD - IMD New Adult	$	2,146,822
SUD IMD Total Expenditures	**$**	**2,920,327**
Surplus (Deficit)	$	(346,434)
Hypothetical Test 3: SMI IMD		
SMI - IMD ABD - Non-Medicare - Adult	$	3,070,568
SMI - IMD ABD - Dual	$	357,432
SMI - IMD Non ABD - Non-Medicare - Adult	$	726,715
SMI - IMD New Adult	$	6,391,025
Limit SMI IMD PMPM*MM	**$**	**10,545,741**
SMI - IMD ABD Non Medicare Adult	$	1,622,662
SMI - IMD ABD - Dual	$	525,974
SMI - IMD Non ABD - Non-Medicare - Adult	$	700,983
SMI - IMD New Adult	$	5,491,100
SMI IMD Total Expenditures	**$**	**8,340,719**
Surplus (Deficit)	$	2,205,022
Hypothetical Test 4: Housing Pilot		
Limit Housing Pilot PMPM*MM	$	-
Housing Pilot Total Expenditures	$	-
Surplus (Deficit)	$	-
Hypothetical Test 5: Maternal Health and Treatment Services		
Limit Maternal Health and Treatment Services PMPM*MM	$	1,105,887
Maternal Health and Treatment Services Total Expenditures	$	1,179,899
Surplus (Deficit)	$	(74,012)
Hypothetical Test 6: CRT		
Limit CRT PMPM*MM	$	6,149,760
CRT Total Expenditures	$	4,735,011
Surplus (Deficit)	$	1,414,749
Hypothetical Test 7: SUD CIT		
Limit SUD CIT PMPM*MM	$	-
SUD CIT Total Expenditures	$	-
Surplus (Deficit)	$	-
Hypothetical Test 8: Global Rx		
Limit Global Rx PMPM*MM	$	4,978,916
Global Rx Total Expenditures	$	5,708,962
Surplus (Deficit)	$	(730,046)
Hypothetical Test 9: Moderates		
Limit Moderates PMPM*MM	$	610,327
Moderates Total Expenditures	$	445,519
Surplus (Deficit)	$	164,808
Hypothetical Test 10: Marketplace Subsidy		
Limit Marketplace Subsidy PMPM*MM	$	2,027,688
Marketplace Subsidy Total Expenditures	$	1,955,249
Surplus (Deficit)	$	72,439

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
July 1, 2022 – December 31, 2022

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.

July 2022:

- Provider Complaint - Caller requested to submit negative feedback regarding the VT Medicaid Provider Look up Portal. Caller stated the providers that are listed on the website, are not accepting SOV Medicaid. Caller is requesting that someone go through the list and update the information accurately to show which providers no longer accept VT Medicaid. The Agent apologized for the inconvenience, assisted with searching for another provider in a different town close to the customer and documented the feedback.
- Provider Complaint - Caller submitted negative feedback regarding her DME (Oxygen Machine). Caller states XXXXX XXXXX has not called them back when they have tried to contact them many times. Caller called the Williston branch and the main branch located in New Hampshire and neither facility has returned their call. Caller has made many phone calls this past week trying to get the issue resolved. The Agent apologized for the inconvenience, documented the feedback and provided the phone number to VT Legal Aid as well as mailed out a Provider Complaint Form.
- Provider Complaint - Caller called to report negative feedback as they cannot find any dental providers in their area that are accepting new Medicaid Patients. Caller states that they have had to pay out of pocket for visits as the only dentist they could find did not

accept VT Medicaid as insurance. Caller feels that they should be reimbursed for those visits. The Agent apologized for the inconvenience, assisted the customer with finding a dental provider that accepts VT Medicaid and mailed out a Provider Complaint Form.

August 2022:

- Provider Complaint - Caller states that they do not believe they are ready to leave XXXXX XXXXX and are advised that Medicaid will only cover a certain number of days. Caller states that Dr. XXXXX has mistreated them and has not given them the medication that they need. The Agent apologized for the inconvenience, documented the feedback and offered to mail out a Provider Complaint Form.

September 2022:

- Provider Complaint - Caller is concerned with not being able to find any dentists in the area. Caller states they have reached out to over 25 Dental Offices and none of them are accepting new patients that have Medicaid for insurance. Caller states they have all advised that they are over capacity and have no availability. The Agent apologized for the inconvenience, documented their feedback and provided more numbers to local dentists that are around the area.
- Caller submitted negative feedback regarding the lack of Dental Providers that accept VT Medicaid. Caller states that no one is accepting new dental patients in their area except for one location and they do not have any appointments available until 10/31/22. The Agent apologized for the inconvenience, documented their feedback and offered to provide more numbers to local dentists that are around the area.
- Provider Complaint - Caller would like to document negative feedback as they state that they have called over 26 different PCP Doctors and have received the same response every time, that they are currently not accepting new patients. Member has called Vermont Health Connect a total of six times in one day trying to find a PCP that is accepting new patients. The Agent apologized for the inconvenience, documented the feedback and assisted the customer by providing more PCP's in the customers area.
- Provider Complaint - Caller requested to document negative feedback about her experience at XXXXX XXXXX on 6/1/22. Caller states they had fallen which caused damage to their legs. Caller was in extreme pain and went to the Emergency Room where they had to wait several hours just to be seen. The doctors wrapped their legs in ace bandages very tightly. A couple days later, caller took another trip to a clinic where advised her XXXXX XXXXX should've never wrapped their legs so tightly and is in immediate danger of blood clots and infections. Caller states this is very scary, and all could've been avoided. Caller is now suffering from severe neuropathy from the misdiagnosis from XXXXX XXXXX. The Agent apologized for the inconvenience, documented the feedback and offered to mail out a Provider Complaint Form.
- Provider Complaint - Caller wanted to file negative feedback about XXXX XXXX. Caller states that the facility is not ready to release them. Caller feels well enough to take care of their own health now. Caller also stated that they do not get their daily medications on time and they do not provide them with proper meals on time. Caller is on a high protein diet with supplements which they should be getting in a timely manor. The Agent apologized

for the inconvenience, documented the feedback and offered to mail out a Provider Complaint Form.

- Covered Services - Caller would like to report 3 out of 4 of their children have received flu vaccines on Wednesday, at XXX XXXX. They are on a list to get the flu vaccine, as a priority, due to one of the children is type 1 Diabetic. 4th child was not available to go to appt, is 14yrs old and eligible for the new Covid Booster which is not available at XXXX XXXXX at this time. Caller went to XXXXX hoping to get child's Covid Booster along with the Flu Vaccine, however Medicaid denied coverage for Flu Vaccine. Caller states that "this is not acceptable and does not promote Preventive Health Care. Two of the children cannot get the new Covid Booster as of yet and had to go the Pediatricians Office for the Flu Shot but XXXXX should be able to get the Flu shot and covered at XXXX. What is the difference between XXXXX and XXXXX to get these Vaccinations? By requiring so many different stops many children may not get Vaccinated for the Flu and/ or Covid Booster. Your coverage policy starting Oct. 1st discriminates against Medically Compromised Households, and this needs to be changed". The Agent apologized for the inconvenience and documented the customers feedback.
- Provider Complaint - Caller wanted to document negative feedback regarding the lack of Dental Providers that accept Medicaid. Caller states there are no dentists available in their area to accept Medicaid patients. This causes customers having to travel long distances to find a Dentists. Caller also states there are not many incentives for Dentists to accept Medicaid which could be the reason there are not many that do. The Agent apologized for the inconvenience, documented their feedback and provided more numbers to local dentists that are around the area.
- Provider Complaint - Caller called to report that they do not like their providers and feels discriminated against. Caller also feels that VHC/GMC are not doing enough as we are only Member Services and cannot provide them with much assistance other than resources. The Agent apologized for the inconvenience, documented their feedback and referred the customer to VT Legal Aid for assistance.

October 2022:

- Covered Services **-** Caller believes that they should be able to take their children to a Flu Vaccine Clinic to receive their Flu Shots. Their PCP is 35 minutes away and with having to pull the children out of school due to the PCP booking 2 months out, this is a hardship for their family. The Agent apologized for the inconvenience, documented the feedback and provided phone number to health clinics in the area they could check in with.

- Provider Complaint – Caller is upset as it appears organizations are being paid for taking care of them that weren't actually helping. Caller stated that the Visiting Nurse Association will not come any longer as the caller refuses to have multiple people helping but Medicaid is still paying the VNA. The agent documented the customers feedback and provided the phone number to Vermont Legal Aid for assistance in researching the claims.
- Provider Complaint - Caller expressed frustration regarding the VTMedicaid portal and searching for a dental provider that will accept them as a new patient. Caller stressed how the portal was not up to date/accurate. All the offices they called cannot see them for several months and they need to see a Dentist as soon as possible. The Supervisor provided more Dental Providers within the customers area and documented the feedback.
- Covered Services - Caller is requesting to submit negative feedback regarding Medicaid covered services. Caller states that they want Medicaid's dental benefits to be expanded to include paying for dentures, and that the yearly limit on dental benefits should be removed completely. Caller also states that they want eyeglasses and contact lenses to be fully covered under Medicaid for all ages with no limits. The agent apologized for the inconvenience and documented the feedback. They also explained how to obtain a Dental Voucher through their local DCF Office to assist with Dental services.
- Covered Services - Member called with concerns about the local Pediatrician did not have any Flu Shots available. This left the member to have to pay out of pocket with the local Pharmacy. Member thinks it would be helpful if you could receive a Flu Shot anywhere, and not just at Provider offices. The agent apologized for the inconvenience and documented the feedback.
- Provider Complaint - Caller requested to document Negative Feedback about an experience she had at the XXXXXX XXXXXX. Member called to get their prescription filled and at 10 AM it would be ready. When they went to pick up the prescription, the Pharmacist explained that the refill was too soon. The Pharmacists asked to speak with the member’s Doctor, who is an on call Doctor out of Massachusetts. Caller kept calling the Pharmacy as they needed that specific medication. The Pharmacists advised that he would fill it this one last time. Caller states they filled it for the wrong time release, with this medication being a pain medication, they needed it without the immediate release. Caller feels that they were treated with indifference and the Pharmacist threatened to never fill their prescriptions again. The agent apologized for the inconvenience and documented the feedback. They also offered to mail the customer a Provider Complaint Form.
- Provider Complaint - Caller requested to speak to a Supervisor and document Negative Feedback about the VT Medicaid Portal not being up to date. Caller believes that Providers should be updating GMC daily if they are no longer accepting new patients or accepting Medicaid for insurance. Caller states this makes it really difficult when searching for a Provider to make an appointment. The Supervisor apologized for the inconvenience, documented the feedback and assisted with finding Providers in the customers area.

November 2022:

- Provider Complaint - Member called to report that they had some dental work done at an office. After the procedure was done, they had to pay out of pocket due to the Dentist

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

refusing to bill Medicaid for the services. The Agent apologized for the inconvenience, documented the feedback and offered GAC.

- Provider Complaint - Caller wanted to document feedback as they cannot find a Dentist that accepts VT Medicaid. They state they have tried to use the VTMedicaid.com website and all the numbers listed are not accepting new patients. The agent apologized for the inconvenience, documented the feedback and assisted the customer with finding more providers around their area.
- Provider Complaint - Member called to submit negative feedback about the inability to find a Dentist that accepts VT Medicaid insurance. Member states having called dozens of offices, and they indicate that they will not accept new Medicaid patients. Some offices have mentioned that it is a financial loss to have a Medicaid patient, which is why they won't accept new Medicaid patients for months. Even local Community Health Centers since May 2022, have not accepted any new Medicaid patients for dentistry for this reason. The Agent apologized for the inconvenience, documented the feedback and assisted the customer with finding more providers around their area.

December 2022:

- Provider Complaint - Caller requested to document negative feedback as they cannot find a Dentist that is accepting new patients in the State of VT. Caller states "This is an issue and needs Dental Treatment. I have Dental Issues and am not able to get the help that I need. I have called all the Dentists from the Provider Look Up Portal in Rutland, Barre and Randolph. It is very stressful if you and have an emergency that needs to be taken care of. Some of the Dentists give a negative stigma Associated with Medicaid as well." The agent apologized for the inconvenience and assisted with finding another Dentist within the area.
- Provider Complaint - Member called to document negative feedback regarding not being able to find any Dentists that accept VT Medicaid new patients. Member states having called seven Dentists and no one is accepting new patients. Their current dentist currently has a waiting list of 6 months. Member continues to look for an opening daily and thinks this is a serious problem in the State of VT. The agent apologized for the inconvenience and assisted with finding another Dentist within the area.
- Provider Complaint - Caller requested to document feedback regarding the lack of availability of dentists in their area, who accept Medicaid and having to travel two to three hours to a dentist's office. The dental offices in their area have stopped taking Medicaid and other offices have closed. They would like someone to look into dentists availability

in the Bennington area. The agent apologized for the inconvenience and assisted with finding another Dentist within the area. They also provided the phone number to VT Legal Aid for further help.

- Provider Complaint - Caller states the company XXXX XXXX XXXX XXXX has been negligent and non-responsive when it comes to issues with their DME. Caller has had an issue with the machine whistling causing further sleep disturbance. Caller states it's impossible to get through to them, and says even their nurse and doctor are having issues getting through to them. It is taking too long to resolve the caller's health problem and feels its ruining their life. The agent documented the feedback as well as filed a Formal Grievance for the customer.

Grievance and Appeal Quarterly Report
Medicaid Managed Care Model
All Departments Combined Data
October 1, 2022 – December 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 October 1, 2022, through December 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 12 grievances filed; six 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, 75% were filed by the beneficiary, 17% were filed by a representative, and 8 were filed by other. DMH had 50%, DAIL had 17%, and DVHA had 33% of the grievances filed.

Grievances were filed for service categories case management, dental, mental health, and personal care.

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 19 appeals filed. Of these 19 appeals, 19 were resolved (100%).

Of the 19 appeals that were resolved this quarter, 95% were resolved within the statutory time frame of 30 days. The average number of days it took to resolve these cases was 13 days. Acknowledgement letters of the receipt of an appeal must be sent within five days; the average was two days.

Of the 19 appeals filed, DVHA had 15 appeals filed (79%), and VDH had 4 (21%). There were no appeals filed for DAIL or DMH this quarter.

The appeals filed were for service categories prescriptions, speech therapy, personal care, and transportation.

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

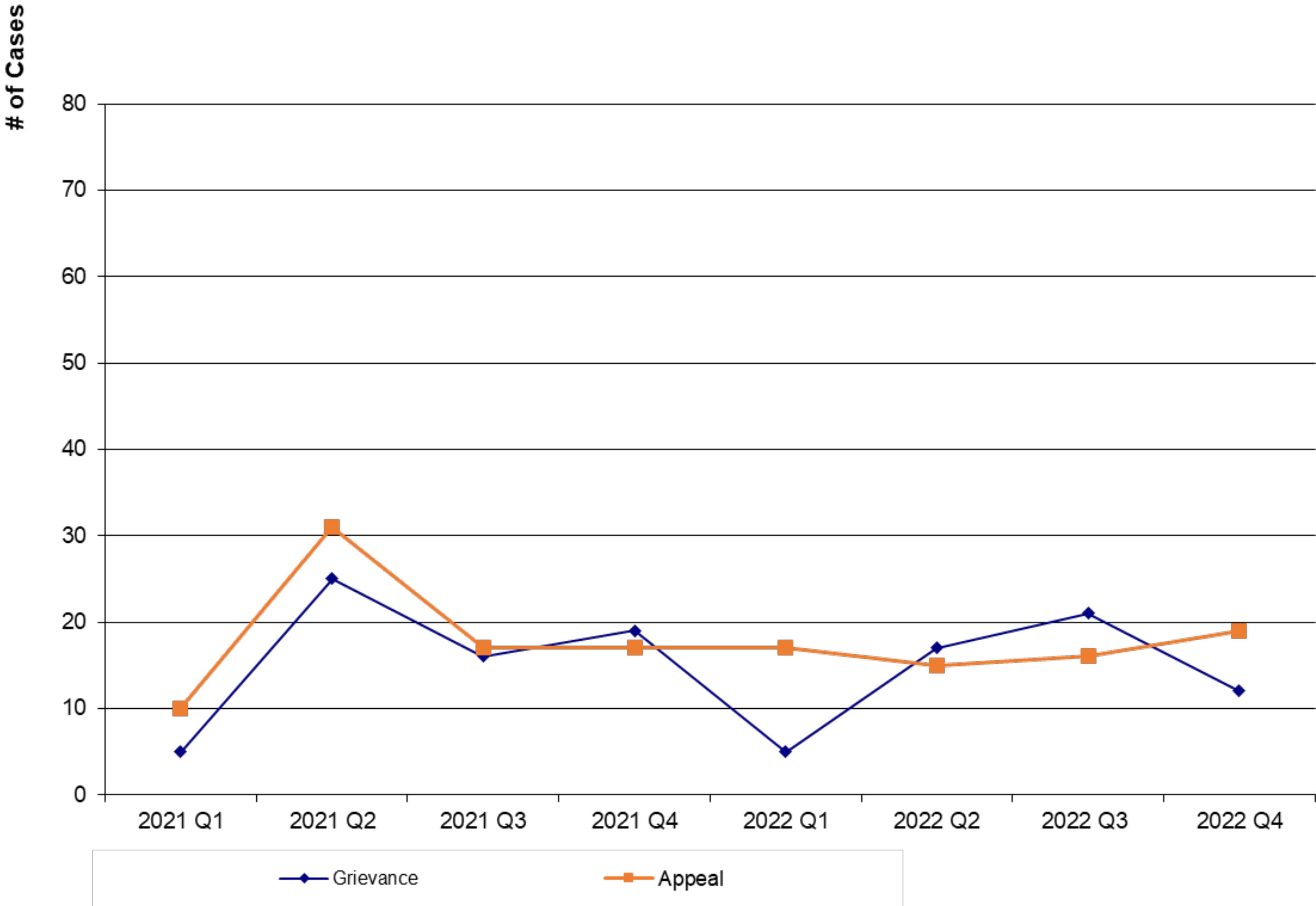
Enrollees may participate in appeals, by written testimony, telephonically, and by video or virtual communication.

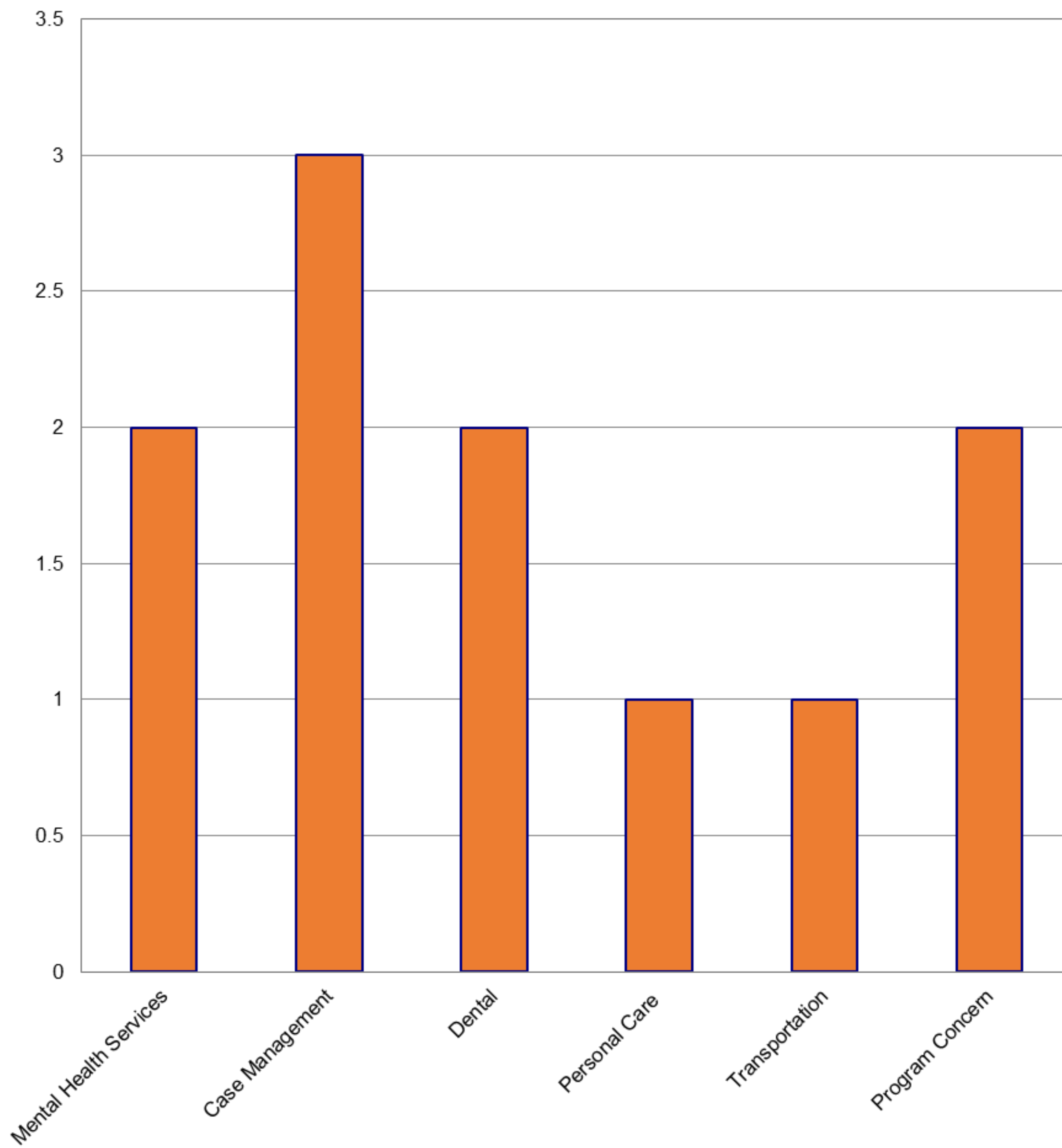
2022 Yearly Summary

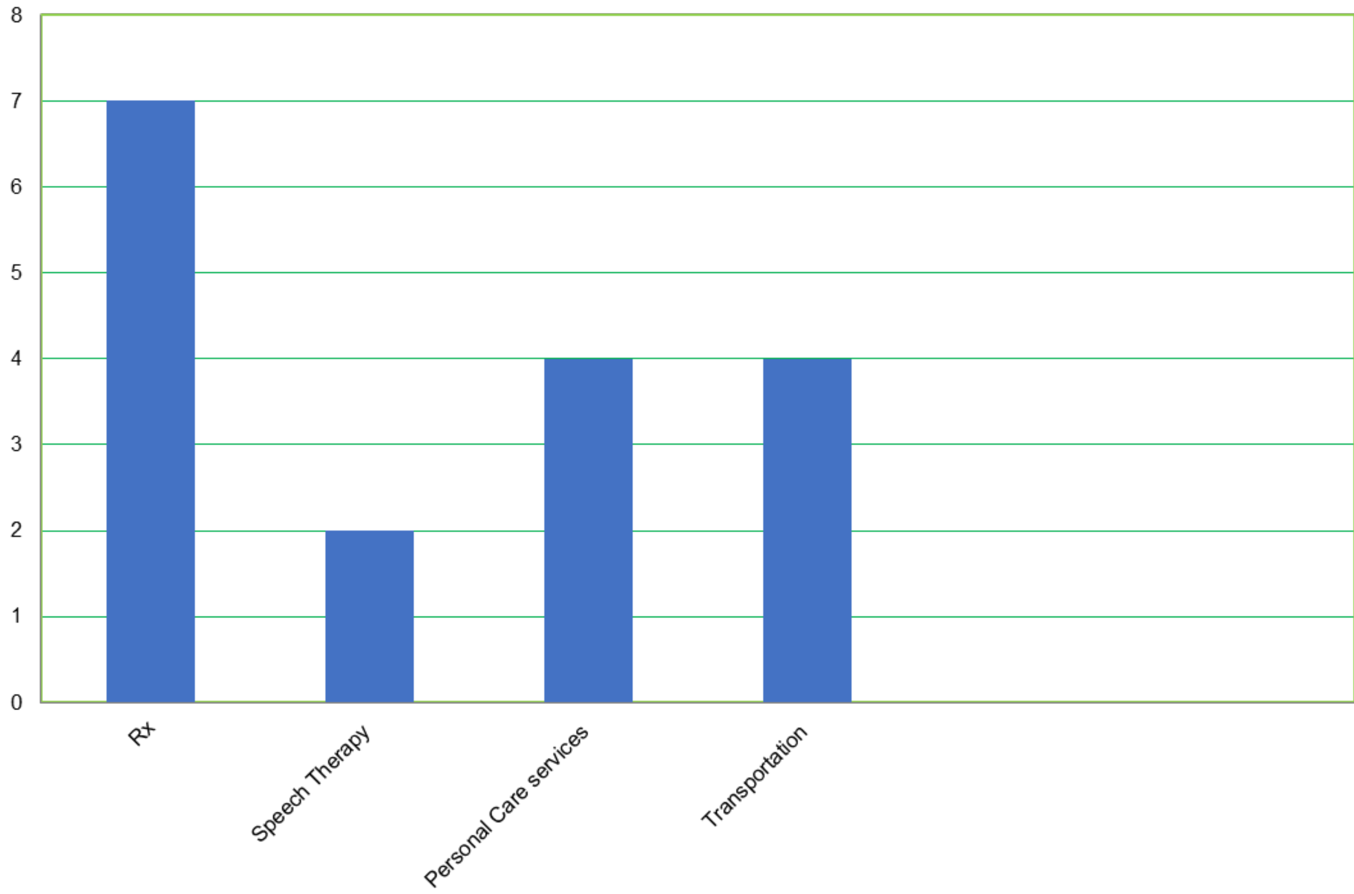
Grievances: There were 55 Grievances filed in 2022. Of those 55 grievances filed, DAIL had 18%, DMH had 69%, DVHA had 9% and VDH had 4%. The top service categories for grievances filed were for mental health, community/social support and case management.

Appeals: There were 67 appeals filed in 2022. Of those appeals filed, DAIL had 9%, DMH had 3%, DVHA had 76%, and VDH had 12%. The top reasons for appeal were prescriptions, transportation services, and personal care services.

Grievances and Appeals
January 1, 2021– December 31, 2022




Grievance by Service Catagory
3.5
3
2.5
2
1.5
1
0.5
0
Mental Health Services
Case Management
Dental
Personal Care
Transportation
Program Concern


Appeals by Service Category
8
7
6
5
4
3
2
1
0
Rx
Speech Therapy
Personal Care services
Transportation

Vermont Legal Aid

Office of the Health Care Advocate

Quarterly Report

October 1– December 31, 2022

to the

Agency of Administration

submitted by

Michael Fisher, Chief Health Care Advocate

Office of the Health Care Advocate

January 21, 2023

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.

This past quarter, Vermont Legal Aid and the HCA implemented a new client management system (CMS). This new CMS has better technical support, increased agility, and enables data capture, management, and security best-practices. The HCA strived to minimize the impact of the CMS implementation on client experience. Currently, frontline HCA advocates are fully trained on the usage of the new CMS, and client experience with the HCA Helpline has not been impacted. Due to this decision, however, the HCA continues to evolve our reporting capacity and the integration of the CMS with HCA management processes. Reported data this past quarter reflects that we changed systems mid-quarter and reporting capacity is currently being increased. The HCA expects that reporting capacity will be fully implemented by the next quarter.

The HCA Helpline now has eight advocates working to resolve issues and answer questions. We opened 821 cases this quarter. This quarter the HCA advocates focused on helping Vermonters navigate open enrollment for Vermont Health Connect Plans and for Medicare Part D. The top issue that consumers called about was Medicaid eligibility. Dental access was also again near the top. Visits to the HCA website reflected our calls. There were over 2,000 visits to the Medicaid income limits page, and our dental page also had over 1,000 visits.

Henry's Story:

Henry called the HCA Helpline because he was losing his health care coverage. Henry had been on employer coverage through his spouse. His spouse had left their job and was now on Medicare. But Henry was not eligible for Medicare for a couple more years. He was thinking of going without coverage. He did not think that he could afford a Vermont Health Connect plan. The HCA advocate explained that because Henry had lost his employer sponsored insurance, he would have a special enrollment period to enroll on a plan. Also, most Vermonters are now eligible for more Premium Tax Credit (PTC) to help pay for monthly premiums. When the HCA advocate reviewed Henry's income, she found that he qualified for a Silver 94 plan. This meant that his premium was only a couple dollars a month and the plan also had cost-sharing help to keep his out-of-pocket costs low. He was able to pick a plan, and his coverage started the next month.

During the Open Enrollment Period, the HCA advocates engaged in outreach to Vermonters about a potentially beneficial rule change. This year the "family glitch" rule changed. Under former regulations employer-based health insurance was defined as "affordable" if the coverage solely for the employee, and not for family members, met the affordability requirements. That meant that affordability was calculated based on what it would cost for the employee to purchase a self-only plan. If the cost of the employee only plan met the current affordability test, the employee *and their family members* were not eligible for Premium Tax Credits (PTC). This is called the "family glitch" because it makes family members ineligible for PTC, even though the cost of a *family plan* with the employer is not "affordable." The new rule for 2023 allows for two separate calculations: one for the employee and the other for family members. If the cost of covering family members is not affordable, those family members would be eligible to buy a plan on the exchange and receive PTC. The family glitch has been a long-standing problem for Vermonters and it has prevented families from accessing health care coverage.

Advocates reached out to consumers who we had advised on this issue over the last several years to alert them to the rule change. Because of the outreach, some consumers called the HCA with more questions and re-applied on VHC. They were found eligible for PTC and were able to enroll on an affordable plan for 2023. The HCA also reached out to consumers who were direct enrolled on plans with insurance carriers. If you are direct enrolled on a plan, you are not eligible for PTC. You must be enrolled with VHC to qualify for PTC. With the expansion of PTC eligibility, many direct enrolled individuals may now be eligible for PTC for the first time. We engaged this group with education about the expansion of the PTC eligibility and advice on how to enroll on VHC and get advance PTC for 2023. This quarter we also continued work with community and state partners on the Immigrant Health Insurance Plan (IHIP). HCA advocates helped individuals apply and get coverage on IHIP. We also worked with community partners to help identify systemic issues in the application process. The HCA is focused on improving the accessibility of the program. It is also focusing on expanding the eligibility for the program to include income eligible adults.

This past quarter, the HCA was also involved in the stakeholder group working on plan designs for 2024 Qualified Health Plans (QHP) on Vermont Health Connect. The HCA meets with stakeholders from the insurance carriers, DVHA, and DFR to review and give feedback on proposed plan designs for the 2024 year. The HCA works to represent the consumer perspective in the process. The group strives to keep the QHPs as accessible as possible both in terms of premiums and cost-sharing.

During this quarter, the HCA worked with key legislators to lay the groundwork for the coming session. The HCA will continue its work on affordability next quarter in the State House. A key area of focus will be on making Medicare more affordable for Vermonters by increasing the income thresholds for Medicare Savings Programs (MSP). The HCA continues to hear from many Vermonters who struggle with Medicare costs. Vermonters with low incomes who are moving onto Medicare for the first time are especially vulnerable. For people under 65, eligibility for Medicaid for Children and Adults (MCA) extends up to 138% FPL. Above the MCA Medicaid limit help is available with cost-sharing and premiums on VHC. For example, a Silver 94 QHP on VHC has very low premiums and cost-sharing and an income limit of 150% FPL. Once Vermonters turn 65, eligibility for Medicaid for the Aged Blind and Disabled ranges from 76% to 112% FPL depending on household size. Currently, eligibility for QMB, the most generous Medicare Savings Program that pays for both premiums and cost-sharing, ends at 100% FPL. The HCA is working to increase that threshold so more Vermonters can get the help that they need.

Case Stories:

Glenn and Lana's Story:

Glenn and Lana had been enrolled on a couple plan with VHC and been getting PTC to help pay for it. But Glenn called the HCA because VHC sent him a notice saying that he was no longer eligible to get PTC, and he did not understand. Getting a couple plan without Glenn's PTC would be much more expensive. The HCA advocate investigated and found that Glenn had enrolled onto VA health benefits. Because he had VA health benefits, he lost his eligibility for PTC. In general, you cannot get PTC once you have other health care coverage that meets the requirements for "minimum essential coverage." Glenn's VA health coverage met that requirement, so that made him ineligible for PTC. Although Glenn lost his eligibility, Lana still was eligible. They decided that for next year, Glenn would use the VA health benefits while Lana would remain on an individual VHC plan. The HCA advocate helped Lana understand how much PTC she would be eligible for and to review the individual plans. Lana was able to enroll on a new plan for 2023.

Mary Kate's Story:

Mary Kate called the HCA because she could not afford her Medicare Part B premiums. When the HCA advocate spoke with her, she found that Mary Kate had been on Medicare for several years. She was struggling with the Part B premiums, and she had not signed up for a Medicare Part D prescription drug plan. This meant that she had no drug coverage. Because she had failed to sign up for a Part D plan when she was first eligible for Medicare, Mary Kate was also subject to a late enrollment penalty, which would increase her monthly Part D premium. When the HCA advocate reviewed Mary Kate's income, she found that she was eligible for a Medicare Savings Program (MSP). The MSP would pay for her Part B premium. Also, being on an MSP made Mary Kate eligible for Low Income Subsidy (LIS). This program pays for Part D premiums and reduces co-payments. It also waives the late enrollment penalty for Part D. The HCA advocate helped her with the application, and she was approved for an MSP. This meant that Mary Kate had help with her Part B and Part D costs and no longer had an added monthly penalty.

Lionel's Story:

Lionel called the HCA because he was having trouble signing up for a Vermont Health Connect (VHC) plan. He told the HCA advocate that he had applied on VHC, but VHC could not find a record of the application, which meant Lionel still did not have coverage. He needed to make an appointment with a provider, so he was anxious to get his coverage started. The HCA investigated and found out that Lionel had done an application with his case manager. The case manager had submitted the application at a state of Vermont office, but it was never faxed to VHC. No one could find the original application. The HCA advocate helped Lionel do a new application and submit it to VHC. Lionel was found eligible for a Silver 94 plan, and his premium was less than $1 a month. He also needed dental care, so the HCA advocate helped him sign up for a dental plan through VHC. Lionel was able to make an appointment to see his provider.

Jannik and Anna's Story:

Jannik called the HCA because he was about to lose his health care coverage. He had coverage through his spouse, Anna, but she was leaving her job. They both needed help getting new coverage. Jannik was eligible for Medicare. He had delayed enrolling on Medicare Part B while he was on his Anna's employer insurance. The HCA advocate explained that Jannik now had a special enrollment period (SEP) for Part B. This SEP starts the month after the employer coverage ends and lasts for eight months. The HCA advocate also helped Jannik understand the process for signing up for Medicare Part D coverage. The HCA advocate explained that he should enroll as soon as possible, so he would not have a gap in coverage. Anna was not Medicare eligible, but she had the option to enroll on COBRA or get a plan on VHC. The HCA advocate discussed how COBRA coverage is often prohibitively expensive. Anna thought that they would be over income for PTC, but the HCA advocate explained that there was no longer an upper income cut off for PTC. This meant households that were formerly ineligible because of their income could possibly now be eligible for PTC. When Jannik and Anna explored the plans on VHC, they discovered that she was eligible. Anna was able to get an individual VHC plan that was much more affordable than the COBRA coverage.

Overview

The HCA assists 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 821 calls this quarter. We divided these calls into broad categories. The figures below are based on the All-Calls data. The percentage and number of calls in each issue category, based on the caller's primary issue, were as follows:

- **21.48%** about **Access to Care**
- **9.48%** about **Billing/Coverage**
- **6.36 %** about **Buying Insurance**
- **12.48%** about C**omplaints**
- **12.24%** about **Consumer Education**
- **24.48%** about **Eligibility** for state and federal programs
- **8.28%** 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.

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 2022 includes:

- This narrative
- Five data reports, including three based on the caller's insurance status:
    - **All Calls/All Coverages**: 821

The Top Issues Generating Calls

The listed issues in this section includes only the primary issues for All Calls (821 calls this quarter compared to 820 prior quarter).

Top Issues, All Cases:

1. Eligibility Medicaid/ MAGI
2. Provider Complaints
3. Consumer Education Medicare
4. Access to Care Dental
5. Complaints-Hospital
6. Buying Insurance-QHP-VHC
7. Eligibility-Premium Tax Credit
8. Eligibility Medicaid/ Non-MAGI
9. Access to Care Prescription Drugs
10. Access to Care Nursing Home and Home Health

Consumer Protection Activities

Rate Review

The HCA reviews and analyzes all commercial insurance carrier requests to the Green Mountain Care Board (Board) to change premium prices. The Board decided two premium price change requests during the quarter from October 1, 2022, through December 31, 2022. There are no premium price change requests pending at the close of the quarter.

MVP Health Plan, Inc. (MVP) submitted a premium price change request decided by the Board this quarter: the MVP 2023 Large Group HMO filing. MVP's proposed premium price change impacts approximately 1,800 Vermonters. MVP requested a total annual increase of 26.7% for groups renewing in the first quarter of 2023. The HCA filed a Notice of Appearance and a Memo In Lieu of Hearing in this matter. On November 17th, 2022, the Board modified the proposed rate downward and approved the modified rate.

Cigna Health and Life Insurance Company (CHLIC) submitted the other premium price change request decided by the Bord this quarter: the Cigna Health and Life Insurance Company – Large Group filing. CHLIC's proposed premium price change impacts approximately 3,760 Vermonters. CHLIC requested an overall rate increase of 7.6%. The HCA filed a Notice of Appearance and a Memo In Lieu of Hearing in this matter. The Board reduced the proposed manual rate change to 6% on December 19th, 2022

Hospital Budgets

The HCA provided feedback to the GMCB through their contractor – Mathematica Research – who is leading an outreach and research project for the GMCB on how to improve the hospital budget review process. Our office highlighted the importance of seeking and incorporating community input in the GMCB's regulatory work. In the forthcoming months, the HCA will work with the GMCB to provide edits and recommendations to the FY24 hospital budget guidance with a focus on improving data standardization, increasing price and cost transparency.

Certificate of Need Review Process

The HCA has statutory authority to assert interested party status in certificate of need (CON) proceedings before the GMCB. In the last quarter, the HCA did not intervene or participate in any proceedings. We continue to actively monitor certificate of need applications as they are submitted and assert party status when the interests of Vermonters are clearly implicated

Oversight of Accountable Care Organizations

The HCA provided written and oral comments as a part of the FY23 OneCare Vermont (OCV) budget hearing process. Our questions and comments (as well as recommendations to the Board) focused on the lack of demonstrated impact of OCV programs on health outcomes for Vermonters or reducing system costs to the state, concerns about the proposed contractual relationships with the University of Vermont Health Network, and the need for objective quantitative and/or qualitative evaluation of their programs. The HCA looks forward to continuing to work with the GMCB ACO Budget team and Board members to provide recommendations to improve their oversight of OCV's budget and programs.

Additional 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, quarterly Prescription Drug Technical Advisory meetings, and several other legislatively established workgroups focused on affordability and access.

H.489 Market Structure and Affordability Workgroup

This workgroup was formed with a particular charge by the legislature to consider what policy options should be evaluated if the ARPA enhanced premium tax credits were not extended. Because the premium tax credits were extended, the pressure was taken off the group for the current year. There is broad agreement between the carriers, the administration, and the HCA to continue the unmerged market structure for an additional 3 years, or as long as the enhanced Premium Tax Credits continue on the Federal level. The HCA will support proposed legislation this year to keep the markets unmerged while the enhanced premium tax credits are available.

The HCA raised additional concerns about the adverse selection dynamics between the self-funded market and the QHP small group. We note that in the current environment, the QHP small group can be used as a safety net for small groups with higher morbidity and that healthier small groups would migrate to the self-funded market. The workgroup recognized the relatively narrow charge of this workgroup, and therefore did not engage in this area of health policy. The HCA will continue to raise this concern in future policy discussions.

S.239 Medicare Supplemental DFR workgroup

This work group was created in response to a policy proposal that the HCA brought to the Legislature last biennium. The HCA participated in these meetings, assisted in the development of a consumer survey. We also intend to submit comments on the group's final report. Next quarter, the HCA will advocate for a set of policy changes to address affordability challenges that low-income Vermonters on Medicare face.

The Medicaid and Exchange Advisory Committee

The Advisory Committee met two times this quarter taking the month of December off. The content of this quarter's meetings included a focus on messaging and planning for the QHP open enrollment period and discussions about the end of the Federal Public Health Emergency and the unwinding process.

Legislative Advocacy

Because this quarter included the November election for the General Assembly, there were fewer legislative activities. The HCA asked candidates for assistance in getting the word out about information that could be of assistance to Vermonters before election day and started the process of engaging with key legislators about the upcoming session during the brief period between election day and the start of the new session.

Collaboration with Other Organizations

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

- American Civil Liberties Union of Vermont
- Bi-State Primary Care
- Bridges to Health
- Blue Cross Blue Shield of Vermont
- Committee on Vermont Elders
- Department of Financial Regulation
- Families USA
- IRS Taxpayer Advocate Service
- Let's Grow Kids
- 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)
- Rural Vermont
- South Royalton Legal Clinic
- SHIP, State Health Insurance Assistance Program
- 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 Public Interest Research Group (VPIRG)
- Vermont Workers' Center
- You First

Increasing Reach and Education Through the Website

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

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

Popular Web Pages

* means the page moved into the top 20 this quarter

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

1. *Income Limits - Medicaid* – 2,462 pageviews
2. *Health* - section home page – 1,790 pageviews
3. *Dental Services* – 1,080 pageviews
4. *Medicaid, Dr. Dynasaur & Vermont Health Connect* – 818 pageviews
5. *Medicaid* – 619 pageviews
6. *HCA Help Request Form* – 593 pageviews and 133 online help requests
7. *Services Covered – Medicaid* – 526 pageviews
8. *Long-Term Care* – 503 pageviews
9. *Resource Limits - Medicaid* – 447 pageviews
10. *Medicare Savings Programs* – 394 pageviews
11. *Choices for Care Income Limits* – 324 pageviews
12. *Medical Decisions: Advance Directives* – 294 pageviews
13. *Dr. Dynasaur* – 287 pageviews
14. *Advance Directive forms* – 275 pageviews
15. *Choices for Care* – 266 pageviews
16. *Choices for Care Giving Away Property or Resources* – 255 pageviews
17. *Choice for Care Resource Limits* – 246 pageviews *
18. *Vermont Long-Term Care Ombudsman Project* – 243 pageviews *
19. *Requirements for Getting Choices for Care* – 234 pageviews *
20. *Buying Prescription Drugs* – 231 pageviews *

This quarter we had these additional new items:

- *Your Benefits and the Public Charge Rule for Immigration* – 65 pageviews
- *You May Be Eligible for New Financial Help for Health Insurance (ARPA)* – 9 pageviews

Outreach and Education

The Office of the Health Care Advocate (HCA) engaged in multiple in-person outreach events this quarter. Some highlights include:

- **VT Professionals of Color Network Webinar**: October 27, 2022. HCA advocate gave an online webinar and answered questions about Open Enrollment Period, the Public Health Emergency, and the Immigrant Health Insurance Plan.
- **Open Enrollment Webinar Rural Vermont**: November 1, 2022: HCA advocate provided consumer education about Open Enrollment.
- **Training on lump sums and Medicaid Eligibility for VTAJ**: November 18, 2022. HCA Helpline director did an in-person and online training on maintaining Medicaid eligibility
- **Front Porch Forum outreach during Open Enrollment**: Posted outreach about important Open Enrollment dates and numbers.
- **Meeting with the UVM Area Health Education Center**. The Health Care Advocate met with this group to discuss plans for their summer courses. AHEC and the HCA are collaborating this year on the research questions that their students will explore.

Office of the Health Care Advocate

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

https://vtlawhelp.org/health

TOTAL NUMBER OF CASES BY ISSUE CATEGORY

	Q4 2022 Count of Cases
Eligibility	205
Access to Care	179
Complaints	107
Consumer Education	102
Billing	79
Other	65
Buying Insurance	53
Data Issues - Unknown	16
Appeals	14
Medicare	1
TOTAL	**821**

PRIMARY ISSUE SUMMARY

Primary Issue	Q4 2022 Count of Cases
Eligibility - Medicaid / MAGI	65
Communication/Complaint: Provider	53
Consumer Education - Medicare	41
Access to Care - Dental	34
Other	34
Complaints - Hospital	31
Buying Insurance - QHP - VHC	29
Eligibility - Premium Tax Credit	26
Eligibility - Medicaid/Non-MAGI	26
Access to Care - Prescription Drugs	23
Other - Not Health Related	17
Data issues - Unknown	16
Access to Care - Nursing Home & Home Health	16
Hospital billing	14
Eligibility - Medicare	13
Eligibility - Long Term Care Medicaid & Choices for Care	13
Eligibility - MSPs/Buy-In Programs	12
Access to Care - Nursing Home	12
Buying Insurance - Medicare Supplement Insurance	12
Information about DVHA	10
Info/Applying For DVHA Programs	10
Access to Care -Mental Health Treatment	10
Termination of insurance	10
Claim Denials	10
Access to Care -Transportation	9
Provider Billing	8

Medical Malpractice	8
Eligibility - Medicaid for Working People with Disabilities	8
ACA Family Glitch	8
Eligibility - VPharm	8
Access to Care - Specialty Care	8
Hospital Billing & Financial Assistance	7
Access to Care - Primary Care	7
Access to Care - Pain Management	7
Consumer Education - HIPAA	7
Choices for Care	5
Eligibility - Special Enrollment Period	5
Consumer Education - Advance Directive	5
Coordination Of Benefits	5
Appeals - Fair Hearing - Eligibility	4
Delay in Obtaining Care	4
Billing - Ambulance	4
Copayments & Coinsurance	4
Other - Health Related	4
Access to Care - DME & Supplies	4
Information about HCA	4
Access to Care - Home Health	4
Consumer Education - Family Law Interface w/ Health Ins	3
Billing - Nursing Home	3
Complaint - Carrrier	3
Complaints - Insurance Scam	3
Access to Care - Hearing Aids	3
Care Coordination	3
Billing	3
Balance Billing	3
Employer Sponsored Insurance	3
Complaints	3
Other -Power of Attorney	3
Eligibility	3
Eligibility - Part D Plan	3
Appeals - Medicare A, B, or C	3
Collections	2
Billing - Preventive Services	2
Buying Insurance - COBRA	2
Buying Insurance - QHP - Direct Enrollment	2
Appeals - Private Insurance - Covered Service	2
Billing - Mental Health Treatment	2
Buying Insurance: Medicare Part C	2
Consumer Education	2
Diabetic Meds & Supplies	2
Eligibility - Citizenship & Identity	2
Access to Care	2
Access to Care - Autism Treatment	2

Out of Network Billing	2
Medicare Billing	2
Medical Marijuana	2
Emergency Care	2
Access To Medical Records	2
Access to Care - Prior Authorization Delay	2
Access to Care - Urgent Medical Need	2
Developmental Services	2
Access to Care - PT/OT/ST	2
General Questions About Insurance	2
Access To Medical Records, HIPAA	1
Billing - Mammography	1
Billing - Dental	1
Access to Care - Dentures	1
Access to Care - Quality of Care	1
Access to Care - Hospice & End of Life Care	1
Access to Care - Hospital	1
Access to Care - Medicaid/MAGI	1
Complaints - VHC – Website	1
Access to Care - Naturopathy	1
Access to Care - Preventive Care	1
Access to Care - Prior Authorization Criteria	1
Access to Care - Nutritional Supplements	1
Access to Care - Orthodontics	1
Appeals - VHC APTC Reconciliation	1
Access to Care - Prescriptions-Medicaid PBM	1
Appeals - Medicare Part C	1
Access to Care - Imaging	1
Medicare	1
Disability Insurance	1
DVHA/VHC premium billing	1
Education -Medicaid/MAGI	1
Eligibility - Act 48	1
Eligibility - Act 49	1
Eligibility - Act 50	1
General Billing Questions	1
HIPAA General	1
Complaints - Primary Care	1
IRS Reconciliation	1
Coverage & Contract Questions	1
Other - Access to Care	1
Other - Internet Insurance Scams	1
Other - Mental Health Court Order	1
Other - Severe MI plus other problems	1
Out of State Billing	1
Premium Too High	1
Provider Error/Med Mal	1

Surprise bills in VT (PARE, OON problem, etc.)	1
Internal Appeal - Medicaid Eligibility	1
Complaints - VHC - 1095 Problems	1
Billing - Prior Authorization Criteria	1
Billing - Third Party Liability	1
Buying Insurance	1
Buying Insurance In Another State	1
CCommunication/Complaint: Provider	1
Complaint - Discriminatory Practices	1
Complaint - DME & Supplies	1
Complaint - HIPAA	1
Disability Determination	1
Complaints - Nursing Home Complaint	1
Debt Collection	1
Consumer Education - ARPA	1
Consumer Education - Medicare Part D	1
Consumer Education - Notice - Confusing	1
Consumer Education - Other Insurance Laws and Regulations	1
Consumer Education - Public Charge	1
Consumer Education - VPharm	1
Consumer Eduction - COBRA	1
Consumer Eduction - Dental	1
Billing - Premiums (non-VHC)	1
Complaint about State Worker	1
TOTAL	**821**

Attachment 5 – GC Investments

DY18 Investment Expenditures					
Department	Final Receiver Suffix	Investment Description	QE 0922	QE 1222	DY18 Total
AHSCO	9090	Investments (STC-79) - Designated Agency Underinsured Services (54)	1,704,648	1,778,704	**3,483,352**
AHSCO	9421	HCBS Investment	9,928,667	6,891,941	**16,820,608**
DCF	9402	Investments (STC-79) - Medical Services (55)	107,476	49,373	**156,849**
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)	973,859	990,538	**1,964,397**
DCF	9406	Investments (STC-79) - Aid to the Aged, Blind and Disabled Res Care Level III (57)	26,515	27,151	**53,666**
DCF	9407	Investments (STC-79) - Aid to the Aged, Blind and Disabled Res Care Level IV (58)	59,070	59,160	**118,230**
DCF	9408	Investments (STC-79) - Essential Person Program (59)	190,058	179,739	**369,797**
DCF	9409	Investments (STC-79) - GA Medical Expenses (60)	32,349	43,450	**75,799**
DCF	9411	Investments (STC-79) - Therapeutic Child Care (61)	363,073	431,299	**794,372**
DCF	9412	Investments (STC-79) - Lund Home (2)		-	-
DCF	9413	Investments (STC-79) - Prevent Child Abuse Vermont: Shaken Baby (33)		-	-
DCF	9414	Investments (STC-79) - Prevent Child Abuse Vermont: Nurturing Parent (34)	18,091	25,752	**43,843**
DCF	9415	Investments (STC-79) - Challenges for Change: DCF (9)	31,537	45,188	**76,725**
DCF	9416	Investments (STC-79) - Strengthening Families (26)	225,190	59,615	**284,805**
DCF	9417	Investments (STC-79) - Lamoille Valley Community Justice Project (62)	45,903	-	**45,903**
DCF	9418	Investments (STC-79) - Building Bright Futures (35)	58,585	88,263	**146,848**
DCF	9419	Investments (STC-79) - United Ways 2-1-1 (41)	113,235	113,183	**226,418**
DAIL	9421	HCBS Investment		2,859,351	**2,859,351**
DAIL	9602	Investments (STC-79) - Mobility Training/Other Svcs.-Elderly Visually Impaired (63)	89,128	101,820	**190,948**
DAIL	9603	Investments (STC-79) - DS Special Payments for Medical Services (64)	71,918	731,030	**802,948**
DAIL	9604	Investments (STC-79) - Flexible Family/Respite Funding (27)		484,634	**484,634**
DAIL	9605	Investments (STC-79) - Quality Review of Home Health Agencies (42)		-	-
DAIL	9606	Investments (STC-79) - Support and Services at Home (SASH) (43)		492,401	**492,401**
DAIL	9607	Investments (STC-79) - HomeSharing (77)	73,451	69,764	**143,215**
DAIL	9608	Investments (STC-79) - Self-Neglect Initiative (78)	126,099	-	**126,099**
DAIL	9609	Investments (STC-79) - Seriously Functionally Impaired: DAIL (65)		-	-
DMH	9501	Investments (STC-79) - Special Payments for Treatment Plan Services (28)	22,221	14,856	**37,077**
DMH	9502	Investments (STC-79) - Mental Health Outpatient Services for Adults (66)	27,083	1,389,189	**1,416,272**
DMH	9504	Investments (STC-79) - Mental Health Consumer Support Programs (79)	55,948	165,987	**221,935**
DMH	9505	Investments (STC-79) - Mental Health CRT Community Support Services (16)		13,114	**13,114**
DMH	9506	Investments (STC-79) - Mental Health Children's Community Services (12)	66,669	1,083,216	**1,149,885**
DMH	9507	Investments (STC-79) - Emergency Mental Health for Children and Adults (29)		4,586,400	**4,586,400**
DMH	9508	Investments (STC-79) - Respite Services for Youth with SED and their Families (67)		631,554	**631,554**
DMH	9510	Investments (STC-79) - Emergency Support Fund (22)		-	-
DMH	9511	Investments (STC-79) - Institution for Mental Disease Services: DMH (3) - VPCH	7,467,669	9,108,662	**16,576,331**
DMH	9512	Investments (STC-79) - Institution for Mental Disease Services: DMH (3) - BR	(4,316)	(34,446)	**(38,762)**
DMH	9514	Investments (STC-79) - Seriously Functionally Impaired: DMH (68)	9,405	(1,182)	**8,223**
DMH	9516	Investments (STC-79) - Acute Psychiatric Inpatient Services (13)	217,650	249,796	**467,446**
DOC	n/a	Return House	107,075	43,564	**150,639**
DOC	n/a	Northern Lights			-
DOC	n/a	Pathways to Housing - Transitional Housing	267,180	448,872	**716,052**
DOC	n/a	St. Albans and United Counseling Service Transitional Housing (Challenges for Change)	-	65,425	**65,425**
DOC	n/a	Northeast Kingdom Community Action	2,296	-	**2,296**
DOC	n/a	Intensive Substance Abuse Program (ISAP)			-
DOC	n/a	Intensive Domestic Violence Program			-
DOC	n/a	Community Rehabilitative Care	854,120	-	**854,120**
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)	644,937	945,505	**1,590,442**
DVHA	9103	Investments (STC-79) - Buy-In (52)	1,021	1,691	**2,712**
DVHA	9104	Investments (STC-79) - HIV Drug Coverage (53)		-	-
DVHA	9106	Investments (STC-79) - Patient Safety Net Services (18)	181	29,622	**29,803**
DVHA	9107	Investments (STC-79) - Institution for Mental Disease Services: DVHA (7)	1,301,961	2,100,135	**3,402,096**
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)		(165,521)	**(165,521)**
DVHA	9111	DSR Investment (STC-83) - One Care VT ACO Primary Prevention Development (83)		-	-
VDH	9201	Investments (STC-79) - Emergency Medical Services (19)	168,200	221,033	**389,233**
VDH	9203	Investments (STC-79) - TB Medical Services (74)	501	-	**501**
VDH	9204	Investments (STC-79) - Epidemiology (40)	243,388	285,870	**529,258**
VDH	9205	Investments (STC-79) - Health Research and Statistics (39)	312,978	370,397	**683,375**
VDH	9206	Investments (STC-79) - Health Laboratory (31)	867,223	1,055,555	**1,922,778**
VDH	9207	Investments (STC-79) - Tobacco Cessation: Community Coalitions (50)	335,124	461,330	**796,454**
VDH	9208	Investments (STC-79) - Statewide Tobacco Cessation (76)		-	-
VDH	9209	Investments (STC-79) - Family Planning (75)	259,050	182,769	**441,819**
VDH	9210	Investments (STC-79) - Physician/Dentist Loan Repayment Program (25)	353,500	1,867,253	**2,220,753**
VDH	9211	Investments (STC-79) - Renal Disease (73)		-	-
VDH	9213	Investments (STC-79) - WIC Coverage (37)	315,422	999,512	**1,314,934**
VDH	9214	Investments (STC-79) - Area Health Education Centers (AHEC) (21)	355,239	-	**355,239**
VDH	9217	Investments (STC-79) - Patient Safety - Adverse Events (47)	22,559	11,033	**33,592**
VDH	9219	Investments (STC-79) - Substance Use Disorder Treatment (30)	549,503	176,012	**725,515**
VDH	9220	Investments (STC-79) - Recovery Centers (17)	436,133	516,534	**952,667**
VDH	9221	Investments (STC-79) - Enhanced Immunization (46)	85,875	79,405	**165,280**
VDH	9222	Investments (STC-79) - Poison Control (48)		34,834	**34,834**
VDH	9223	Investments (STC-79) - Public Inebriate Services, C for C (23)	258,998	76,196	**335,194**
VDH	9224	Investments (STC-79) - Fluoride Treatment (38)	17,480	25,132	**42,612**
VDH	9225	Investments (STC-79) - Medicaid Vaccines (24)		-	-
VDH	9226	Investments (STC-79) - Healthy Homes and Lead Poisoning Prevention Program (49)	47,416	56,301	**103,717**
VDH	9228	Investments (STC-79) - VT Blueprint for Health (44)	190,201	305,466	**495,667**
VDH	9421	HCBS Investment	333	-	**333**
VSC	n/a	Health Professional Training			-
			30,099,079	**42,923,427**	**73,022,506**

Institution for Mental Disease (IMD)

P Investment IMD

Budget Information

CY 2022 (DVHA Only) = $2,586,491

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.
- In SFY2022, there were a total of 1307 (ACO and non-ACO) adult psychiatric hospital admissions across the state. Of those 1307 admissions, 361 of them (or 27.6%) were at the Brattleboro Retreat.
- Continued funding is necessary to ensure access to needed care.

Who We Serve

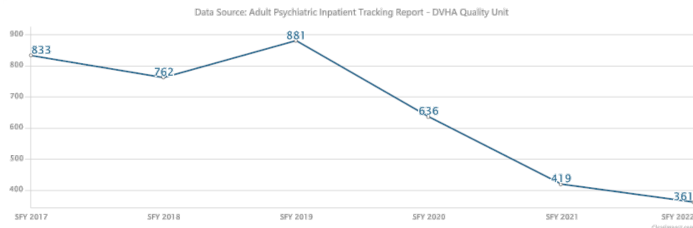
Vermont Medicaid members (children, adolescents and adults) who are experiencing mental health crisis who are in need of stabilization.

How We Impact

Investment Objective:
Increase the access of quality health care to uninsured, underinsured Vermont Medicaid members.

Measures

PM DVHA # of adult psychiatric admissions to the Brattleboro Retreat



Most Recent Period	Current Actual Value	Current Target Value	True	Current Trend	Baseline % Change
SFY 2022	361			3	-57%
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	SFY22
ACO	33	152	254	312	215	190
Non-ACO	800	610	627	324	204	171
Total	**833**	**762**	**881**	**636**	**419**	**361**

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:

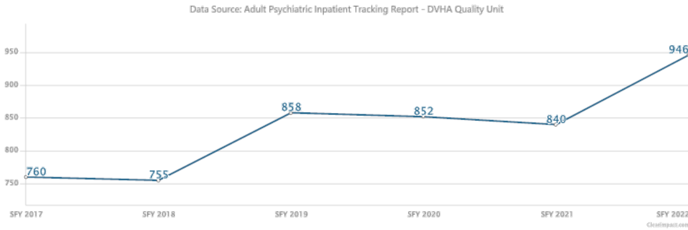
- 28,593 members in 2017
- 42,342 members in 2018
- 79,004 members in 2019
- 114,335 members in 2020
- 111,532 members in 2021
- 126,291 members in 2022

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 adults in need of treatment. The Retreat supplies 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 trendline above shows a decrease in total admissions in SFY20, SFY21 and SFY22. The impact of COVID-19 significantly threatened the Retreat's ability to provide mental health care to Vermonters. The Retreat closed beds during the height of the pandemic, including permanent closure of the detoxification unit. Staff and members contracted COVID therefore causing the Retreat to hold admissions and postpone discharges. There was an increase in length of stay due to community and residential treatment program placements for adults being temporarily shut down or having holds on admissions themselves. These longer stays meant that fewer beds were available for new admissions. Additionally, there was a statewide shortage of mental health providers. The Retreat struggled to stay fully staffed, often utilizing traveling staff. The Retreat is working to build capacity by hiring and training of staff and has reopened and reorganized units.

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. This stability and predictability should allow the Retreat to increase bed capacity and therefore serve more members.

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



SFY 2022	946	1	24%
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**	**SFY22**
ACO	38	147	217	441	550	599
Non-ACO	722	608	641	411	290	347
Total	**760**	**755**	**858**	**852**	**840**	**946**

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

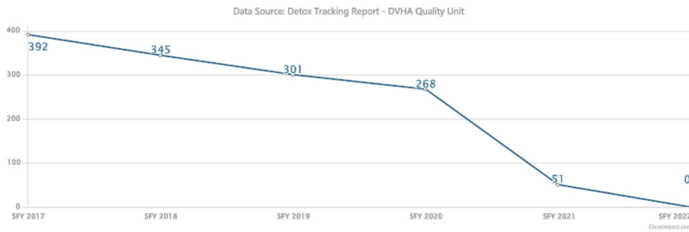
This performance measure includes both ACO and non-ACO admissions; they are broken out in the grid above.

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 for the above-mentioned VT facilities.

The Brattleboro Retreat provides essential capacity and Medicaid services in Vermont's mental health system of care and supplies over 50% of Vermont's adult mental health inpatient capacity. During the PHE the Brattleboro Retreat's overall bed capacity was reduced, and therefore number of admissions reduced. As a result of this reduction, there was an increase in adult psychiatric admissions to all other psychiatric facilities as seen in the trendline above. As the Brattleboro Retreat is building bed capacity, it would be expected to see a decrease in this trendline in SFY23.

Last updated: February 2023

PM DVHA # detoxificiation admissions to the Brattleboro Retreat



SFY 2022	0	5	-100%
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**	**SFY22**
ACO	17	75	122	152	35	0
Non-ACO	375	270	179	116	16	0
Total	**392**	**345**	**301**	**268**	**51**	**0**

- *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.

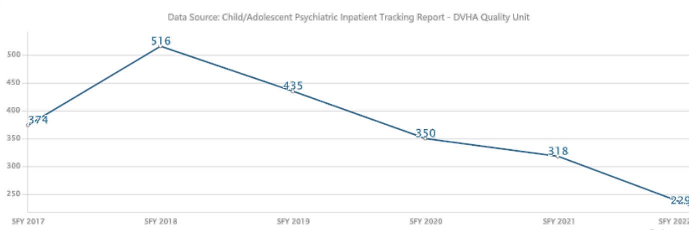
Please note that the non-ACO admissions are authorized by both the Department of Vermont Health Access (DVHA) and the Department of Mental Health (DMH) utilization review clinicians but DO NOT include DMH Level 1 admissions. The UR Teams review all admission notifications within 1 business day of receipt.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

The Retreat provides essential capacity and Medicaid services in Vermont's mental health system of care, serving adults in need of treatment, to include substance use disorder treatment and detoxification. the Retreat supplies 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. The retreat closed its detoxification unit during the pandemic resulting in a decline in admissions down to zero between SFY20 and SFY22. The Retreat is no longer treating members with the primary reason of admission of detoxification. Members in need of detoxification services are being served at other facilities both instate and out of state.

Last updated: February 2023

PM DVHA # of child psychiatric admissions to the Brattleboro Retreat



SFY 2022	229	4	-39%
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	SFY22
ACO	33	132	225	266	243	166
Non-ACO	341	384	210	84	75	63
Total	**374**	**516**	**435**	**350**	**318**	**229**

- *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.

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 and adolescents in need of treatment. The Retreat supplies 100% of Vermont's children's mental health inpatient.

Vermont's mental health system was rendered even more fragile due to the PHE. The trendline above shows a decrease in total admissions in SFY20, SFY21 and SFY22.The impact of COVID-19 significantly threatened the Retreat's ability to provide mental health care to Vermonters. The Retreat closed beds during the height of the pandemic, therefore reducing capacity. Staff and members contracted COVID causing the Retreat to hold admissions and postpone discharges. There was an increase in the length of stay due to almost all out of state programs having a hold on admissions for children and adolescents. The Interstate Compact Placement of Children (ICPC) process was temporarily shut down. Residential programs in Vermont for children and adolescents experienced overall reduced capacity. These longer stays meant that fewer beds were available for new admissions. Additionally, there was a statewide shortage of mental health providers, impacting number of members who could be served. The Retreat is working to build capacity to include hiring and training staff and has specifically expanded beds for children and adolescents. With the increase in bed capacity, it is expected to see the trendline increase in total number of admissions.

Last updated: February 2023

Actions

Name	Assigned To	Status	Due Date	Progress

IFS Performance Measures for CMS - FY22

***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 was 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.

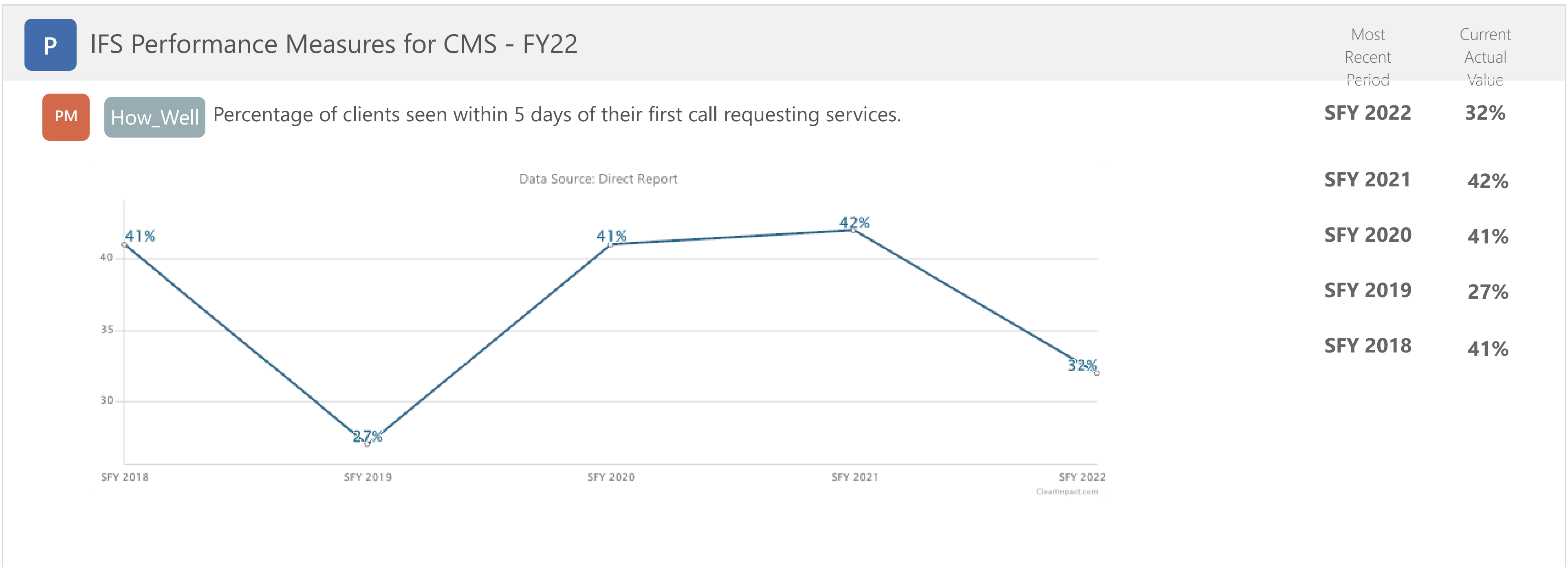
What IFS offers (Activities): IFS offers families an expanded array of service domains, including: mental and behavioral health, developmental disabilities, and substance use. Services include the following Medicaid State Plan and Demonstration services: Section 1115 Demonstration Services: specialized 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 state requirements for performance measurement in accordance with the broader scope of services included in those regions.

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

Current status of the mental health system: The toll the pandemic has taken on everyone is profoundly felt by the mental health staff in Vermont as they respond to others while managing their own experience of trauma. Vacancy rates were at 22% in FY18 and they are now at 33.6%. This is impacting service delivery for individuals, children, and families.



Story Behind the Curve

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

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

For both of these agencies, as is true for the entire designated mental health system in Vermont, there is a workforce crisis which is impacting services being available.

Partnerships

- Northwestern Counseling and Support Services (NCSS)
- Counseling Service of Addison County (CSAC)

Notes on Methodology

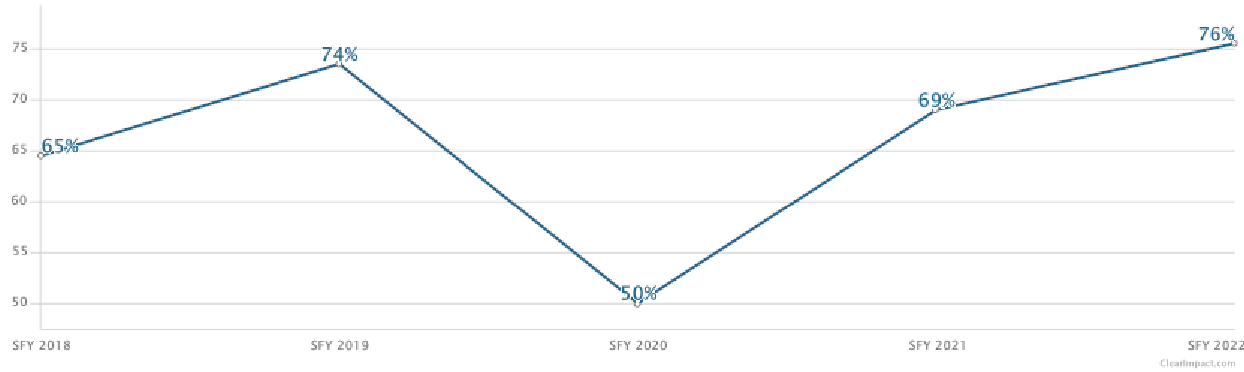
The definition of first call is when contact with the client/family themselves has been made and they have stated they would like or need services.

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

Denominator: Total number of inactive clients requesting services.

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

PM How_Well Percentage of eligible clients with a CANS administered



SFY 2022	**76%**
SFY 2021	**69%**
SFY 2020	**50%**
SFY 2019	**74%**
SFY 2018	**65%**

Story Behind the Curve

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

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

Partners

- Northwestern Counseling and Support Services (NCSS)

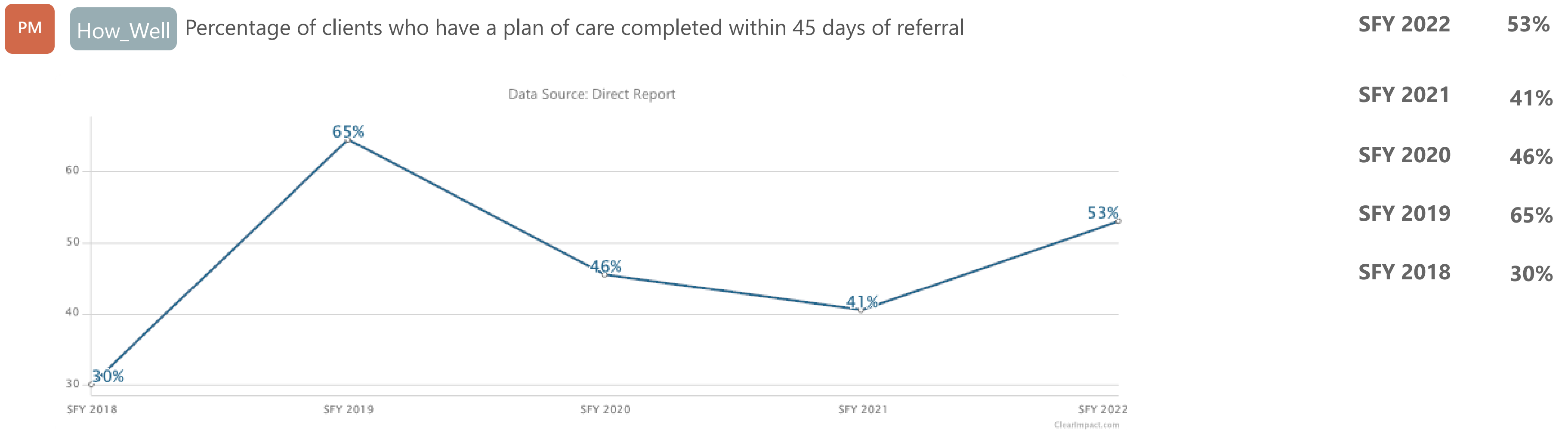
- Counseling Service of Addison County (CSAC)

Notes on Methodology

Numerator: All children with a first CANS administered

Denominator: All children eligible for a CANS receiving services

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



Story Behind the Curve

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

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

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 across the system of care.

Partners

- Northwestern Counseling and Support Services (NCSS)
- Counseling Service of Addison County (CSAC)

Notes on Methodology

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

Denominator: All children eligible for a plan of care

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.

Blueprint All-Payer PCMH

Blueprint PCMH

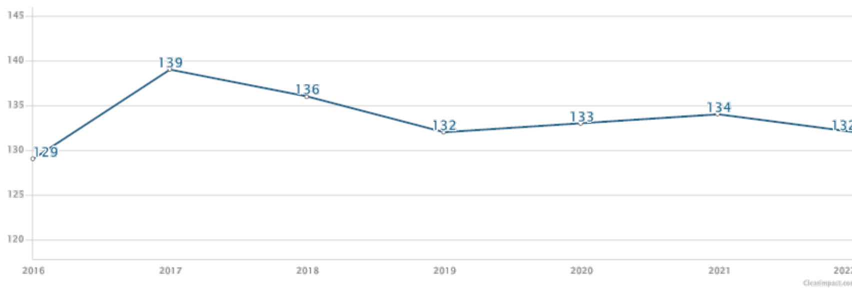
What We Do

The Vermont Blueprint for Health is a nationally recognized initiative that designs community-led strategies for improving health and well-being. The Blueprint invests in and supports Patient-Centered Medical Homes, Community Health Teams, the Women's Health Initiative, Accountable Communities for Health, the Hub & Spoke system of care, Support and Services at Home (SASH), Self-Management and Healthier Living workshops, and a series of learning collaboratives for communities and teams. Blueprint interventions have been shown to maintain or improve health outcomes while controlling growth in health care costs. Of note, the first three have payment models authorized under Vermont's Global Commitment to Health 1115 waiver.

The Patient-Centered Medical Home model utilizes a per patient per month base payment to incentivize primary care practices to be recognized as patientcentered medical homes by the National Committee for Quality Assurance (NCQA). This payment also includes performance-based payments for quality and utilization. The quality payment is determined based on the results of four measures that were selected to be representative of outcomes across the lifespan (developmental screenings that occur within the first three years of life, adolescent well-care visits, and the management of 2 chronic conditions: hypertension and diabetes).

Measures

PM PCMH All-Payer PCMH: Number of primary care practices participating in the Blueprint as PCMHs.



Most Recent Period	Current Actual Value	Current Target Value	Current Trend
2022	132		1
2021	134		2
2020	133		1
2019	132		2
2018	136		1
2017	139		2
2016	129		1
2015	124		1

Story Behind the Curve

These are practices who meet the NCQA standard of a patient-centered medical home (PCMH) and participate in Blueprint initiatives. This measure is fundamental in assessing the reach of the Blueprint program. As larger numbers of practices are qualified as PCMHs and supported by Blueprint payments, increasing numbers of Vermonters should have access to high quality primary care.

The Blueprint has approached a saturation point where the program has recruited most of the available primary care practices in the state with more than 1 provider, and the rate of onboarding of new practices has generally plateaued. Program expansion is continuing due to the outreach efforts of the Blueprint QI Facilitators, who are making a coordinated effort to reach primary care practices in their communities that have not participated in the Blueprint as a patient-centered medical home in the past. Generally, the practices that are continuing to join the Blueprint are independent and naturopathic practices.

Partners

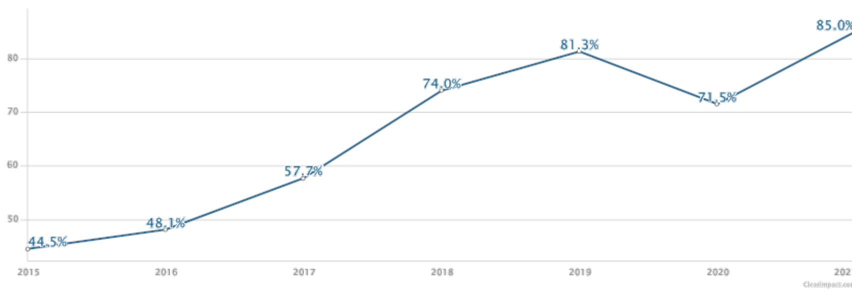
The Local Blueprint Transformation Network, which includes:

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

Notes on Methodology

The number of participating practices per quarter is generated from data stored in the Blueprint portal (https://vitl.knack.com/blueprint-portal-at-vitl). The Blueprint Data Analyst manages information stored in the Blueprint portal.

PM PCMH All-Payer PCMH: Percent of Blueprint PCMH Patients With Clinical Measures in Vermont Clinical Registry Extract.



2021	85.0%	1
2020	71.5%	1
2019	81.3%	4
2018	74.0%	3
2017	57.7%	2
2016	48.1%	1
2015	44.5%	1
2014	44.9%	0

Story Behind the Curve

This measure is an indicator of the effectiveness of the HIE to aggregate data and the effectiveness of the clinical registry to populate clinical measures. This measure also reflects the ability of EHR systems to send structured data in Clinical Continuity Documents (CCDs) or via FHIR. These data can be used to enhance patient care and inform improvements throughout the system.

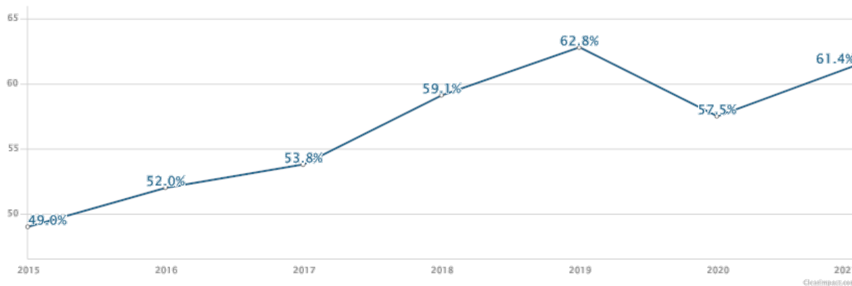
Partners

- Vermont Information Technology Leaders (VITL)
- Capitol Health Associates (until 12/31/2019)
- Electronic Health Record (EHR) vendors
- Patient-Centered Medical Homes (PCMHs)
- DVHA HIE/HIT Unit

Notes on Methodology

All-Payer PCMH: Percent of Blueprint PCMH Patients With Clinical Measures in Vermont Clinical Registry Extract. Source is the Onpoint patient-attribution stepdown graphic for clinical data linkage. The denominator is the number of primary care patients attributed to Blueprint Patient-Centered Medical Homes from the VHCURES all-payer claims data, and the numerator is the subset of those patients who could be linked to electronic clinical records and who had machine-readable clinical measures in the clinical data extract.

PM PCMH All-Payer PCMH: HEDIS Adolescent Well-Care Visits (AWC) 12-21 [or WCV 12-21].



2021	61.4%	1
2020	57.5%	1
2019	62.8%	4
2018	59.1%	3
2017	53.8%	2
2016	52.0%	1
2015	49.0%	1
2014	49.0%	0

Story Behind the Curve

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

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

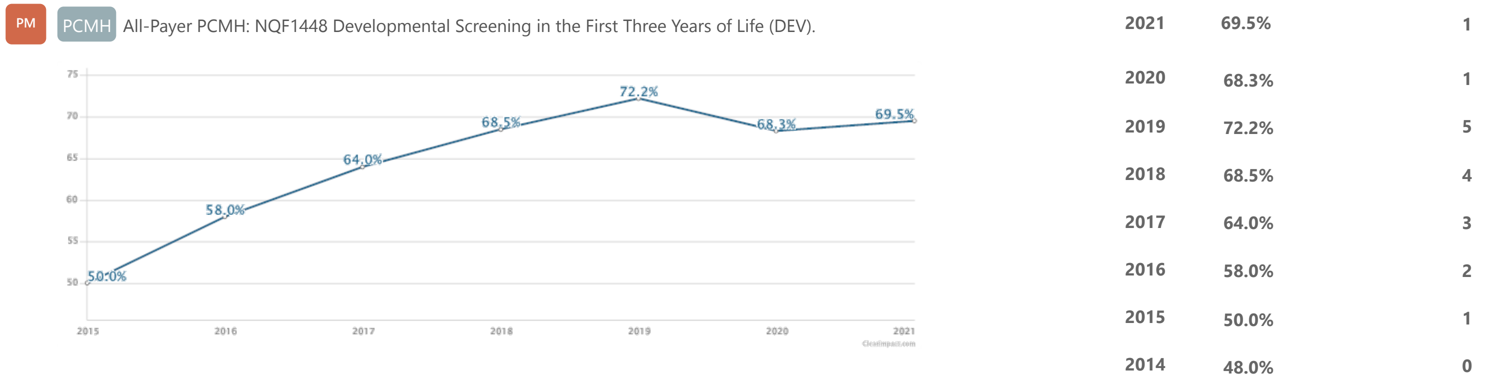
The Blueprint implemented the pay-for-performance model on this measure in January 2016. This measure was chosen for payment because it reflected a priority of the provider network (ACO) in Vermont, it could be generated at the Health Service Area level using Vermont's centralized data source without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

Partners

- The local Blueprint Transformation Network, which includes: QI Facilitators, Community Health Team leaders, and Project Managers
- Staff at Blueprint Patient-Centered Medical Homes

Notes on Methodology

All-Payer PCMH: HEDIS Adolescent Well-Care Visits (AWC) 12-21 [or WCV 12-21]. Statewide value. Population is attributed patients of Patient-Centered Medical Homes (PCMHs). Used as a Blueprint performance payment measure at the hospital service area level. The statewide average percentage of the Adolescent Well-Child Visit performance measure was generated by Onpoint Health Data, the statewide administrator of the All-Payer Claims Dataset. Onpoint updated this measure every six months, accounting for the next 6-month time period. The statewide average percentage of the Adolescent Well-Child Visit performance measure is a claim-based measure pertaining only to a subset of the Vermont population: insured patients who received the majority of their primary care from a Blueprint practice. This measure is not a Vermont population-level estimate.



2021	69.5%	1
2020	68.3%	1
2019	72.2%	5
2018	68.5%	4
2017	64.0%	3
2016	58.0%	2
2015	50.0%	1
2014	48.0%	0

Story Behind the Curve

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

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

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

Partners

- The local Blueprint Transformation Network, which includes: QI Facilitators, Community Health Team leaders, and Project Managers
- Staff at Blueprint Patient-Centered Medical Homes (PCMHs)
- Vermont Department of Health

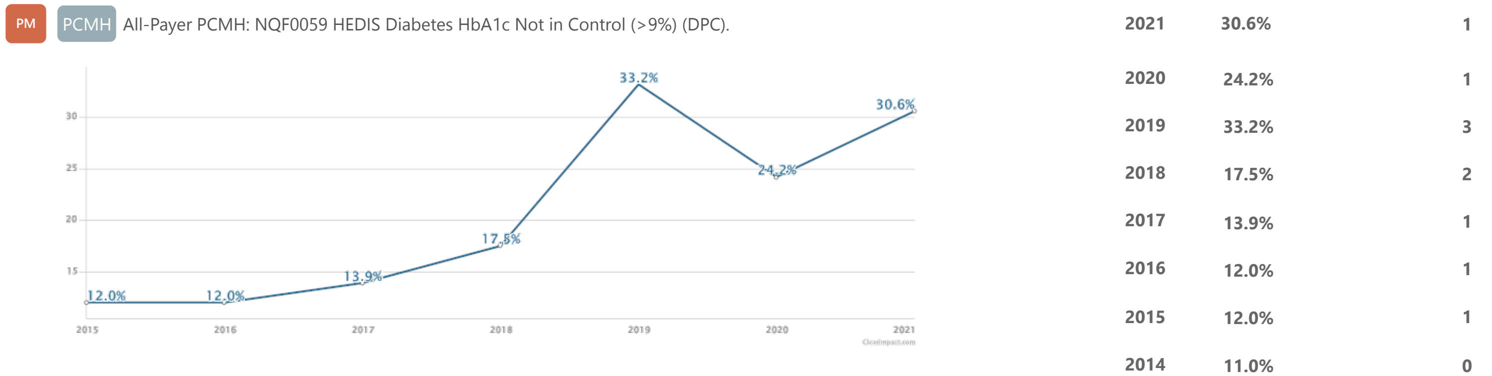
- Vermont Child Health Improvement Program

Notes on Methodology

All-Payer PCMH: NQF1448 Developmental Screening in the First Three Years of Life (DEV). Statewide value. Population is attributed patients of Patient-Centered Medical Homes (PCMHs). Used as a Blueprint performance payment measure at the hospital service area level. The statewide average percentage of the Developmental Screening in the First Three Years of Life performance measure was generated by Onpoint Health Data, the statewide administrator of the All-Payer Claims Dataset.

The statewide average percentage of the Developmental Screening in the First Three Years of Life performance measure is a claim-based measure pertaining only to a subset of the Vermont population - insured patients who received the majority of their primary care from a Blueprint practice. This measure is not a Vermont population-level estimate.

PM PCMH All-Payer PCMH: NQF0059 HEDIS Diabetes HbA1c Not in Control (>9%) (DPC).



2021	30.6%	1
2020	24.2%	1
2019	33.2%	3
2018	17.5%	2
2017	13.9%	1
2016	12.0%	1
2015	12.0%	1
2014	11.0%	0

Story Behind the Curve

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

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

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

The community health team staff will assess and track the effectiveness of the outreach by performing in-depth chart reviews and ensuing notification of follow-up appointments and referrals.

Partners

- The local Blueprint Transformation Network, which includes: QI Facilitators, Community Health Team leaders, and Program Managers
- Staff at Blueprint Patient-Centered Medical Home

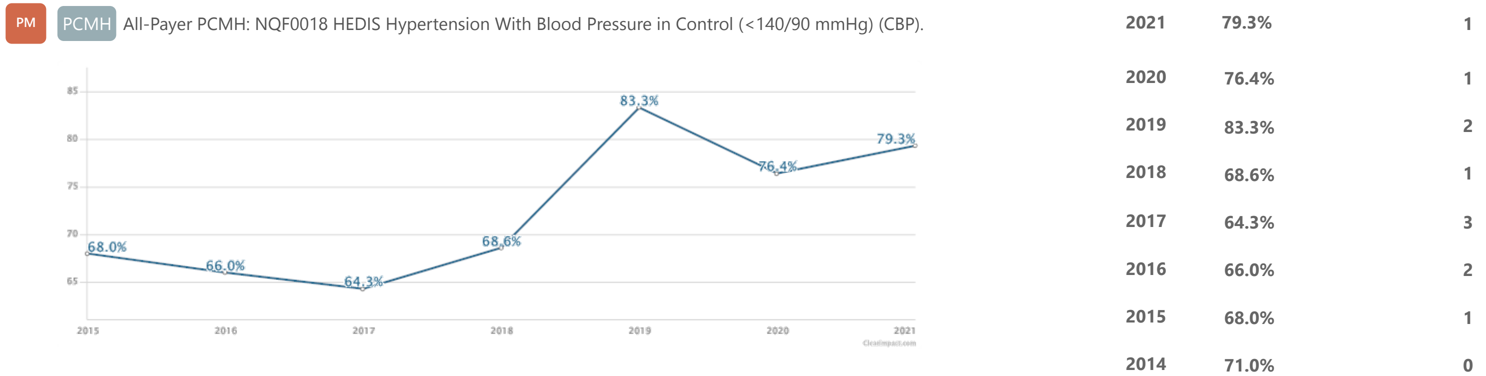
Notes on Methodology

All-Payer PCMH: NQF0059 HEDIS Diabetes HbA1c Not in Control (>9%) (DPC). Statewide value. Population is attributed patients of Patient-Centered Medical Homes (PCMHs). Used as a Blueprint performance payment measure at the hospital service area level.

The statewide average percentage of the Diabetes in Poor Control performance measure was generated by Onpoint Health Data, the statewide administrator of the All-Payer Claims Dataset (APCD). Onpoint linked claims in the APCD to clinical records extracted from the Vermont clinical registry. The statewide average percentage of the Diabetes in Poor Control performance measure relies on data from the state's Clinical Registry and therefore is influenced when practices interrupt their data feed to the Clinical Registry. The outcomes described here are estimated using data only from individuals for whom claims data could be linked with valid Clinical Registry data. This non-random sampling variability is not accounted for in the measure.

Starting in 2019, a methodology changed was made when Onpoint generated the data, where they began to look at clinical data as well as claims for patients with an Hba1c result > 9. This means more patients are found with Hba1c > 9, so the percentage increased from 2018 to 2019. Prior to 2019, the numerator did not include claims data, only clinical data, therefore the percentage was lower.

PM PCMH All-Payer PCMH: NQF0018 HEDIS Hypertension With Blood Pressure in Control (<140/90 mmHg) (CBP).



2021	79.3%	1
2020	76.4%	1
2019	83.3%	2
2018	68.6%	1
2017	64.3%	3
2016	66.0%	2
2015	68.0%	1
2014	71.0%	0

Story Behind the Curve

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

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

Partners

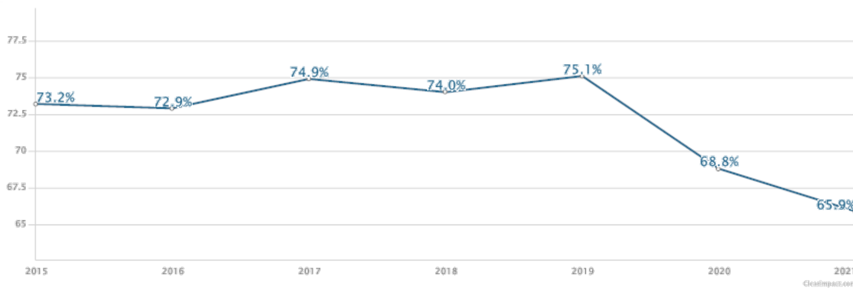
- The local Blueprint Transformation Network, which includes: QI Facilitators, Community Health Team leaders, and Program Managers
- Staff at Blueprint Patient-Centered Medical Homes
- Vermont Department of Health
- OneCare Vermont
- Support and Services at Home (SASH)
- New England Quality Innovation Network-Quality Improvement Organization
- Community Health Accountable Care, LLC
- Vermont Program for Quality in Health Care, Inc.

Notes on Methodology

All-Payer PCMH: NQF0018 HEDIS Hypertension With Blood Pressure in Control (<140/90 mmHg) (CBP). Statewide value. Population is attributed patients of Patient-Centered Medical Homes (PCMHs). Used as a Blueprint performance payment measure at the hospital service area level.

The statewide average % for the Blood Pressure in Control performance measure was generated by Onpoint Health Data, the statewide administrator of the All-Payer Claims Dataset. Onpoint linked claims in the APCD to clinical records from the Vermont clinical registry. The statewide average percentage of the Hypertension in Control performance measure relies on data from the state's Clinical Registry and therefore is influenced when practices interrupt their data feed to the Clinical Registry. The outcomes described here are estimated using data only from individuals for whom claims data could be linked with valid Clinical Registry data. This non-random sampling variability is not accounted for in the measure.

PM PCMH All-Payer PCMH: Percent of Primary Care Patients Attributed to PCMHs. 2021 65.9% 2



2020	68.8%	1
2019	75.1%	1
2018	74.0%	1
2017	74.9%	1
2016	72.9%	2
2015	73.2%	1
2014	75.9%	0

Story Behind the Curve

This is a measure of the percentage of Vermonters who receive their primary care from a Blueprint PCMH from the population of VHCURES members with a primary care visit.

PCMHs provide top-quality primary care centered on several key evidence-based standards. By increasing the percentage of Vermonters who receive their primary care through PCMHs, we are increasing access to high quality care and the opportunity for improved health outcomes.

Partners

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

Notes on Methodology

All-Payer PCMH: Percent of Attributed Primary Care Patients Attributed to Patient-Centered Medical Homes (PCMHs). Source is the Onpoint patient-attribution stepdown graphic for clinical data linkage. The denominator is the number of members in the VHCURES all-payer claims dataset who were attributed to any primary care provider. The numerator is the number of primary care patients who were attributed to Blueprint Patient-Centered Medical Homes. This percentage was generated by Onpoint Health Data, the statewide administrator of VHCURES.

Strategies

Name	Assigned To	Status	Due Date	Progress

P **Blueprint GC WHI**

Blueprint WHI

What We Do

The Vermont Blueprint for Health is a nationally recognized initiative that designs community-led strategies for improving health and well-being. The Blueprint invests in and supports Patient-Centered Medical Homes, Community Health Teams, the Women's Health Initiative, Accountable Communities for Health, the Hub & Spoke system of care, Support and Services at Home (SASH), Self-Management and Healthier Living workshops, and a series of learning collaboratives for communities and teams. Blueprint interventions have been shown to maintain or improve health outcomes while controlling growth in health care costs. Of note, the first three have payment models authorized under Vermont's Global Commitment to Health 1115 waiver.

The Women's Health Initiative includes 3 types of payments designed to incentivize Women's Health practices, and patient-centered medical homes providing women's health services, to provide high quality, integrated, and well-coordinated preventative care for women aged 15-44. Participating practices implement enhanced psychosocial screening and evidence-based interventions for depression, substance use disorder, interpersonal violence, housing instability, and food insecurity are provided by Women's Health Initiative-funded licensed mental health clinicians. Participating practices also offer comprehensive family planning services and increase access to long acting reversible contraceptives when chosen by the patient and clinically appropriate (by removing barriers that frequently
prevent patients from being able to access these devices). As a result, measures that are indicative of access to care and preventative care were chosen to evaluate the overall impact of the Women's Health Initiative.

Measures

Measure	Most Recent Period	Current Actual Value	Current Target Value	Current Trend
PM WHI Medicaid: NQF0033 HEDIS Chlamydia Screening in Women, 16-24y (CHL)	2020	46.5%		2
	2019	53.0%		1
	2018	54.2%		2
	2017	53.2%		1
	2016	50.8%		1
	2015	52.5%		1
	2014	49.8%		1
	2013	50.6%		0

Data Source: Administrative Claims

Story Behind the Curve

In 2018 and 2019, the Blueprint for Health worked with DVHA's Quality Unit, the Vermont Department of Health, and Planned Parenthood of Northern England to identify strategies to improve chlamydia screening rates in Women's Health Initiative participating practices.

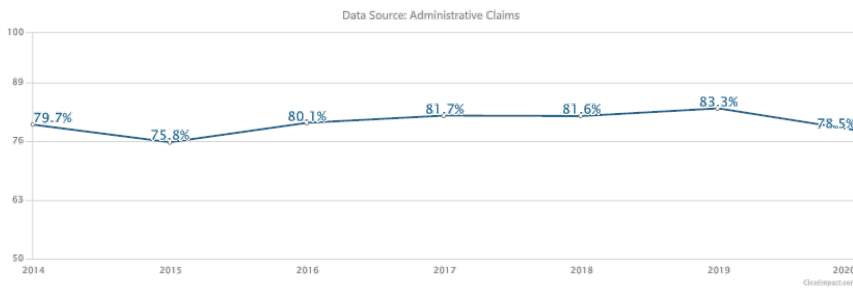
Partners

1. DVHA Quality Unit
2. VT Department of Health
3. Planned Parenthood of Northern New England

Notes on Methodology

The population sample for this measure consists of Medicaid-primary members, over 70% of whom are attributed to patient-centered medical homes. This measure shows the percentage of female members, ages 16 to 24, identified as sexually active and who had at least one test for chlamydia in the measurement year. This measure is derived from claims data.

Measure	Most Recent Period	Current Actual Value	Current Target Value	Current Trend
PM WHI Medicaid: HEDIS Adults' Access to Preventive/Ambulatory Health Services (AAP)	2020	78.5%		1



2019	83.3%	1
2018	81.6%	1
2017	81.7%	2
2016	80.1%	1
2015	75.8%	2
2014	79.7%	1
2013	87.3%	0

Story Behind the Curve

This measure looks at whether adult members receive preventive and ambulatory services. It looks at the percentage of Vermont adults with Medicaid who have had a preventative or ambulatory visit to their physician. Consider the other side of this measure: How many patients never access the system? If they never access the healthcare system, how does preventive care and counseling (diet, exercise, smoking cessation, seat belt use, etc.) occur? This measure is an indicator as to whether there may be barriers to our beneficiaries accessing preventive care.

Partners

1. DVHA Quality Unit
2. VT Department of Health
3. Planned Parenthood of Northern New England

Notes on Methodology

The population sample for this measure consists of Medicaid-primary members, over 70% of whom are attributed to patient-centered medical homes. This measure shows the percentage of Medicaid-primary members 20 years and older who had an ambulatory or preventive care visit during the measurement year.

This is a Healthcare Effectiveness & Data Information Set (HEDIS) administrative measure.

Based on the advice of their External Quality Review Organization (EQRO), DVHA's rates include only Medicaid Primary beneficiaries in HEDIS administrative measures as of 2014.

Strategies

Name	Assigned To	Status	Due Date	Progress

P

Blueprint GC CHT

Blueprint CHT

What We Do

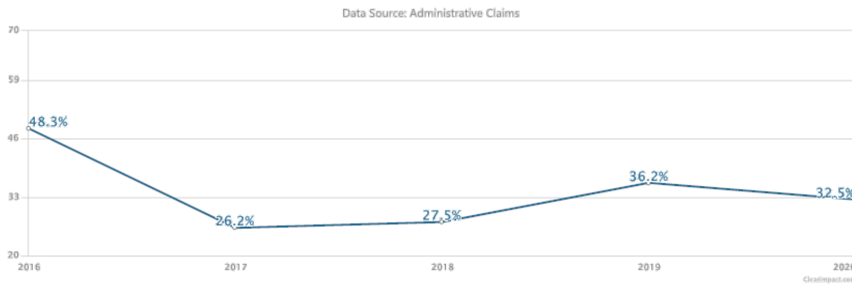
The Vermont Blueprint for Health is a nationally recognized initiative that designs community-led strategies for improving health and well-being. The Blueprint invests in and supports Patient-Centered Medical Homes, Community Health Teams, the Women's Health Initiative, Accountable Communities for Health, the Hub & Spoke system of care, Support and Services at Home (SASH), Self-Management and Healthier Living workshops, and a series of learning collaboratives for communities and teams. Blueprint interventions have been shown to maintain or improve health outcomes while controlling growth in health care costs. Of note, the first three have payment models authorized under Vermont's Global Commitment to Health 1115 waiver.

Community Health Teams partner with patient-centered medical homes, hospital systems, health care and social service organizations to supplement the services available in primary care, support coordinated care, and promote prevention and wellness. A per patient per month payment is made to regional entities accountable for managing ongoing Community Health Team operations, including hiring and management of staffing, in order to meet identified community health priorities while offering services that are available for patients to access with minimal barriers (no eligibility requirements, prior authorizations, referrals or co-pays). Measures used to evaluate the overall impact of the Community Health Teams are representative of the provision of coordinated care in each region (follow-up after discharge from the emergency department for mental health or substance use disorders and patient experience of coordinated care composite).

Measures

PM CHT Medicaid: NQF3488 HEDIS Emergency Dept Visits for Substance Use Disorder, 30-Day % With Follow-Up (FUA)

Most Recent Period	Current Actual Value	Current Target Value	Current Trend
2020	32.5%		1
2019	36.2%		2
2018	27.5%		1
2017	26.2%		1
2016	48.3%		0



Story Behind the Curve

In support of people with substance use disorders, Vermont has committed to expanding access to treatment and services that can address factors contributing to these disorders, in much the same way that other chronic conditions are managed. This effort requires coordination and partnership among social, medical, and mental health providers. Community Health Teams play a critical role in this coordination and navigating individuals to the most appropriate level of treatment and support services. Following up with individuals who have an Emergency Department visit due to substance use is an important point of contact and an opportunity to engage a person in treatment if needed. Measuring whether this contact is made is one way to monitor the Community Health Team's engagement in the health care system. The population for this measure consists of Medicaid-primary members, over 70% of whom are attributed to patient-centered medical homes, and who therefore have access to Community Health Teams. One factor that could have affected the outcomes was the reinstatement of eligibility redetermination after 2016, which led to a number of individuals (often healthier and younger) removed from the Medicaid rolls, thereby changing the composition of the Medicaid population. Community Health Teams, in collaboration with practices, OneCare Vermont, and community-based services, continue to work on strategies to address improving these rates.

Partners

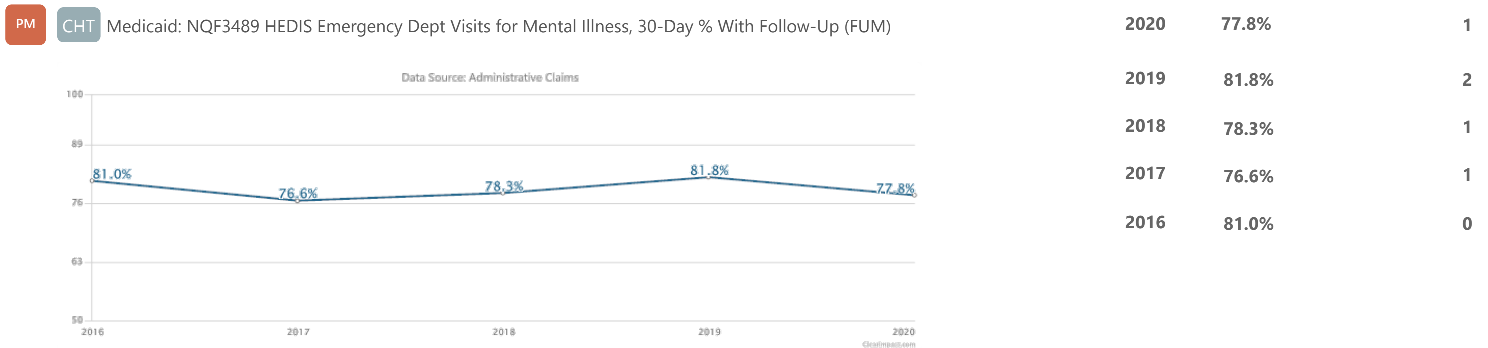
1. Patient-Centered Medical Homes
2. Community Health Teams
3. Vermont Department of Health
4. Green Mountain Care Board

5. OneCareVermont

Notes on Methodology

The population sample for this measure consists of Medicaid-primary members, over 70% of whom are attributed to patient-centered medical homes, and who therefore have access to Community Health Teams. The red dot on the graph represents the target value the State aims to achieve by the year 2022 for this measure as outlined in the Vermont All-Payer ACO model Agreement. The solid blue trend line represents the actual data values for Medicaid-primary members.

This HEDIS measure shows the percent of emergency department (ED) visits for members, age 18 years and older, with a principal diagnosis of substance use disorder who had a follow-up visit for substance use disorder within 30 days of the ED visit. (NQF #3488)



2020	77.8%	1
2019	81.8%	2
2018	78.3%	1
2017	76.6%	1
2016	81.0%	0

Story Behind the Curve

The population for this measure consists of Medicaid-primary members, over 70% of whom are attributed to patient-centered medical homes, and who therefore have access to Community Health Teams. While the Community Health Team payments are not dependent on performance measurement, the Blueprint for Health closely follows this measure to identify service areas that that may benefit from additional assistance to improve this measure. One factor that could have affected outcomes was the reinstatement of eligibility redetermination after 2016, which led to a number of individuals (often healthier and younger) removed from the Medicaid rolls, thereby changing the composition of the Medicaid population. Nevertheless, the state continues to work on improving how people with mental health conditions move through the system and receive the services they need. To do so requires coordination and partnership among social, medical, and mental health providers. Community Health Teams play a critical role in this coordination and navigating individuals to the most appropriate level of treatment and support services. Following up with individuals who have an Emergency Department visit due to mental health is an important point of contact and an opportunity to engage a person in treatment if needed. Measuring whether this contact is made is one way to monitor the Community Health Team's engagement in the health care system.

Partners

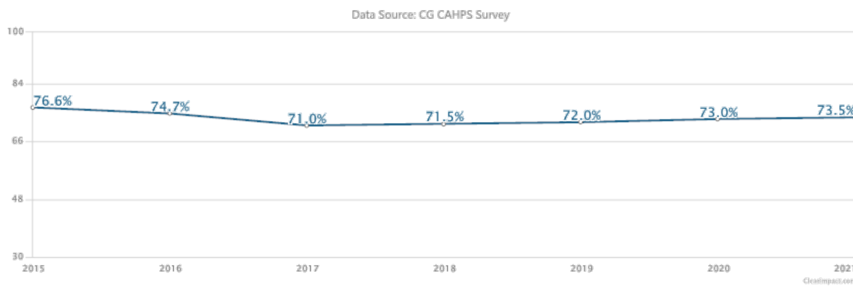
1. Patient-Centered Medical Homes
2. Community Health Teams
3. Vermont Department of Health
4. Green Mountain Care Board
5. OneCareVermont

Notes on Methodology

The population sample for this measure consists of Medicaid-primary members, over 70% of whom are attributed to patient-centered medical homes, and who therefore have access to Community Health Teams. The red dot on the graph represents the target value the State aims to achieve by the year 2022 for this measure as outlined in the Vermont All-Payer ACO model Agreement. The solid blue trend line represents the State's actual values for Medicaid-primary members.

This measure shows the percent of emergency department (ED) visits for members, age 18 years and older, with a principal diagnosis of mental illness who had a follow-up visit for mental health within 30 days of the ED visit. (NQF #3489)

PM CHT Medicaid: % of Patients Responded Yes or Always to Coordinated Care Composite, CG CAHPS Survey



2021	73.5%	4
2020	73.0%	3
2019	72.0%	2
2018	71.5%	1
2017	71.0%	2
2016	74.7%	1
2015	76.6%	1
2014	75.0%	0

Story Behind the Curve

How patients experience their care is a core element in assessing the quality of their care. As the state of Vermont works to increase integration and coordination across medical and community services, supported by Community Health Teams, to improve health outcomes and reduce unnecessary or duplicative care, the state needs to understand whether patients are seeing the results of these efforts in their own experience.

This measure shows the percent of respondents who reported that their primary care provider was always up-to-date on and discussed with them the care received from specialists, prescription medicines they were taking, and/or tests they had received. More work can be done to improve this measure. Shifting this trend involves continual improvement in person-to-person communication, practice workflows, and information technology. While the community health team payments are not dependent on performance measurement, the Blueprint for Health closely follows this measure to identify service areas that that may benefit from additional assistance to improve this measure.

Partners

1. Patients
2. Patient-Centered Medical Homes
3. DVHA Payment Reform Unit
4. Green Mountain Care Board
5. OneCare Vermont

Notes on Methodology

The Department of Vermont Health Access annually administers CG CAHPS survey with PCMH supplemental questions to patients of patient-centered medical homes. All practices are offered the option to participate, and typically more than 75% do. Of note, almost all primary care practices in the state are recognized as patient-centered medical homes. This measure represents responses from patients covered by all major payers, including Medicare and commercial, and is therefore not Medicaid specific.

Strategies

Name	Assigned To	Status	Due Date	Progress